arrow
asian-pacific resource & research centre for women

Universal Access to Sexual and Reproductive Health and Rights

REGIONAL PROFILE: ASIA

Universal Access to Sexual and Reproductive Health and Rights

REGIONAL PROFILE: ASIA

arrow
asian-pacific resource & research centre for women

UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN ASIA: A REGIONAL PROFILE

ISBN 978-967-0339-27-6

Asian-Pacific Resource and Research Centre for Women (ARROW)

1 & 2 Jalan Scott, Brickfields 50470, Kuala Lumpur, Malaysia

Telephone (603) 2273 9913/9914/9915
Fax (603) 2273 9916
E-mail arrow@arrow.org.my
Web www.arrow.org.my
Facebook The Asian-Pacific Resource & Research Centre for Women (ARROW)
Twitter @ARROW_Women
Youtube youtube.com/user/ARROWomen
Pinterest arrowomen

Production Team

Overall Supervision Sivananthi Thanenthiran
Production Coordinators Yukari Horii & Mangala Namasivayam
Author Arpita Das
External Reviewer Sundari Ravindran
Internal Reviewers Maria Melinda Ando, Mangala Namasivayam, & Tabinda Sarosh
Copy Editor Aleah Taboclaon
Graphic Design Nicolette Mallari
Cover Photo Credit Eduardo Lopez/Shutterstock

CONTENTS

LIST OF BOXES AND TABLES

Introduction

In 2016, the Asia-Pacific region is home to approximately 4.3 billion people, equivalent to approximately 60 percent of the world population.[1] It is a very significant region to focus on as it includes a large number of developing countries with poor development and health indicators. As we reached the end of the Millennium Development Goals (MDGs) period in 2015 and looked ahead to the onset of a brand-new set of goals that the world had committed to achieve in the 2030 Agenda, it is crucial to acknowledge that we have our work cut out for us. The Global South, especially the Asia-Pacific region, continues to show very poor indicators related to poverty, employment, education, and health. While economic growth remained steady in Asia and the Pacific, it has been uneven across the region and within countries, where income inequalities continue to increase especially in developing countries. While the number of people living in this region who are poor (i.e., living on less than US$1.25 a day) has fallen, the world's poor remain overwhelmingly concentrated in these parts of the world where many people continue to be amongst the poorest of the poor, with women and girls constituting the majority.

The development of any region or country could be best gauged by the situation of the marginalised and vulnerable population groups, e.g., women and young young people. It is therefore extremely important to study these population groups' access to health services, including sexual and reproductive health. As we monitor this, the focus also needs to be on the fulfilment of these groups' sexual and reproductive rights.

Since the year 2015 has been crucial in evaluating the gains and losses after the International Conference on Population and Development (ICPD) Cairo agenda and in reformulating the next set of sustainable development goals (SDGs), it is also timely to highlight the specific gains and losses on sexual and reproductive health and rights (SRHR). Do governments in the Global South understand the significance of attaining SRHR goals for all? What are the specific ways in which the (in)action of the governments and states affect marginalised communities including women and young people? These are some of the questions that we at the Asian-Pacific Resource and Research Centre for Women (ARROW) hope to address through this report.

Evidence-generation and monitoring of SRHR has been one of the primary aspects of ARROW's work. ARROW has been monitoring the progress made (or lack thereof) in the Asia-Pacific region since ICPD. Towards this, we—along with our partners—have generated reports looking at data every five years. In the last few years, ARROW's role has also been instrumental in monitoring SRHR indicators in five regions of the Global South, including the Middle East and North Africa, Latin America and the Caribbean, the Central Eastern European region, the African region, and the Asia-Pacific region. These monitoring reports have not only been vital in measuring the gaps and successes since ICPD on SRHR, but also helped look at similarities and differences across regions, as well as collectively advocate for SRHR issues across the Global South. These have been used to hold governments, both at the national and local levels, accountable to the needs and concerns of the people. These reports have also helped focus on specific SRHR issues related to women and young people that are most often ignored in policy spaces.

This regional profile is an effort in this direction in once again highlighting indicators related to sexual and reproductive health (SRH) and sexual and reproductive rights (SRR) across the 15 countries in the region.

Methodology

This report looks at the status of SRHR within the following countries in Asia: Bangladesh, Cambodia, China, India, Indonesia, Lao PDR, Malaysia, Maldives, Mongolia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Vietnam. ARROW, together with partners in these countries, have come together to promote SRHR for all.[2] Given the diversity and heterogeneity of the region in terms of socio-economic development, demography, geography, culture, and religion, however, wide disparities exist within as well as amongst countries, which are hidden in these statistics of regional average. The attempt of this report is to synthesise information on SRHR across the 15 countries that can be used as a tool for advocacy within the region and to make SRHR a priority for the

post-2015 agenda. For country-specific information, refer to the national SRH and SRR profiles[3] developed by these partners.

SRHR is defined by two key concepts: the right to make decisions on reproduction and sexuality free from discrimination, coercion, and violence; and the right to the highest standard of sexual and reproductive health (SRH). Through this regional profile, we aim to look at a variety of factors concerning SRHR. In the first section of the report, we provide a broad overview of international human rights declarations and the adherence of these 15 countries towards these declarations and conventions. While agreement to adhere to some of these declarations and conventions shows commitment on the part of countries to follow these international conventions, merely ratifying them is hardly enough for real development to take place.

In the second section, we focus on looking at specific issues related to SRH, including access to interventions and services on maternal health, access to skilled birth attendance, antenatal and postpartum care, and emergency obstetric care. We also look at access to information and services related to contraception and abortion. In addition, we also discuss specific issues related to HIV and AIDS.

In the third section, we progress to look at issues of sexual and reproductive rights (SRR), focusing on laws, policies, and incidences related to early and child marriages. In addition, we also examine the presence of laws and policies to prevent gender-based violence including laws related to rape and sexual assault. While there may be sound laws and policies in certain countries, through this report we also aim to highlight the status of implementation of such laws

DEFINITIONS

Reproductive Health
Reproductive health implies that people are able to have a responsible, satisfying, and safe sex life, and that they have the capacity to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed of and have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of a healthy infant (WHO).

Reproductive Rights
Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These 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. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (ICPD).

Sexual Health
Sexual health implies a positive approach to human sexuality and the purpose of sexual healthcare is the enhancement of life and personal relations as well as counselling and care related to reproduction and sexually transmitted diseases (adapted, UN).

Sexual Rights
Sexual rights embrace human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These include the right of all persons, free of coercion, discrimination, and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decision to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe, and pleasurable sexual life (WHO working definition).

Source: Asian-Pacific Resource and Research Centre for Women (ARROW). 2009. Reclaiming and Redefining Rights. ICPD +15: Status of Sexual and Reproductive Health and Rights in Asia. *Kuala Lumpur: ARROW.*

and policies. People of diverse sexual orientations and gender identities face additional challenges including discrimination from society as well as their families. In this section of the report, we therefore aim to look at the presence of anti-discrimination laws and policies for people of diverse sexual orientations and gender identities.

While the relevant services may be present in some of the countries, these may not be easily accessible for young people, especially for those who may not be married or adhere to standards of heteronormativity. The mere presence of these services is not going to suffice unless they are affordable, non-discriminatory, have a standard of quality, are geographically spread out to rural, urban, and semi-urban areas, and are monitored and accountable to people via the state. Thus, it is important to highlight the importance of universal access as opposed to universal coverage. Universal health coverage with people obtaining the services they want and benefiting from risk protection cannot happen unless there is universal health access, which is the opportunity and the ability of doing both things.[4]

While we attempt to look at a wide gamut of issues related to SRHR in 15 countries, this is by no means an exhaustive list. Due to constraints of time and space, there are issues that we may not have included. Similarly, there are other country-specific contexts that are of equal concern but do not find a mention in this report because of the scope of this document. This report relies heavily on secondary data and available analyses from 15 country profiles that have been developed for more in-depth discussions on individual contexts and as advocacy tools. Although attempts have been made to include information on all 15 countries in each section, this may not have been uniformly possible because of lack of uniform and easily accessible data on all issues being discussed as part of this report. The lack of uniform data on SRHR issues, as well as the lack of reliable and adequate data and information across all countries, adds to the limitations of this study.

DEFINITIONS

Universal Access

Despite its wide acceptance as an objective of health systems, the term *universal access* lacks a clear definition. A commonly used definition of universal access in relation to reproductive health is that information and services are "available, accessible, and acceptable" to meet the different needs of all individuals. The limitation of this definition is the tautological inclusion of the word "access" in the definition of access, which renders it logically untenable. In its broadest sense, universal access implies the ability of those who need healthcare to obtain it. It has also been defined as "the absence of geographic, financial, organizational, socio-cultural and gender-based barriers to care."

Universal Coverage

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

Source: Asian-Pacific Resource and Research Centre for Women (ARROW). 2012. Thematic papers presented at Beyond ICPD and the MDGs: NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional, and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO UNFPA Dialogue for Strategic Engagement. Kuala Lumpur: ARROW.

International Human Rights Instruments

When looking at information on SRHR, it is vital to look at international conventions and treaties that governments in the 15 countries included in this report have ratified and signed on. Neither SRH nor SRR are new rights; both have already been mentioned in existing treaties. The ratification of these international treaties and conventions are important as an indicator of the government's willingness to invest in issues of SRHR, as ratifying obliges them to take steps to show their compliance with the vision of the particular treaties. Ratifying states are also required to report on the implementation of the treaty in their national contexts during the periodic review processes. Different treaties and conventions have different requirements in terms of submission of documents. While ratification may not be enough to indicate implementation of these treaties and conventions in the national contexts, it does allow for activists and advocates to hold their states accountable to the international law.

The Universal Declaration of Human Rights (UDHR), adopted in December 1948, marks the beginning of the transformation of human rights from moral imperatives into rights that are legally recognised. The UDHR lays down the duties of the state and that of individuals. In order to implement the UDHR, two covenants were developed by 1966 and came into effect when a number of countries ratified them in 1976; one dealing with civil and political rights known as the International Covenant on Civil and Political Rights (ICCPR) and another on social and cultural rights known as the International Covenant on Economic, Social, and Cultural Rights (ICESCR).

While some countries, including Cambodia, India, Lao PDR, Nepal, the Philippines, and Thailand, have signed and ratified the ICCPR and the ICESCR, China and Malaysia have not. China signed on to the ICCPR in 1998 but it has yet to ratify it.[5] As for the ICESCR, although China ratified it in 2001, a statement was issued mentioning that the Chinese government will only implement Article 8, Clause 1 of the Covenant within the parameters of the Chinese Constitution, Trade Union Law, and the Labour Law.[6]

TABLE 1: Countries and the Year of Ratification of the ICCPR, ICESCR, CEDAW, and the CRC

	International Convention on Civil and Political Rights (1966)	International Convention on Economic, Social and Cultural Rights (1966)	Convention on the Elimination of all forms of Discrimination Against Women (1979)	Convention on the Rights of the Child (1989)
Country	**ICCPR**	**ICESCR**	**CEDAW**	**CRC**
Bangladesh	2000	1998	1984	1990
Cambodia	1992	1992	1992	1992
China	1998	2001	1980	1992
India	1979	1979	1993	1992
Indonesia	2006	2006	1984	1990
Lao PDR	2009	2007	1981	1991
Malaysia	–	–	1995	1995
Maldives	2006	2006	1993	1991
Mongolia	1974	1974	1981	1990
Nepal	1991	1991	1991	1990
Pakistan	2010	2008	1996	1990
Philippines	1986	1974	1981	1990
Sri Lanka	1980	1980	1981	1991
Thailand	1996	1999	1985	1992
Vietnam	1982	1982	1982	1990

Source: UN OHCHR, "Ratification of 18 International Human Rights Treaties," n.d., http://indicators.ohchr.org/.

Sri Lanka has signed onto the ICCPR, but it has yet to ratify the ICESCR. One reason could be that unlike the civil and political rights that are considered enforceable and immediately applicable, economic and social rights can be implemented progressively (depending on resources and competing claims and priorities of the state). Also, whereas the former are considered the rights of the individual against the state, the latter can be implemented through positive action by the state. It is also considered more contentious.

Many of the countries that we are currently evaluating in this report have ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC), with some even signing up on them earlier than they have signed on to the ICCPR and the ICESCR. The CEDAW provides the basis for realising equality between women and men through ensuring women's equal access and opportunities in political and public life including health and education. It is the only human rights treaty which affirms the reproductive rights of women. The CRC, on the other hand, provides a valuable framework for child health. It is also an important tool for advocacy on sexual and reproductive rights of children, adolescents, and young people (below the age of 18 years), especially with regard to the right to bodily integrity, the right to information related to health and well-being, the right to be free from any kind of violence, and protection from all forms of sexual exploitation and abuse.

Although all of the 15 countries have ratified the documents, many have done so with reservations. For example, China, India, Indonesia, Pakistan, Thailand, and Vietnam consider themselves not bound by paragraph 1 of Article 29 of the convention which outlines that any dispute between two or more states can be submitted for arbitration and if agreement is not reached within six months of the arbitration process, the dispute could be referred to the International Court of Justice. Bangladesh and Malaysia do not consider themselves bound by Article 16 (1)(c), which could conflict with the *Sharia* law in their countries. Bangladesh is also not bound by Article 2 of the convention. Malaysia, in addition, does not consider itself bound to Articles 9(2), 16(1)(a), 16(1)(f), 16(1)(g), and interprets provisions of Article 11 as a reference to the prohibition of discrimination on basis of equality between men and women alone. Malaysia has reservations related to the transmission of citizenship from Malaysian mothers to children born overseas, through polygamy, child marriage, guardianship and custody, and the religious conversion of children when a spouse converts to Islam.[7]

With reference to some other conventions and treaties, countries like China, India, Lao PDR, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Vietnam, and Thailand have not signed on to the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (CMW).[8] In addition, although Cambodia has signed the convention, it has not ratified it. This is also an important convention considering that migration is a reality in many countries, especially in this region, and affects women in direct and indirect ways. The status of SRHR of women migrants is usually poor because of HIV screenings and pregnancy amongst others during or before migration, inadequate access to SRHR services including counselling, and access to maternal health services including contraception and abortion. Further, they often have to face sexual exploitation and abuse without any substantial recourse. These situations are further exacerbated in cases of undocumented women migrant workers.

Sexual and Reproductive Health (SRH)

In this section, we look in depth at a variety of indicators related to sexual and reproductive health, including those related to maternal health, skilled birth attendance, antenatal and postpartum care, availability and accessibility to Emergency Obstetric Care (EmOC), and access to contraception and abortion.

MATERNAL HEALTH INDICATORS

Maternal health refers to a woman's overall physical, mental, and emotional health and well-being during, before, and after pregnancy. Comprehensive services related to maternity care should include high-quality antenatal care that screen mothers for malnutrition, anaemia, sexually transmitted infections (STIs) including HIV and AIDS and other diseases, and educates women about high-risk symptoms. It should also constitute skilled birth attendance during the delivery, emergency obstetric care, and

quality postpartum care and service. Provision of quality care services easily accessible to women can be instrumental in saving women from high-risk conditions, including eclampsia and postpartum haemorrhage.

Maternal mortality is a significant indicator of the progress made by different countries towards development and the recognition of women's health and rights and the attention paid towards mitigating preventable maternal deaths. It points towards the initiative and willingness on the part of several stakeholders, including the government, medical institutions, and civil society organisations to prioritise efforts towards the prevention of maternal deaths. While the number of women dying globally due to pregnancy and childbirth-related complications has reduced by 45 percent between 1990 and 2013, from 380 to 210 deaths per 100,000 live births, the goal of reducing maternal mortality rates (MMR) remains far away.[9] In 2013, approximately 289,000 women died due to preventable maternal mortality during pregnancy, childbirth, or within 42 days of termination of the pregnancy.[10] The situation is far worse in developing nations with a record of 230 maternal deaths per 100,000 live births in 2013, almost 14 times higher than that of developed countries which recorded only 16 maternal deaths per 100,000 live births in the same year.[11]

As per studies, out of the 15 countries under our consideration for this report, only four countries—Cambodia, Lao PDR, Maldives, and Nepal—have been considered early achievers in achieving low MMR as part of the Millennium Development Goals.[12] An overwhelming majority of ten out of 15 countries—Bangladesh, China, India, Indonesia, Malaysia, Mongolia, Pakistan, Sri Lanka, Thailand, and Vietnam—have been considered off-track with making a slow progress, which is expected to improve after 2015.[13] They could achieve it from 2016 to 2020, or from 2021 to 2030, or they might even be unlikely to meet it by 2030. The Philippines is considered to be off-track in achieving this target, with no progress or regression.[14]

SKILLED BIRTH ATTENDANCE

One target of both ICPD+5 and the MDGs is ensuring that 90 percent of all births are assisted by skilled birth attendants, which include doctors, nurses, midwives, and other health workers. Although not all pregnancy complications are preventable, they are better handled in the presence of a skilled birth attendant. "Skilled attendant" refers to an accredited health professional, such as a midwife, doctor, or nurse, who has been educated and trained to possess skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns. Traditional birth attendants, trained or not, are excluded from the category of skilled attendant at delivery.[15] It was agreed at the ICPD in 1994 that all births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. The key actions for further implementation of the PoA of the ICPD noted that countries have to achieve 85 percent skilled attendance by 2010.

Four countries—China, Indonesia, Malaysia, and Sri Lanka—are considered early achievers for the goal of achieving skilled birth attendance. They have already met their target for 2015.[16] Only two countries, Mongolia and Vietnam, appear to be on track to meet the goal by 2015.[17] Eight countries—Bangladesh, Cambodia, India, Lao PDR, Maldives, Nepal, Pakistan, and the Philippines—are considered to be off-track in achieving the goal for SBA and are expected to achieve the target after 2015.[18] Thailand is one of those countries where there has been no progress since 1990 and instead showed indicators of regression.[19]

Several measures are being undertaken throughout the region to reduce MMR and provide incentives to women to seek antenatal services. For example, the substantial decrease in MMR in Nepal has been credited to the country's National Safe Motherhood Programme coupled with the recent policy on skilled birth attendants.[20] In Bangladesh, India, and Pakistan, there have been experiments with providing cash incentives to pregnant women to attend antenatal services for institutional deliveries.[21] However, research is needed to investigate the impact of such programmes. In addition, in Bangladesh, training initiatives have been introduced by the government in midwifery skills including basic emergency obstetric care services to increase the availability of skilled birth attendants.[22]

ANTENATAL CARE

Antenatal care (ANC) coverage is an indicator of access and utilisation of care during pregnancy. It is defined as the percentage of women who utilised antenatal care provided by skilled birth attendants for reasons related to pregnancy at least once during pregnancy amongst all women who gave birth to a live child in a given time period.[23]

The ANC is an important indicator in the promotion of maternal health as it helps detect and manage conditions during pregnancy that can potentially lead to complications and adverse maternal outcomes. It includes measures to predict potential health risks of pregnant women as well as improve maternal health.

The World Health Organisation (WHO) recommends a minimum of four antenatal visits, with an emphasis on the mother's health. This package of four visits, called "focused ANC," includes the identification and management of pregnancy complications, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy, and identification and management of infections, HIV, and other STIs during pregnancy, among other services. It also enhances the chances for skilled birth attendance, natural breastfeeding, and better pregnancy spacing.

Antenatal care coverage has improved over the years with some studies stating that in 2012, 52 percent of pregnant women had four or more antenatal care visits during their pregnancy, an increase of 15 percent from 1990.[24] Despite this, only half of pregnant women in developing countries get the recommended four antenatal check-ups.[25] The proportion of women in developing countries who sought skilled birth attendance at least once during their pregnancy increased from 65 percent in 1990 to 83 percent in 2012 (a difference of 18 percent).[26]

Six countries—Indonesia, Malaysia, Maldives, Mongolia, Sri Lanka, and Thailand—are considered as early achievers for the goal of having at least one antenatal care visit. They have already met their target for 2015.[27] China and Vietnam appeared to be on track and were expected to meet their goal by 2015.[28] Seven countries—Bangladesh, Cambodia, India, Lao PDR, Nepal, Pakistan, and the Philippines—are considered off-track and are expected to meet this goal after 2015, which can be anywhere between 2016 to 2020, 2021 to 2030, or may even be unlikely to achieve it by 2030.[29] However, even if some of the countries show signs of being on track with this goal, it is not enough. It is vital that women get the recommended minimum of four antenatal care visits for their overall well-being as well as to curb the high incidence of maternal mortality and maternal morbidity. Some of the factors that could affect the quality of antenatal care coverage include awareness among women and families about the need for ANC, easy availability and accessibility of ANC, its availability at public health services, the distance to the ANC facility, literacy levels of women and their families, and the socio-economic status of families.

EMERGENCY OBSTETRIC CARE

Obstetric emergencies are not predictable, therefore adequate delivery care is dependent on the availability of highly skilled staff. Emergency Obstetric Care (EmOC) can only be provided through investment in training, staff, and equipment which are not available in home deliveries.[30] Based on the updated emergency obstetric care guidelines in 2009, the current recommendation is to have at least five emergency obstetric care facilities, including at least one comprehensive facility, per 500,000 population.[31] In order to prevent maternal deaths, basic and comprehensive EmOC must be available to women who need them. The UN Guidelines divide health facilities into two groups: basic EmOC facilities and comprehensive EmOC facilities. Basic EmOC facilities include administering antibiotics, uterotonic drugs, and anti-convulsants for pre-eclampsia and eclampsia; and performing manual placenta removal, removal of retained products, assisted vaginal delivery, and basic neonatal resuscitation. In addition to the above-mentioned basic functions, comprehensive EmOC facilities include caesarean section and blood transfusion.

EmOC services are inadequate in Asia. The availability, utilisation, and quality of emergency obstetric care services were evaluated using the UN process indicators in more than 40 countries between 1999 and 2003. The results showed that 63 to 87 percent of designated basic emergency obstetric care services were not fully functional in countries surveyed in South Asia.[32] Factors contributing to lack of utilisation of EmOC facilities include out-of-pocket expenditure for women and their families, non-functional referral system, distance, and non-equitable distribution of

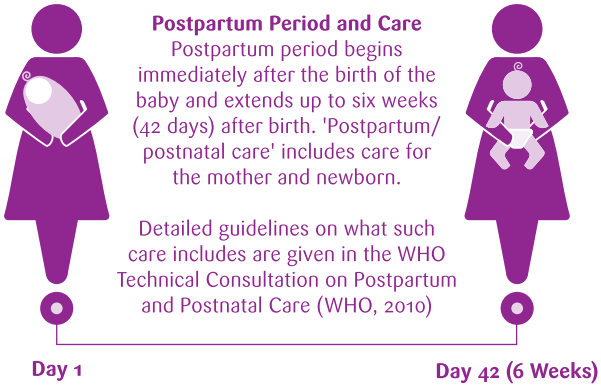
health facilities.[33] In addition, limited human resources, lack of transportation facilities, and lack of blood transfusion facilities impede the effective functioning of EmOC services.

Meanwhile, in Lao PDR where an assessment of EmOC services was carried out across three provinces, results indicated that only 14 out of 30 hospitals were providing EmOC services. Nine out of these were basic and the other five were comprehensive.[34] These services rank below the UN-recommended EmOC facilities. It is worthwhile to note that out of the nine basic EmOC services, six were in a province that had an existing hydroelectric project, which is required by the government to use income generated by the project to fund the Lao national growth and poverty eradication strategy. This has resulted in the upgrade of basic infrastructure targeting the poor and has focused on increasing road access and developing new health facilities. However, the rest of the studied health facilities did not have the infrastructure to perform surgery and provide blood transfusions due to budgetary constraints.

Although governments have been showing an increasing priority towards women's health, these efforts are often thwarted in several regions due to the lack of adequate transport options for women to seek emergency obstetric care services. This often forces them to deliver either at home or at marginally-equipped facilities. Universal access to EmOC services also needs to take into account the need to strengthen procurement and distribution chains for basic drugs and equipment, and improvement in the skills of health service providers to provide EmOC services. Efforts around task shifting can be seriously considered in designing effective and functional EmOC interventions. Legal barriers also need to be addressed to allow trained midwives to perform manual vacuum aspiration and other procedures, given the shortage of skilled medical professionals especially in remote geographical settings. Maternal death audits have to be institutionalised and all efforts should be geared to provide universal access to quality EmOC services at all levels to women who need them.

POSTPARTUM CARE

A large proportion of maternal and neonatal deaths occur during the 48 hours after delivery. It is therefore recommended that all women receive a health check-up within two days of delivery. Key elements of postpartum care for the mother include monitoring for blood loss, pain, blood pressure, and other warning signs that can lead to maternal death. The single most common cause of maternal mortality continues to be obstetric haemorrhage. The rate of death due to postpartum haemorrhage (PPH) varies widely in the developing world. Despite the realisation of the importance of postpartum care in the overall picture of maternal health, it is neither an indicator of the MDG5 target, nor is it highlighted in the ICPD PoA.



Although we do not have any consolidated data for our sample countries under consideration, a few of these countries, including Cambodia, have cited postpartum haemorrhage as a cause of deaths for many mothers. According to the Indonesia DHS 2012, 80 percent of women receive postnatal care within the first two days after delivery.[35] In Lao PDR, only two-fifths of women received either a health check or a PNC visit within two days of delivery.[36] According to the 2012-2013 Pakistan DHS survey, from 2011 to 2013, three-fifths of women received postnatal care within 48 hours of delivery, leaving almost 38 percent who did not receive any postnatal care.[37] In Nepal, only about 19 percent of the women have been able to seek postpartum care within 48 hours after giving birth.[38]

Although the postpartum coverage by a skilled health provider within 48 hours of delivery in China is not high, postnatal care rate has gone up from 86 percent in 2005 to 92.6 percent in 2012.[39] According to the Sri Lanka DHS data of 2006-2007, since most births take place in health facilities, almost 91 percent of women seek postnatal care within 48 hours of delivery.[40]

However, it has been observed in many of the countries that the percentage of women in the 20-34 age range who received postnatal care within 48 hours of delivery is higher for women having first experience of delivery in comparison to those having their second or third deliveries. Similarly, mothers with primary or secondary education and better socio-economic status were more likely to seek postnatal care as opposed to women with no education. In certain countries, e.g., Nepal, women are also secluded during their menstruation and postpartum period by forcing them to stay in a nearby shed, not being allowed to enter their homes.

CONTRACEPTION

The right to decide on the number, spacing, and timing of children is a critical element of women's reproductive autonomy and is an important element of women's sexual and reproductive health and rights. Towards this end, it is important that women and young girls have access to contraceptive methods, especially modern ones, as well as information on the pros and cons of different methods.

Comprising 60 percent of the world's population, the Asia-Pacific region had a growth rate of 0.9 percent in 2014, lower than the global population growth rate of 1.1 percent.[41] Although the population increase in the region still remains huge, the growth rate has continued to slow from 1.4 percent during 1990-2000 to 1 percent from 2000 to 2010.[42]

The total fertility rate has declined for all the 15 countries included in this report. Since 1970 to 2013, there has been a marked decrease in the average number of children per woman during her lifetime in the region, with the population replacement level of 2.1 children per woman.[43] In looking at a population and its dynamics, it is however important to not only look at the total fertility rate, but also at the contraceptive prevalence rate (CPR) and the unmet need for contraception.

According to the WHO, the CPR "is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time."[44] However, it is also important to note that data on contraception in the Asian region takes

TABLE 2: Comparative TFR Between 1970 and 2013

Percentage of Married Women Using Contraception

	Total Fertility Rate		Percentage of Married Women (15-49) Using Contraception**	
Country	1970	2013*	All Methods	Modern Methods
Bangladesh	7.0	2.2	61	52
Cambodia	6.5	2.8	51	35
China	5.5	1.6	85	84
India	5.5	2.4	55	48
Indonesia	5.5	2.6	62	58
Lao PDR	6.0	3.2	50	42
Malaysia	4.9	2.1	49	32
Maldives	7.2	2.3	35	27
Mongolia	7.6	2.9	55	50
Nepal	6.0	2.4	50	43
Pakistan	6.6	3.8	35	25
Philippines	6.3	3.0	55	37
Sri Lanka	4.3	2.1	68	53
Thailand	5.6	1.8	79	77
Vietnam	6.5	2.1	76	67

Source: Population Reference Bureau, "2014 World Population Data Sheet," http://www.prb.org/pdf14/2014-world-population-data-sheet_eng.pdf.

into account only heterosexual and married women, excluding women who may not conform to such societal norms. Unmet need for family planning is defined as "the number of women with unmet need for family planning who are fecund and sexually active but are not using any method of contraception and report not wanting any more children or wanting to delay the birth of their next child."[45] Unmet need is expressed as a percentage of women of reproductive age who are married, in a union, or are sexually active but are not using any method of contraception despite not wanting any children.

The concept of unmet need is important as it shifts the focus from the limits on family size set by the government to rightly focus "on the 'need' for contraception based on whether and when a woman wants a child."[46] However, there are certain limitations as to how the data for unmet need for contraception is being sampled and calculated in the national surveys. One limitation is the fact that, in the region, the sample population for this indicator is married, heterosexual women and not single, unmarried women, which do not accurately represent a holistic picture of unmet need in a country. Another limitation arises from an assumption that all current users of contraceptive methods are having their needs "met" when there are examples of women using a particular contraceptive method due to provider bias or government policy and not because of their free choice. Lastly, the current analysis around contraception is primarily focused on pregnancy prevention and is not heavily inclusive of the need for reproductive healthcare in general, which also incorporates contraception that also protects against STIs.[47]

It could be assumed that in countries where there are larger proportions of women using contraception, especially modern methods, the Total Fertility Rates (TFR) would be low. For example, China which had 84 percent women using modern methods of contraception had a TFR of 1.6. Similarly, Thailand with 77 percent women using modern contraceptive methods had a TFR of 1.8. However, it is interesting to also observe that some of the countries with similar TFR did not necessarily have similar percentages of women using modern contraceptive methods. For example, while the TFR is 2.1 for Malaysia, Sri Lanka, and Vietnam, the percentages of women using modern contraception were 32, 53, and 67 percent respectively.

In the case of Malaysia, this could be attributed to the higher level of CPR for all available methods which is 55 percent and also to the fact that contraceptive use in Malaysia had stagnated for 25 years now. Its unmet need for family planning remains high and is increasing, resulting in unplanned pregnancies and unwanted births especially for women with less education. Therefore, although the TFR seems low, the consequences of low contraceptive prevalence—the most important reason for out-of-wedlock pregnancies in Malaysia—was the non-use of contraceptive methods. Around 2.5 million babies were born in 5 years (2006-2010) and out of that, 234,674 (9.45 percent) were born out of wedlock to very young mothers who did not practise any contraceptive method.[48]

ABORTION

Abortion is restricted in many parts of the region. In some countries, like the Philippines and Sri Lanka, for example, abortion is restricted on all grounds, except when it is to save the life of the woman. Conditions such as these jeopardise not just the woman's health but also her life. In five countries—Cambodia, China, Mongolia, Nepal, and Vietnam—however, abortion is allowed on all grounds.

In Bangladesh, although the Penal Code outlaws all induced abortion except those needed to save the life of the pregnant woman, a legal ruling exempted menstrual regulations (MR) from being regulated by the Penal Code and subsequently the procedure became part of the National Family Planning programme in 1979.[49] MR procedures, which are officially provided by the government free of charge, are safe uterine evacuations that meet governmental criteria. Currently, a lot of women who would like to get an MR face barriers to obtaining one; many of them resort to unsafe abortion as a result. Because induced abortions are highly legally restricted in Bangladesh, they are often practised clandestinely in unhygienic settings, performed by untrained providers, or both. By averting unsafe abortions and their associated health complications, MRs could have a positive impact on women's health and survival.[50]

The abortion law in the Philippines is one of the most restrictive. The term "abortion" includes intentional abortion, "unintentional abortion," abortion practised

by the woman herself or her parents, and abortion practised by a physician or midwife. On the other hand, Lao PDR is governed by the Criminal Code Article 92, which deems abortion as illegal with no exceptions, under general criminal law principles of necessity. However, an abortion can be performed to save the life of the pregnant woman or to preserve her physical health.

The presence of a restrictive environment does not stop abortions; instead, they push women to seek illegal abortions performed by non-medical personnel including self-trained practitioners. In Thailand, the prevalence of illegal abortions is widely documented especially in rural areas. Additionally, whereas abortions can be obtained in urban hospitals using vacuum aspiration and Dilatation and Curettage, the most commonly used procedure in rural areas is traditional massage abortion and uterine injections,[51] thus endangering the lives of women. Limited data available in Lao PDR indicate widespread prevalence of unsafe abortion, often during the second trimester or later, and in dangerous circumstances. This puts women at high risk of serious complications such as haemorrhage, septicaemia, infertility, and even death.[52]

In a few countries, even if abortion may be legal, it is difficult for women to access abortion-related services in the face of socio-cultural and religious attitudes and norms. For example, although abortion is legal on some grounds in Malaysia, most people do not generally know this. Even if religion allows for abortion below 120 days of gestation if the foetus is abnormal or the pregnancy poses a risk to the mother's life, married Muslim women are still required to get the consent of their husbands to access abortion. Similarly, while progressive abortion policies have been considered by the Thailand government, the Buddhist religious order interjects and stops the passage of more progressive legislation, such as the legalisation of Mifepristone and Misoprostol (medications used for early abortion), which have been approved by the WHO.[54]

Abortion is legal on all grounds in China[55] and on all but one ground in India. However, it is not provided from a women's rights perspective, but instead with the

TABLE 3: Legal Status of Abortion (2013)

Country	To Save a Woman's Life	To Preserve a Woman's Physical Health	To Preserve a Woman's Mental Health	In Case of Rape or Incest	Because of Foetal Impairment	For Economic or Social Reasons	On Request
Bangladesh	☒	—	—	—	—	—	—
Cambodia	☒	☒	☒	☒	☒	☒	☒
China	☒	☒	☒	☒	☒	☒	☒
India	☒	☒	☒	☒	☒	☒	—
Indonesia	☒	—	—	☒	☒	☒	☒
Lao PDR	☒	☒	—	—	—	—	—
Malaysia	☒	☒	☒	—	—	—	—
Maldives	☒	☒	—	—	—	—	—
Mongolia	☒	☒	☒	☒	☒	☒	☒
Nepal	☒	☒	☒	☒	☒	☒	☒
Pakistan	☒	☒	☒	—	—	—	—
Philippines	☒	—	—	—	—	—	—
Sri Lanka	☒	—	—	—	—	—	—
Thailand	☒	☒	☒	☒	☒	—	—
Vietnam	☒	☒	☒	☒	☒	☒	☒

Source: UN Department of Economic and Social Affairs Population Division, Abortion Policies and Reproductive Health Around the World *(NY: UN, 2014), http://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf.*

rhetoric of "controlling the population." Furthermore, both countries show a skewed sex ratio in favour of boys and therefore, sex selective abortions for non-medical purposes has been strictly prohibited. In many of these countries, even if abortion is legal and allowed on most grounds, women find it difficult to access public health services because of the unsympathetic attitude of healthcare officers. Thus, they opt for privatised services instead, which are exorbitant and unaffordable.

Safe abortion is legal in Mongolia on all grounds; however, there are increasing threats coming from ultra-nationalist groups and religious fundamentalists to stop abortion, claiming that women should produce more babies to ensure national security and sustain the so-called "pure Mongolian blood."[56]

It is heartening to witness changes to restrictive abortion policies in some parts of the region. For example, since 2002, Nepal has emerged from criminalising to legalising abortion on all grounds. And although the Thailand Penal Code (1956) states that abortion is illegal except in cases when a pregnancy endangers the physical health of the mother or when the pregnancy is the result of rape or incest,[57] in 2006 the criteria for legal abortion was expanded to include cases where the mother is suffering from mental health issues on the certification by at least one other doctor in addition to the one performing the termination.

HIV and AIDS

HIV/AIDS has had and continues to have a high impact in the region. Stigma and discrimination remain key barriers to HIV prevention, treatment, and care. The stigma experienced by people living with HIV and AIDS (PLWHA) inhibits them to seek public health services. Several countries in the region have enacted laws and policies to protect people from being discriminated.

As per studies, new HIV-related infections have been declining through the years; there were 2.1 million new infections in 2013, down 38 percent from 2001.[58] Prevention of new infections among children has also been dramatic with a decline of 58 percent from 2002 to 2013, a decline from 580,000 to 240,000.[59] Similarly, AIDS-related deaths have also declined with almost 1.5 million deaths in 2013; the figure is still high, but compared to 2005, there has been a decline of about 35 percent.[60]

Of the 35 million PLWHA worldwide at the end of 2013, almost 4.8 million are in the Asia-Pacific region.[61] Six countries account for as high as 90 percent, five of which are covered in this report—China, India, Indonesia, Thailand, and Vietnam. Cambodia, Malaysia, Nepal, and Pakistan together constitute 6 percent.[62] Thus, nine out of the 15 countries covered in this report need better indicators on HIV and AIDS. Additionally, India is the third highest in the world, with 2.1 million PLWHA.[63] Due to the size of the regional population, even low prevalence translates into high numbers of people living with HIV.

The Asia-Pacific region registered a reduction of 27 percent of AIDS-related deaths between 2005 and 2013; however, this was not uniform across different countries—in India, AIDS-related deaths fell by as much as 38 percent due to the improved access to HIV-treatment services, while Cambodia and Thailand recorded a decline of 72 percent and 56 percent, respectively.[64] On the other hand, AIDS-related deaths increased 427 percent in Indonesia, and 352 percent in Pakistan. In Malaysia, it increased by 20 percent and in Nepal by 8 percent.[65] One reason is that access to HIV treatment remains different across countries; only 1 out of 3 people have access to antiretroviral therapy in the region.[66] While there has been a decline of new HIV infections in South and Southeast Asia, the increase in Indonesia by 48 percent and in Pakistan are a cause for concern.[67] Among women in Asia, a majority of infections can be seen in long-term sexual partners who may be clients of sex workers, gay men, men who have sex with men (MSM), and injecting drug users; this is especially the case when women are the wives or regular partners of migrants. Migration remains common in the region with men and women migrating either within countries or outside to seek economic and other opportunities.

The incidence of HIV is highest amongst communities including MSM, injecting drug users, female sex workers, and male and transgender sex workers. As per studies, transgender women are 49 times more likely to acquire HIV than adult males and females of reproductive age.[68]

TABLE 4: Number of People Eligible for and Accessing Antiretroviral Treatment (2012)

Country	Number of People Eligible for Treatment	Number of People Accessing Treatment	Proportion of People Being Covered (%)
Bangladesh	783	2,900	27
Cambodia	44,318	54,000	82
China	NA	NA	–
India	570,620	1,000,000	57
Indonesia	29,960	170,000	17.6
Lao PDR	2,212	4,100	53.9
Malaysia	14,594	35,000	41.6
Maldives	NA	NA	–
Mongolia	NA	NA	–
Nepal	7,168	22,000	32.5
Pakistan	2,996	21,000	14.2
Philippines	3,459	4,500	76.8
Sri Lanka	NA	NA	–
Thailand	232,816	280,000	83.1
Vietnam	68,883	120,000	57.4

Source: UNAIDS, HIV in Asia and the Pacific: UNAIDS Report 2013.

From the table above, it can be seen that in 2012, the proportion of people being covered by antiretroviral treatment among the countries in the Asia-Pacific region is highest in Thailand, followed closely by Cambodia, and then the Philippines. The countries that seem worst covered are Pakistan followed by Bangladesh and Indonesia.

In terms of legal and policy reform, some of the changes in these 15 countries under study include the amendment of laws in Vietnam to end compulsory detention of sex workers in 2012; the elimination of HIV-related restrictions on entry, stay, and residence and other punitive laws in Mongolia in 2013; and the elimination of restrictions preventing employment of PLWHA as teachers in Guangdong, China in 2013.[69] Additionally, Cambodia, Lao PDR, and Vietnam have allowed for young people in certain circumstances to consent to HIV testing in accordance with the principles of the UNCRC.[70] Constitutional rights have been used to uphold the rights of people living with HIV in countries like Bangladesh, India, Nepal, Pakistan, and the Philippines.[71]

LAWS AND POLICIES ON HIV AND AIDS

Issues that can serve as an impediment to effective service delivery include inadequate laws and policies that look into prevention, service-delivery, and anti-discrimination against PLWHA. Additionally, poor implementation of these laws and policies also add to the concerns.

Some countries in the region have laws and policies that address potential discrimination against people living with HIV and AIDS. For example, the Philippine AIDS Prevention and Control Act in 1998 codifies the rights of people with HIV and AIDS (PLHIV) to privacy and confidentiality, access to basic healthcare, and protection against compulsory testing and discrimination in different spheres of life. In Lao PDR, the right to access health services is mentioned in the National Strategy Plan on HIV/AIDS Control and Prevention 2011-2015, stating that there should be no discrimination on the basis of gender, disease status, sexual behaviour, or sexual orientation. In Thailand, Article 2 of the Declaration of Patients' Rights of 1998 entitles patients to receive full medical services

regardless of race, nationality, religion, sex, age, and the nature of their illness from their medical practitioner.[72] Refusal to treat on the grounds of HIV and AIDS is clearly prohibited by the National AIDS Plan (1997–2001).[73] Cambodia has put in place national level policies and strategies to eliminate HIV and AIDS, strengthened its policy and programmatic response in the fight against HIV and AIDS to zero new infections, zero AIDS-related deaths, and zero discrimination. Indonesia, too, released a policy on the prevention of HIV and AIDS and universal access to PLWHA which stipulates the right to health and the right to be free from discrimination for PLHIV.

This is also the case for most of South Asia. The National AIDS Control Policy in India in 2002 aims to provide support programmes for PLHIV and targeted interventions for high-risk groups, and prevent mother-to-child HIV transmission. Additionally, the National Policy Guideline on HIV/AIDS interventions in the workplace in 2002 also helps prevent arbitrary discrimination on the basis of one's HIV status to avail healthcare services, education, and employment. In Nepal, in addition to the 1995 National HIV and AIDS Policy, the most recent National Strategic Plan (2011-2016) lays out a comprehensive mapping of programmes and interventions. Additionally, in 2007, the national policy on HIV/AIDS in the workplace was also formulated prohibiting HIV-related discrimination in the workplace including prohibition of HIV testing.

Meanwhile, in Pakistan, the National HIV and AIDS Prevention and Treatment Act was passed in 2007 to provide treatment for PLHIV as well as to prevent discrimination on the basis of one's HIV status. In Bangladesh, the 2nd National Strategic Plan (2004-2010) identifies five priority areas, including support and services for priority groups, prevention of HIV and AIDS-related vulnerability, and minimisation of the impact of the HIV epidemic.

Article 3 of the Regulation on AIDS Prevention and Treatment for AIDS initiatives in China explicitly protects the legal rights of HIV patients, which includes the right to marriage, employment, assessment of medical treatment, and education. Based on this regulation, arbitrary discrimination on the basis of HIV status of an individual is prohibited. In 2010, China cancelled its long-standing restrictions that forbid the entry of foreigners living with HIV/AIDS into China.[74] Similarly, Mongolia also lifted HIV-related restrictions on entry, stay, and residence for PLWHA in addition to removing barriers to employment in 2013.[75]

The 2012 amendment to the Law on Combating HIV/AIDS in Mongolia introduced the principles of non-discrimination and confidentiality, whereas the National Strategic Plans for 2010-15 defined vulnerable sub-populations, such as female sex workers, MSM, and drug users.

However, in some instances, the policies tend to just focus on prevention, treatment, care, and support such as The National Strategic Plan on HIV and AIDS (2011-2015) in Malaysia (MOH Malaysia, 2006 and 2011). Unlike other countries, there is no legislation on prohibiting arbitrary discrimination on the basis of HIV status of an individual. Similarly, there is also no regulation that protects vulnerable populations including female and transgender sex workers, injecting drug users, and MSM.

It is worthwhile to note that the enactment of anti-discrimination laws and policies does not ensure that PLHIV are not discriminated against and receive the best of care and services. HIV-positive patients often have limited access to medical healthcare and treatment. Among PLHIV, people with diverse sexual orientation and gender identities, including transgender people, are often deprived of quality services. Anti-discrimination is not necessarily ensured in workplaces where employees may be fired on the basis of their HIV status, more so in the non-formal work sector. Confidentiality of HIV and AIDS testing, diagnosis, treatment, care, and support are also often not taken care of when catering to PLHIV, thus subjecting them to possible stigmatisation from their families and communities.

Sexual and Reproductive Rights (SRR)

In this section, we look in depth at a variety of issues related to SRR, which are essential to human beings. Sexual and reproductive rights are concerned with a variety of aspects of people's lives including, but not limited to, the right to bodily integrity; the right not to be abused or violated (physically, mentally, and sexually); the right to have consensual sexual relations (within or outside marriage); the right to be able to

decide if, whom, and when to marry or partner with; the right to decide if, when, and how many children to have; the right not to be discriminated against because of one's gender identity and sexual orientation; as well as the right to access comprehensive sexuality education and services and interventions related to one's sexual and reproductive health regardless of diversities of age, gender, marital status, disability, HIV status, gender identity, and sexual orientation, among others. While there remain overlaps between SRH and SRR, the understanding of SRR is comprehensive and includes the right to sound SRH as well.

SEXUAL RIGHTS

Sexual rights embrace human rights that may already be recognised in national laws, international human rights documents, and other consensus documents. These include the rights of all persons to be free from coercion, discrimination, and violence; to achieve the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; to seek, receive, and impart information in relation to sexuality and comprehensive sexuality education; the respect for bodily integrity; the choice of partner; to decide to be sexually active or not; to have consensual sexual relations; to enjoy consensual marriage; to decide whether or not, when, and how many children to have; and to pursue a satisfying, safe, and pleasurable sexual life.

REPRODUCTIVE RIGHTS

Reproductive rights embrace certain human rights that may already be recognised in national laws, international human rights documents, and other consensus documents. These 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 information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents.[76]

Early and Child Marriages

Early and child marriages are a violation of many aspects of rights, including sexual and reproductive rights. The term "early and child marriages" have been used to lay out the complexities within such marriages. As opposed to the usage of the term "child marriage" which is often formulated as taking place among poor, uneducated people in the Global South, the term "early marriages" takes into consideration the global phenomena of teenage pregnancies.[77] Early and child marriages point towards a diverse set of inequalities of age, gender, sexuality, and education, among others, that are rooted in patriarchy and structural inequalities in society. It allows a vast set of inequalities which are not only to do with age, but also about having the choice to marry (or not), the right to be able to choose one's own partner, as well as being prepared physically, financially, and emotionally to get married. Early and child marriages often lead to early pregnancies, which could deprive girls of educational and other opportunities. From the perspective of women's health and reproductive rights, early and child marriage presents a challenge because it "directly threatens the health and well-being" of girls. Some countries in the Asia-Pacific region do not have sound policies to prevent early and child marriages in the country and the community. In some instances, even if there may be laws to prevent it, they are often superseded by religious and community codes of conduct and may also be contradictory to other laws within the same country. Also, even if the laws may be sound, they may be inadequately implemented with people often not being aware of such laws and policies. People contravening laws against early and child marriages are often not punished by state authorities.

In some countries such as Malaysia, Nepal, and the Philippines, the age at marriage is the same for girls and boys. However, in certain countries (like Bangladesh, China, and India), girls have a lower age at marriage than boys, thus jeopardising their sexual and reproductive health through violence within marriages and adolescent pregnancies.

Certain countries in the region have the legal age at marriage below 18. According to the definition of "child" in the UN CRC, marriages taking place below the age of 18 are termed as "child marriages."

In Pakistan, for example, although the Child Marriage Restraint Act states that the legal age at marriage is 16 for girls and 18 for boys, it is inadequately implemented, as many families in rural areas are unaware of this act.[78] In recent years, however, there has been progress as in the case of Sindh where the provincial assembly unanimously passed a new law that prevents under-18s, irrespective of gender, from getting married. This is especially significant because the province of Sindh has the highest rate of child marriages in Pakistan.[79]

Early and child marriages are still acceptable and prevalent in many parts of rural areas of Nepal, and it is even a socially established practice in some parts. According to the Family Law in Lao PDR, the legal age of marriage is 18 years for both boys and girls; however, in certain cases, the age may be lowered to less than 18 but not less than 15 years.[80] In Bangladesh, the actual age of the contracting parties is sometimes concealed when an early marriage takes place. The marriage registrars usually confirm the age by looking at the birth certificate. But in reality, in most cases, the girl's age is raised and a fake birth certificate is prepared as revealed through research by local organisations and activists. Hence, under-aged marriages remain undetected. In remote conservative areas of Indonesia, girls' marriage is at 15 years and even younger. Yet, the age of early childbearing varies considerably from province to province or from district to district, depending on the level of religious conservatism and cultural values.

On the other hand, in some countries, young people may be required to get parental or guardian consent even if they may be above or at the legal age at marriage in that country. This is problematic from the stance of young people's sexual and reproductive health and rights and curbs them from actualising their right to be able to choose their partner and exercising their right to marry or not. In some instances, such as in India, it can pose additional issues of parents of young girls filing criminal complaints against the partners on charges of "kidnapping," thus often leading to harassment of young people. The ages at which young people may require parental consent or advice differs across countries and in accordance with the laws of the countries. In the Philippines, for example, contracting parties between 18 and 21 years of age require parental consent, while those between 21 and 25 years old require parental advice.[81] In Nepal, individuals aged 18-20 years also need parental consent.

In other countries, young people may be allowed to marry below the legal minimum age on receiving permission from religious or other legal authorities. Both Muslim boys and girls in Malaysia are allowed to marry below the minimum legal age if the party receives permission in writing from the *Sharia* Judge in

The Family as a Major Factor in Early and Child Marriages

The people in the District of Gunungkidul (DI Yogyakarta Province) in Indonesia tend to marry their pregnant girl-child primarily for the sake of the family's moral status, without regard for the age of their girls. The second most common reason is to save them from poverty.

According to the Law on Marriage (No. 1/1974), the marrying age of girls is 16 years old. However, there are many cases where girls at the age of 10 to 14 were married as a way out of poverty. In remote villages, girls were married to older men in exchange for money, often to pay back a family loan. This is one of the main reasons for the increasing requests for marriage dispensation to the Religious Courts (i.e., exemptions to marry underage children), thereby circumventing the Law on Marriage that already stipulates very early marrying ages.

Data from the District Gunungkidul Religious Court shows that requests for marriage dispensation increased from 90 in 2009 to 145 in 2011. In the first half of 2012, there have been 79 requests. The Religious Court deals with brides aged between 14 to 19 years.

Source: Women's Research Institute, "Fact Sheet: Reproductive Information for Teens and Women Also Helps End Early Marriages," WRI, March 2013, http://wri.or.id/files/Factsheet_kespro_gunungkidul_march_2013_English.pdf.

certain circumstances.[82] Statistics show that there has been a rise in child marriages. In 2012, for example, there were around 1,165 applications for marriage in which one party, usually the bride, is younger than the legal marrying age and the *Sharia* Courts approved 1,022 of them.[83] Non-Muslims can marry when they reach the legal age of 18 years; however, the Family Law permits the marriage of girls at 16 years with the authorisation of the Chief Minister according to Section 10 of the Law Reform (Marriage and Divorce) Act 1978.[84]

Meanwhile, among Muslims in the Philippines, not just the Family Code, but also by the Code of Muslim Personal Laws, determines the age of marriage. The latter allows a Muslim male to be married at 15 years, and a Muslim girl at puberty, presumed to be at age 15. A girl between 12 and 15 may still be allowed to marry upon petition by a wali (proper guardian) who solemnises the marriage.[85]

Violence Against Women

VIOLENCE AGAINST WOMEN IN INTIMATE PARTNER SETTINGS

Violence against women (VAW), including by intimate partners, is a common occurrence throughout the region. In clarifying and addressing VAW, the WHO defines Intimate Partner Violence (IPV) as "one of the most common forms of violence against women and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner."

All countries in this report, except for Lao PDR and Pakistan, have national laws protecting women from domestic violence. There is no law specifically addressing domestic violence in Lao PDR. On the contrary, Article 22 of the Penal Law of 1992 provides exemption from penal liabilities for physical violence between close relatives if these are not of a "serious" nature and if the damaged party does not lodge any complaint.[86] Meanwhile, in Pakistan, the national law on domestic violence has been amended recently so that states can enact their own law on domestic violence; states are currently in the process of enacting laws to prevent and address domestic violence. To this effect, Sindh is the only province so far which has recently passed the Domestic Violence (Prevention and Protection) Act, which makes any violence against vulnerable groups, including women, punishable.[87] Following this, the Balochistan province has passed the Domestic Violence (Prevention and Protection) bill, [88] while similar efforts are underway in Punjab.[89]

The definitions of violence against women are comprehensive in some countries in the region. For example, the Anti-Violence against Women and their Children Act (Republic Act 9262) in the Philippines defines violence broadly to include women whether in marital relationships or outside and includes physical, sexual, and psychological harm. Despite its comprehensiveness, however, divorce is not included as a possible remedy since Philippine law does not allow for it. The Law on Prevention of Domestic Violence and Protection of Victims in Cambodia is also broad in its coverage, as it includes the husband in its purview and looks at all kinds of domestic violence including that against the elderly. Domestic violence according to the law includes the following: an act that could affect life (including premeditated, intentional, or unintentional homicide), physical integrity (including physical violence that may or may not result in visible wounds), any torturous or cruel act (including harassment that causes mental/psychological, emotional, or intellectual harm to persons within the household), or sexual aggression (including violent rape, sexual harassment, or indecent exposure).[90] Meanwhile, domestic violence under the law in China refers to behaviours that bring family members physical and emotional injury by hitting, binding, doing harm to, restraining freedom, and other means. The law explicitly prohibits restraining women's freedom, violating women's rights to health, discriminating against infertile women and women who delivered girls, harming women through violence or in the name of superstitious belief, and abusing or abandoning disabled, sick, and elderly women.[91]

Mongolia enacted the Law to Combat Domestic Violence in 2004, which includes provisions to address domestic violence and a provision for restraining orders focusing on victim safety.[92] Maldives passed the Domestic Violence Act in 2012, defining domestic violence broadly to include physical, psychological, sexual, and financial violence, as well as intimidation, harassment, stalking, and impregnation without concern for the woman's health or against her will when she is trying to remove herself from a harmful marriage.[93]

The Protection of Domestic Violence Victims Act in Thailand defines domestic violence as "any action intended to inflict harm on a family member's physical, mental, or health condition and any use of coercion or unethical domination to compel a family member to commit, omit, or accept any unlawful act, except for that committed through negligence."[94] The Law on the Elimination of Domestic Violence in Indonesia, on the other hand, explicitly criminalises any physical, psychological, or sexual violence, as well as economic abandonment within the domestic area, and aims to provide legal protection to survivors, to provide integrated recovery programmes, and to prevent future violence.

In India, the Domestic Violence Prevention Act of 2005 aims to protect women from physical, sexual, and mental abuse. However, it fails to protect women from sexual violence within marriage. In addition, the Dowry Prohibition Act of 1961 penalises the act of giving and receiving dowry; despite the presence of this law, the practice of dowry giving continues with almost 8,233 recorded cases in 2012 according to the National Crime Records Bureau.[95] Also, as per the Verma Committee recommendations in the Criminal Law (Amendment) Act of 2013, the selling of acid in retail shops has been made punishable. The report expressly noted that:

> *"Though acid attack is a crime which can be committed against any man or woman, it has a specific gender dimension in India. Most of the reported acid attacks have been committed on women, particularly young women for spurning suitors, for rejecting proposals of marriage, for denying dowry, etc. The attacker cannot bear the fact that he has been rejected and seeks to destroy the body of the woman who has dared to stand up to him."*[96]

Whereas sexual violence is not explicitly mentioned in the domestic violence acts of certain countries such as in China or India, it has been declared a punishable crime in Nepal. Ending gender-based violence (GBV) has been identified as a key objective to end violence in general.

In Malaysia, the Domestic Violence (Amendment) Act of 2011 and the National Women Policy of 2009 look at issues of GBV; as with many other countries, though, these laws do not take marital rape into consideration despite advocacy efforts by civil society.

Although laws preventing violence against women may exist in several countries in the region, they are not necessarily effectively and adequately enforced and implemented. Implementation of laws may be hampered by a number of factors, including costly and lengthy litigation, lack of free legal aid system for women, lack of shelter for women and their children, inadequate finances for women to pay for legal aid and other services related to legal aid, fear of violence from the perpetrators of violence, and the messy nature of issues related to intimate partners.

In addition, the legal aid agencies, as well as stakeholders from the criminal justice system, unduly stress "reconciliation," as opposed to a neutral presentation of the various options available to the woman and the ways and means of realising those options. Reconciliation is often opted for despite the women's deep fear of violence from the perpetrators, often leading to grave injuries and even death. There are also times when the police advice women to go back to their families and refuse to file criminal complaints against the perpetrators because of the intimate nature of the violence. These and other factors make it very difficult for women to approach the police and other government officials to seek support and guidance. In situations where there are systems in place to guide and support women in cases of violence, women may often be unaware of such systems and where to approach to seek justice.

VIOLENCE AGAINST MIGRANT AND REFUGEE WOMEN

Migration within countries as well as outside is common across South Asia with people moving to seek better opportunities, whether economic and otherwise. Migrant workers contribute towards development, leading to a rise in GDP in the countries of destination as well as contributing to their families in their countries of origin.[97] Taking into consideration how migration benefits people and countries, many countries in the Asia-Pacific region opt for restrictive policies in countries of destination instead of having just and fair policies for them, making health and other services accessible as well as make these countries safe for them to reside in.[98]

Restrictions often lead to stringent conditions resulting in illegal or underground migration, thus making it even more difficult for them to access services

and interventions and make them vulnerable to exploitation and abuse. While men may move for jobs in construction, women migrate mostly for domestic work. Countries in South and Southeast Asia often place restrictions on women migrant workers; since the removal of the restriction in Bangladesh, migration among women has been steadily increasing.[99]

Also, although Sri Lanka did not have any such restrictions earlier, it has been discouraging migration of women with young children over the years.[100] The proportion of women among all international migrants in the Asia-Pacific region is 48 percent; women comprise low levels of migration through official channels with the exception of Indonesia, the Philippines, and Sri Lanka.[101] Restrictions on women migrating on the basis of age, banning deployment of domestic workers, or the countries they are migrating to, also narrow their chances of migrating through official routes; for example, 80 percent of women migrating from Nepal are undocumented.[102] Thus, it may be more effective to have better ways of preventing risky migration and effective management and regulation. Migrant women face discrimination and abuse both in their home countries and in the country of destination. Injustices are propagated by local authorities, employers, other members of their communities, and sometimes by other members of their own families. The types of abuse are varied and commonly include labour exploitation—underpayment of wages, deductions from wages, confiscation of documents, and unsafe conditions. Some migrant women also face severe forms of labour exploitation, including confinement, no pay, no rest time, verbal and physical abuse, and/or trafficking. Women migrants face additional concerns as they often come from poor families with very little or no education or family support; additionally, since domestic work is not covered by labour standards, it could put them at additional risk.

Additionally, migrant women face multiple levels of resistance when trying to expose abuses, especially sexual abuse. Exploitative conditions are further exacerbated for women migrants who are also undocumented, thus depriving them of access to basic services and interventions. Thailand currently has over three million migrant workers—including both documented and undocumented individuals—and approximately half are women.[103] These women are doubly marginalised as a result of being both migrant workers and female. It was not until 2013 that the

TABLE 5: Migrant Workers Deployed by Select Countries (2013)

Country	Total	Male	Female
Bangladesh	409,253	352,853	56,400
Cambodia	–	–	–
China	–	–	–
India	816,655	–	–
Indonesia	512,168	235,170	276,998
Lao PDR	–	–	–
Malaysia	–	–	–
Maldives	–	–	–
Mongolia	–	–	–
Nepal	521,878	–	–
Pakistan	622,714	–	–
Philippines	1,836,345	–	–
Sri Lanka	–	–	–
Thailand	130,511	107,184	23,327
Vietnam	–	–	–

Source: UNESCAP, Asia-Pacific Migration Report 2015.

Ministry of Public Health announced that any migrant, regardless of documentation status, could register for healthcare; this policy includes such benefits as family planning; health examinations and provision of care for pregnant women, along with afterbirth delivery services; care of neonate from birth to 28 days of age; prevention of mother-to-child transmission of HIV (PMTCT); and, for the first time, antiretroviral (ARV) medicines.[104]

Only four countries—Bangladesh, Cambodia, Indonesia, and the Philippines—have signed the International Convention on the Protection of the Rights of all migrant workers and members of their families. Also, four countries—Bangladesh, Indonesia, the Philippines, and Sri Lanka—have ratified the convention.

Within the larger population of migrants also falls the category of refugees and asylum seekers who have been forced to migrate from their countries to escape war, persecution, or a natural disaster. Due to the circumstances in which they have been forced to, they are rendered vulnerable. At the end of 2014, there were around 5.5 million refugees or people in refugee-like conditions in the region, which is almost 40 percent of 13.6 million, the worldwide refugee population.[105] Women refugees and asylum seekers are additionally vulnerable to GBV due to their stateless status. Very few countries from the Asia-Pacific region have signed the 1951 UN Refugee Convention; signatories include Cambodia, China, and the Philippines.[106] The Malaysian government has not ratified the 1951 UN Refugee Convention or established mechanisms for the protection of the rights of refugees and asylum seekers,[107] which is a grave concern as the women are at risk of being abused due to their vulnerability. In 2009, 236 cases of sexual and gender-based violence towards refugee women were reported according to the UNHCR.[108] Some of the obligations under this convention include non-refoulement, i.e., not to send people back where they may be persecuted as well as not to penalise asylum seekers for entering the country illegally. Some of the problems associated with the convention are its outdated definition for refugees, no obligations on non-signatory countries, the asylum channel being linked to smuggling and criminality, and not taking into consideration the impact of asylum on receiving countries, among others.[109]

TABLE 6: Countries Ratifying the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (2003)

Country	Signature	Ratification/Accession
Bangladesh	1998	2011
Cambodia	2004	NA
China	NA	NA
India	NA	NA
Indonesia	2004	2012
Lao PDR	NA	NA
Malaysia	NA	NA
Maldives	NA	NA
Mongolia	NA	NA
Nepal	NA	NA
Pakistan	NA	NA
Philippines	1993	1995
Sri Lanka	NA	1996
Thailand	NA	NA
Vietnam	NA	NA

Source: UN OHCHR, "Ratification of 18 International Human Rights Treaties."

RAPE AND SEXUAL ASSAULT

All countries in this report have laws and policies against rape and sexual assault. However, despite the enactment of laws, the incidence and extent of cases of rape and sexual assault is still widespread. This could be attributed to different definitions of rape and sexual assault that may not be very broad, the weak implementation of laws in the countries, and the different attitudes towards rape, virginity, and morality in societies that may deter women from reporting or seeking redressal from the criminal justice system. Eleven out of the 15 countries do not consider marital rape as under the ambit of the anti-rape laws. Even for those that do, the definitions of marital rape are often quite narrow.

Definitions of rape vary across countries in the region. In some countries, it is broader. In the Philippines, for example, the amended Republic Act 8353 expands the definition of the act (to include the insertion of objects

Voices from the Ground: Seeking Justice for Sexual Assault

Ma Toe, 38, Burmese, worked on a construction site in Mae Sot, Thailand, where she lived with her husband and daughter, 13, who also performed small jobs on the site. All of them were undocumented migrants along the border in Thailand. One day, the foreman at the site raped Ma Toe. She did not dare tell anyone since the foreman had such authority at the workplace and she was afraid of losing her job. The foreman raped Ma Toe a second time, which made her feel both angry and introverted, as she shrunk from telling others about her ordeal.

On another occasion, the foreman tried to rape Ma Toe's daughter when the daughter was alone at Ma Toe's house. The foreman came by and asked her to follow him. She did so because she knew him and trusted him. He took Ma Toe's daughter outside and tied up her hands and legs. He then stuffed her mouth with plastic and tried to rape her. Fortunately, the foreman's wife happened to come upon the scene and saw everything that was happening. She shouted for help from the neighbours. At first, the wife thought that Ma Toe's daughter was her husband's mistress. Ma Toe rushed over after hearing the commotion and argued on behalf of her child, explaining that such was far from the truth and, rather, the foreman was trying to rape her daughter. At that point, Ma Toe could not be silent any longer. She decided to tell her husband what the foreman did to her.

Mae Toe contacted an NGO, which then referred her to MAP Foundation. MAP explained to Ma Toe what action could be taken, and Ma Toe agreed to take the case to the police. The police arrested the foreman, and he was held for a couple of days. Rather than pursue the case any further, as Ma Toe was concerned that doing so would be too difficult given her undocumented status, she agreed to negotiate with the foreman, who offered compensation instead of justice.

Since then, Ma Toe and her family have moved to a different workplace in another part of Mae Sot. She did not dare stay at the construction site, for the sake of her safety and her daughter's. She continues to live in fear after that traumatic experience.

Source: Erin Biel, Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand.

including fingering), the perpetrator and the victim (to include any person) in the law against rape;[110] thus, the law is broad to include different aspects of rape.

On the other hand, definitions of rape can be very narrow. For example, in Malaysia and in India, rape is limited to the insertion of the penis into the woman's vagina against her will. These cases preclude instances of extreme sexual assault when objects such as glass and metal have been inserted into the vagina; it also excludes instances of sexual assault where penetration has been established but in other orifices apart from the vagina—such as the mouth or the anus. Moreover, definitions of rape that restrict the act of rape to just penetration are also narrow and trivialise women's lived experiences of fear and trauma.

At the same time, while countries may have sound policies with a comprehensive definition for rape, the burden of proof may often lie with the woman to prove that the rape or sexual assault had taken place. Putting the burden of proof on the victim instead of the perpetrator takes women further away from the attainment of their right to live a life free of violence and fear.

In some countries, having sexual intercourse with a girl below the legal minimum age at marriage whether with her consent or not is considered as rape. In these cases, consent of the girl is immaterial. For example, sexual intercourse with a girl below 16 years whether with her consent or not is considered statutory rape in Malaysia.[111] It is interesting to note, though, that early and child marriages are quite common in Malaysia and are in fact granted by the *Sharia* court. In India too, while having sexual intercourse with a girl below 15 years of age is considered rape whether or not she had consented, at the same time, early marriages remain common. These instances show the contradictory nature of laws and policies within the same country.

In China, rape is defined as violating the willingness of women to force them to have sexual intercourse with men by violence, coercion, and other means.[112] In Lao PDR, the definition of rape has been narrowed to include any person using force or other means to have sexual intercourse with a woman either against her knowledge or her will. Where the victim is a girl aged between 15 and 18, a woman under the offender's care or a patient of the offender, an aggravated penalty of imprisonment and a fine may be applied.[113] Articles 276 and 277 of the Criminal Code in Thailand define rape to cover victims of all sexes and all types of sexual penetration. This law technically pertains to all individuals residing in the country, regardless of their citizenship status (i.e., migrants). The Criminal Code of Mongolia regulates rape crimes against victims regardless of one's sex, focusing on the use of violence. This law defines rape beyond vaginal or anal penetration, including attempted rape, use of threats, physical intimidation, and other forms of violence.

In a more progressive vein, the Supreme Court of Nepal declared that sex without the wife's consent is rape and is punishable by law in 2006. This is especially commendable as in the region, rape laws either preclude marital rape from its purview or are completely silent about it. In Thailand as well, the anti-rape law also includes marital rape including that by either spouse—husband or wife.[114] Until 2005, there was no specific criminal offence of marital rape under legislation in Cambodia. Currently, Articles 3 and 7 effectively recognise marital rape by including "sexual aggression" as a form of domestic violence, including "violent sex" as an element of "sexual aggression."[115] Although it includes marital rape, the element of consent is missing, thus shifting the burden on the women to prove that violence was used during the rape. The amended anti-rape law in the Philippines considers penetration of the mouth, and the anal and genital orifices by the penis or any other object and includes marital rape as well unless the "subsequent forgiveness by the wife" extinguishes it.[116]

In Malaysia, with marital rape not being criminalised, no cases on marital rape have been reported.[117] In Indonesia, marital rape is not covered under the criminal code as rape occurs between "a man and a woman who is not the man's wife."[118] In Maldives, the sexual offences bill was vetoed on the grounds that it contravenes *Sharia*. The bill criminalised certain instances of marital rape, including while a case for dissolution of the marriage is in court, while the divorce filed by either spouse is pending, sexual intercourse to intentionally transmit a sexually transmitted disease, and during a mutually agreed separation (without divorce).[119] Similarly, marital rape is not recognised in Bangladesh,[120] China, India, Lao PDR, Pakistan, Sri Lanka, and Vietnam.

While laws and policies are important to ensure the administration of justice for all people, including for women and children, its execution must not be limited to the legal arena alone. Dealing with issues of sexual assault and rape requires an attitudinal shift in societies where there is zero tolerance towards any kind of violence. Definitions of rape and sexual assault must not be narrow and should be able to cover wider aspects. Efforts must also be made to remove the stigma attached to victims of sexual assault and place the blame squarely on the perpetrators where it should belong. Women and girls should be able to feel confident and fearless when approaching police stations for support and for filing of criminal complaints. The criminal justice system in the country must be geared to understand the trauma that the woman is going through, be able to provide options for complaints, be able to reach out for health check-ups, and also provide options for counselling for the victims.

There is also the need to focus on the response and the role of the health sector, as part of a multisectoral initiative to address GBV. The healthcare system is an excellent entry point to initiate care for survivors, given that women are likely to visit a health professional some time during their life for SRH needs or for other illnesses. However, lack of awareness of human rights, gender and GBV, and lack of skills in responding to violence frequently leads to gender bias and poor quality response. Most Asia-Pacific countries are actively responding to this problem. However, there is a wide variation in the scale, scope, quantity, and quality of health sector response and the level of integration that has been achieved in each country.[121]

Sexual Orientation and Gender Identities

People with diverse sexual orientations and gender identities are subject to discrimination and stigmatisation. In this section, we first discuss specific issues of sexual orientation that get reflected for instance in anti-sodomy laws that lead to stigmatisation of non-heterosexual people. Following this, we also look at issues of gender identities that lead to stigmatisation of people who do not follow the gender 'norm,' including transgender people. Although the issues of stigmatisation are common to both, these groups have specific issues and concerns that need attention.

SEXUAL ORIENTATION

People who do not identify as heterosexual are subjected to stigmatisation and ostracisation. This is aggravated in many instances due to the presence of anti-sodomy laws. A number of countries within the region have inherited discriminatory anti-sodomy laws from their colonial past. The language of these laws, which are similar across many of the countries in the region, criminalise any "carnal intercourse against the order of nature," thus effectively criminalising people who do not adhere to the heteronormative framework. The law in essence puts a premium on procreative sex. Thus, if interpreted broadly, this could also criminalise oral sex and anal sex amongst heterosexual people as these do not lead to procreation. Such laws have an adverse effect on how people of diverse sexual orientations and gender identities are treated in society. Even if the presence of such laws in many of the countries in the region have not necessarily led to arrests and sentencing, it still leads to ostracisation and stigmatisation people of diverse sexual orientations and gender identities.

The presence of such laws makes it difficult for people who do not adhere to the heteronormative norm to access health and other services without feeling ostracised. Anti-sodomy laws consider penetration as "sufficient to constitute the carnal intercourse necessary to the offence described in this section." It is therefore generally construed that the law is silent and therefore does not criminalise sex between lesbians. However, the exclusion of lesbians from the purview of the law is not so much because the society or the law is more accepting of sex between lesbians, but rather because lesbian sex is considered out of the public imaginary. The presence of anti-sodomy laws therefore has repercussions on all people irrespective of gender identity and sexual orientation.

Seven out of 15 countries in this report have anti-sodomy laws, thus criminalising gay people: Bangladesh, India, Malaysia, Maldives, Nepal, Pakistan, and Sri Lanka. Out of these, the laws in Maldives and in Sri Lanka do not explicitly mention lesbians.

In Malaysia, the Penal Code criminalises same-sex sexual behaviour and the State *Sharia* laws criminalise same-sex consensual sexual relations between women.[122] In the Philippines, provisions of old laws on "public disorder" and "offenses against decency and good customs" are often used to arrest, detain, and extort LGBT people.[123] Efforts to pass an anti-discrimination bill have been underway since 2000,[124] but keep on failing due to the strong opposition led by Catholic Church officials. In India too, same-sex sexual behaviour is criminalised under the anti-sodomy law. Although there have not been too many arrests or convictions under this law, it has been used to harass and discriminate against people who do not conform to standards of heteronormativity. In 2009, upon hearing a case filed by Naz Foundation, in a historic judgment, the Delhi High Court lifted the ban on same-sex activity amongst consenting adults, saying it violates basic human rights on the protection of life and liberty. In February 2014, however, the Supreme Court upheld the anti-sodomy law pronouncing same-sex sexual activity as a crime. This provided a major setback to the LGBTIQ community in India.

Unlike many other countries, same-sex sexual behaviour is legal in Cambodia, when it involves non-commercial acts between consenting adults in private. Although there is no anti-sodomy law in Cambodia and the King of Cambodia in 2012 had also spoken in favour of same-sex marriages between men and women, studies mention the presence of discrimination on people of diverse sexual orientations and gender identities from their families, employers, and police.[125] In Lao PDR, there are no laws prohibiting discrimination based on sexual orientation or gender identity; additionally, the national Constitution does not address sexual orientation or gender identity issues either. Meanwhile in China, although some advocates think that same-sex sexual activities were criminalised

under the law on hooliganism, other scholars claim that same-sex sexual behaviour is neither criminalised nor decriminalised in China.[126]

Same-sex sexual activities between consenting adults are legal for both gay and lesbian individuals in Mongolia. Due to recommendations at the United Nations, the Government has issued Resolution 13 urging the Parliament to take urgent measures to amend the Criminal Code to include discrimination based on Sexual Orientation and Gender Identity (SOGI) within the definition of hate crime, legislate a broad-based anti-discrimination law to protect LGBT individuals, and amend the Constitution to specifically protect people based on their sexual orientation and/or gender identity and expression. Despite this, constitutional and legal or policy prohibition of discrimination based on sexual orientation is lacking; neither is there any legal provision for marriage of and joint adoption by same-sex couples. Even though there is a political will from the government to protect its LGBT individuals, general public attitude and perception still remains negative.

In a context where anti-sodomy laws are used to discriminate against non-heterosexual people, same-sex marriages are also looked down upon and stigmatised. For example, even if same-sex relationships are not criminalised in China, the government does not accept the legality of same-sex marriages. In Cambodia, same-sex marriage is prohibited under Article 45 of the Constitution, which explicitly defines marriage as an agreement between a husband and wife; this is further reinforced by the law on Marriage and Family, which states in Article 6 that a marriage shall be prohibited between two people of the same sex.[127] Thai law also does not recognise same-sex marriages, civil unions, or domestic partnerships.

Lao PDR does not recognise same-sex marriages or any other form of same-sex union. However, Article 10 of Prohibition of Marriage of the Family Law mentions prohibition of marriage only between individuals of mental and physical health problems and individuals from the same blood.[128]

At the progressive end of the spectrum is Nepal. In 2012, Nepal's Supreme Court recognised a live-in relationship between two lesbians despite the objection of one of the families to separate them.[129] In 2008, it also ruled in favour of laws to guarantee full rights to LGBTIQ, including the right to marry irrespective of sexual orientation.

Most countries in this region are also silent on matters of anti-discrimination in labour and in employment. The labour law in Cambodia does not specifically mention discrimination based on sexual orientation. However, a number of LGBT individuals have noted that they frequently face discrimination in the workplace and from their employers. In China, the labour law and the Law on Promotion of Employment are two laws that have specific provisions to prohibit discrimination based on sexual orientation, but in both laws, sexual orientation is not included.

In addition to laws, non-heterosexual people also face additional discrimination as homosexuality is considered by some as mental illness. Even though it was already removed from the Diagnostic and Statistical Manual of Mental Orders of the American Psychiatric Association, many countries in the region still subject homosexual people to medical tests and treatment to "cure" them of homosexuality. In 2001, the Chinese Psychosis Science Association issued the 3rd edition of the report on the "Categories and Diagnosis Standards of Mentally Disturbed in China" in which same-sex sexual behaviour was no longer considered a disease but related to one's feeling of well-being.

Even though same sex marriages are not allowed in Cambodia, in 1996 the Phnom Penh Post reported on a marriage the previous year between two women in Kandal province. KhavSokha, who married her female partner, named Pum Eth, told the newspaper: "The authorities thought it was strange, but they agreed to tolerate it because I have three children already (from a previous marriage). They said that if we were both single (and childless), we would not be allowed to get married because we could not produce children." The marriage appeared to have official approval and was reportedly a popular event, with 250 attendees, including Buddhist monks and high officials from the province.

Source: Cambodian Centre for Human Rights, Coming Out in the Kingdom: Lesbian, Gay, Bisexual, and Transgender people in Cambodia (Phnom Penh: CCHR, 2010), http://cchrcambodia.org/index_old.php?url=project_page/project_page.php&p=report_detail.php&reid=8&id=3.

In 2002, under pressure from the gay community, the Thai Department of Mental Health removed homosexuality from its list of mental disorders.

GENDER IDENTITIES

Gender identity refers to the complex relationship between a person's experience of self-expression in relation to social categories of masculinity or femininity. People may subjectively feel that their gender identity may be at variance with their physiological characteristics. Transgender people constitute the larger umbrella of people who may not adhere to or identify with the gender they have been assigned at birth (which is mostly in accordance with their biological characteristics) and may therefore express themselves differently from their assigned gender.

Transgender people have to go through discrimination and violence at multiple levels because they do not adhere to societal norms of sexuality. They are very often ostracised from families and communities and have to find shelter with other transgender groups. Being ostracised from society leads to little or no education for transgender children, which also means a limited number of jobs being available for them as adults. In terms of employment, they are often restricted to sex work and other jobs in beauty and massage parlours.

In addition, transgender people are often subjected to ridicule and violence in societies. In countries where anti-sodomy or anti-obscenity laws are present, transgender people may often be subjected to extreme violence. They are also subject to violence, including sexual assault, from police and other authorities from the criminal justice system, thus marginalising them further.

Transgender people often face issues related to their identity documents such as licenses, national ID documents, and passports, among others. For example, there is no law that allows the sex of a person to be changed in the Philippines; the Supreme Court in 2007 disallowed a man from changing his name and sex after a sex-change surgery.[130] The laws and courts decree that sex cannot be changed from the time of entry in the birth certificates. The Society of Transsexual Women of the Philippines (STRAP), in their submission to the 13th Session of the UN Human Rights Council Universal Periodic Review, complained about the

TABLE 7: Sodomy Laws in Asia

Country	Lesbian	Gay/Male	Maximum Penalty
Bangladesh	Illegal	Illegal	Life
Cambodia	Legal	Legal	
China	Legal	Legal	
India	Illegal	Illegal	Life
Indonesia	Legal	Legal	
Lao PDR	No Data Available	No Data Available	Unknown
Malaysia	Illegal	Illegal	20 Years/Caning and Fine
Maldives	Legal	Illegal	Life
Mongolia	Legal	Legal	
Nepal	Illegal	Illegal	Life
Pakistan	Ilegal	Illegal	Death
Philippines	Legal	Legal	
Sri Lanka	Legal	Illegal	12 Years
Thailand	Legal	Legal	
Vietnam	Legal	Legal	

Source: "Sodomy Laws Around the World," GLAPN, November 24, 2007, http://www.glapn.org/sodomylaws/world/world.htm.

lack of a clear-cut law allowing change of sex in legal documents.

Thailand's legal system also fails to afford transgender people many of the rights and protections enjoyed by the rest of the population. Thai citizens cannot legally change their gender on their ID cards. This can endanger their job prospects, as many employers do not want to deal with the possible complications involved in hiring a transgender person.[131] In Malaysia, there is no law that prohibits change of gender identity on a Malaysian identity card. However, the court decisions have been inconsistent. While there was a case where a trans woman was able to change her name and gender, another trans woman was unsuccessful in doing so.[132]

Mongolia allows transgender individuals to change their name and sex on the national identification card based on the psychiatric diagnosis approved by healthcare providers, according to Article 20 of the Civil Registration Law, amended in 2009. So far, three transgender individuals have been through this process to get their renewed ID card.[133] However, transgender people still remain as key affected populations when it comes to employment, education, healthcare and treatment, as well as human safety and dignity.

Nepal was one of the first countries in South Asia to have recognised third gender rights following a 2007 Supreme Court decision establishing self-determination as the only criterion to identify one's gender.[134] Pakistan has also recently allowed third gender designations on state-issued identity documents whereby transgender people are granted equal legal rights and obligations in the society as all citizens, also extending to their right to vote and even run for office.[135] In 2009, India's Election Commission took the first step by allowing transgender people to choose their gender as "other" on ballot forms.[136] Recently, Bangladesh has also decided to recognise the third gender to be accepted in passport identification, to ensure that they receive equal rights like other citizens of the country. However, they remain excluded as they are not included in the national health policy.

Transgender people also face considerable stigma and discrimination because of their sexual expression. For instance, the National Fatwa Council in Malaysia has declared several fatwas condemning pengkids (loosely translated as tomboys), criminalising "cross-dressing," and prohibiting sex change operations.[137]

Hormone treatment, psychological therapy, equal employment opportunity, non-discrimination policy in and around the school and in the workplace, as well as education of healthcare providers and law enforcement officials are necessary to create an enabling environment for transgender people.

In China, cross-dressing and other activities of transgender people are not criminalised and many hospitals provide the gender reassignment treatment/surgery or body modifications upon an individual's request.[138] After surgery, some transgender people have successfully registered their new genders in the national registration system.[139] Transgender people are also able to marry and register their marriage in some cities, after they changed their gender on their citizen identity card.[140] In March 2004, the first "gender-variant" couple was married and aroused nationwide attention.[141] It should be noted, however, that although this may allow for some transgender people to feel more at home after undergoing sex reassignment surgery, they may still continue to feel discriminated in society.

In Indonesia, historically, there is evidence to portray the acceptance and inclusion of transgender people within communities which can be evidenced through stories, fables, and even in temple relics.[142] Yet, religious extremist groups still reject people of diverse sexual orientation and gender identities on different grounds, such as portraying cross-dressing as a "sin." This is reflected in the non-acceptance of transgender people in community groups, which are then followed by the refusal of public services.

Therefore, whether or not transgender people are accepted in society historically or by law, they face multiple levels of discrimination in society. Many of them are subjected to ostracisation and violence, even leading to deaths. It is important that people of diverse sexual orientations and gender identities are treated equal to other citizens and are accorded the respect and dignity that they rightfully deserve.

Young People and SRHR

Young people continue to be marginalised in SRH programmes and interventions all over Asia. Although they may be included in laws and policies, their inclusion and participation may often be tokenistic. Young people, particularly young women and girls, need all sexual and reproductive health services and interventions related to maternal health, including access to contraception and abortion. They also need access to safe, youth-friendly services which cater to both married and unmarried young people. Child and early marriages are a reality in many countries of South and Southeast Asia, making accessibility to SRHR services a must in this region. When SRHR services are aimed at only married people, it leaves out a number of young people who may be sexually active and also young adult women who may be sexually active but unmarried. Information on sexuality is therefore important for all, irrespective of age, gender, marital status, and whether one is sexually active or not. This can enable all people, including young people, to participate in informed decision-making about their own bodies and their sexuality.

There are a number of issues that hamper effective and consistent application of interventions towards young people as a group. First and foremost, there is no consensus on the age limit for defining a young person within the region with different countries defining young people differently. Even within the same country, different laws and policies may have different definitions as well. For example, the law on child protection in Indonesia states that every child shall have the right to health services and social security in accordance with their physical, mental, spiritual, and social needs, thus recognising the evolving capacities of young people. The Penal Code however criminalises people who provide information related to the prevention and termination of pregnancy. This is further supported by the law on pornography, which does not clearly distinguish between pornographic materials, and materials on sexuality education, thus prohibiting people from distributing information on sexuality education. Secondly, young people must also be understood as a non-homogenous group with a variety of concerns and needs. Interventions and services must therefore cater to this population.

Some countries in the region already have sound policies on SRH in place. In Cambodia, the National Reproductive Health Programme was created in 1994 to provide young people with the right to receive information and education about reproductive health, and ensures privacy when receiving healthcare.[143] In addition, the National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010) provides guidelines for youth-friendly reproductive and sexual health services and child survival.[144] Meanwhile, Thailand has promoted a "Positive Youth Development" approach, outlining a strategy that encompasses increasing knowledge of SRH, promoting a safe and supportive environment, offering youth-friendly health services, and enhancing youth participation and empowerment.[145] However, a rising number of adolescent pregnancies, increased usage of emergency contraception, and high rates of unsafe abortions suggest that more needs to be done.[146]

In contrast, in Lao PDR, there is no national youth policy or strategy addressing adolescent sexual and reproductive health (ASRH) and young people are not addressed in the seventh National Socio-Economic Development Plan 2011-2015.[147] There are also no policies or legislations in Pakistan that exclusively protect young people's freedom to control their sexual and reproductive life.

When considering interventions for young people, it is important to look at their evolving capacities to make informed decisions regarding their SRH and that they may be included in all programmes related to SRHR. For example, the right of young people less than 18 years to access reproductive health services from public facilities was denied by the Supreme Court in their decision on the Reproductive Health Law in the Philippines,[148] placing minors under the jurisdiction of both parents and, to a lesser degree, the State. In such situations, adolescents' ability to decide on matters relating to sexuality and reproduction rests on their parents' consent, even though the government may have enabling programmes. In Malaysia, the progressive policies for young people's SRH and SRR services, including contraception, are available in all government hospitals and clinics. However, young people often remain unaware of such services, thus continuing to have an unmet need.[149]

In Mongolia, the Fourth National Reproductive Health Programme adopted for 2012-2016 aims to implement 100 percent condom use to target young people and to expand adolescent-friendly health services. However,

according to the Health Act, guardian or parental consent is still required for girls up to age 18 if they request late abortion. Additionally, although the National Public Health Policy (2001) obligates the state to provide sound sexuality education for adolescents, it is inadequately implemented due to lack of budgetary allocation and negligence of marginalised groups among young people.[150] Similarly, the Bangladesh government has approved an Adolescents Health Strategy (2006) which talks about general services for schoolchildren but has special services for out-of-school and married adolescent girls. A comprehensive sexuality education in the school curriculum is still underway. Although there is no need for consent from parents and guardians when accessing health services, in practice, irrespective of marital status, girls cannot access menstrual regulation services or services related to surgery without parental consent.

In India, the National Population Policy 2000, the National AIDS Prevention and Control Policy 2002, the National Youth Policy 2003, and the Reproductive and Child Health (RCH) Programmes (I and II) recognise adolescents as a distinct group and their SRHR needs requiring special attention. These policies recommend that SRH information, counselling, and services should be affordable and accessible to adolescents. Both RCH and the National Youth Policy state that adolescent-friendly healthcare services should be provided in primary healthcare centres for adolescents. As per the RCH policy, irrespective of one's own marital status, all services available must be youth-friendly. However, abortion services for girls below the age of 18 require parental or guardian consent.

In contrast, the law in China does not necessitate parental consent for young girls obtaining an abortion in both private and public services; this is not from a rights-based perspective but from the point of view of "population control." This assumption is based on the fact that until now there is no specific policy or strategy document on provision of SRH services for Chinese adolescents. There is also no official document that permits minors to give informed consent on their own behalf in relation to SRH.

Nepal developed and published a National Adolescent Health and Development Strategy in 2000. A draft of a national ASRH programme was drafted in 2008 under the leadership of the Family Health Division; it was piloted in 2009 in 26 public health facilities.[151] A national ASRH programme designed in 2011 is also now being implemented nationwide. It aims to introduce 1,000 adolescent-friendly services (AFS) in Nepal by 2015. As of December 2012, 542 health facilities with AFS had been built.[152]

The availability and accessibility of SRH services are limited to married adolescents in some countries, with the assumption that sexual activity takes place only among married people. In Lao PDR, for example, adolescents have almost no access to contraception, including condoms. Although the national policy on birth spacing stipulates the provision of birth spacing methods to those in need, irrespective of their marital or social status, health staff generally do not provide such services to unmarried adolescents.[153] Adult-youth communication on SRH issues is rare in highland communities and remains limited in urban areas.[154] In Indonesia, the Law on Population and Family Development mentions the provision of family planning services, but only for married couples.

Some other barriers that restrict young people from accessing SRH services include physical access barriers (that relate to inadequate services and lack of infrastructure), psychosocial barriers (including myths and misconceptions related to sexuality), and quality barriers (including lack of privacy and confidentiality).

For an effective response it would be important that we not only have an in-depth understanding of the community of young people taking into consideration their heterogeneity and their diverse needs and concerns but also strive towards creating safe spaces for them to access information, services, and interventions. These spaces must cater to all young people irrespective of their age, gender, caste, economic class, disability, marital status, and HIV status, among others. It must work towards providing a comprehensive sexuality education for all. Further, laws and policies in the country must also cater to the rights of young people and provide for an environment that is safe and nurturing their well-being.

Conclusion

Two decades after the ICPD agenda, sexual and reproductive health and rights for all remains a distant dream. Through this regional profile, we have attempted to look at the status of SRHR in 15 countries that have come together to promote SRHR for all within their countries as well as globally.

Although some of the countries within the region have been successful in lowering maternal mortality and maternal morbidity, we find that the actual number of deaths and morbidities still remains high. This is a major cause for concern as it highlights how the agenda for women and young people still does not count for many state governments. This also highlights the lack of sound interventions and services for access to skilled birth attendance, emergency obstetric care, as well as antenatal and postnatal care. While in some countries these services may be present, there is a grave need for a better reach for these services as well as a focus on the quality of services provided. Information and data from a number of countries highlight that services wherever available are not equally accessible for all women with disparities on the basis of the levels of income, education, as well as the rural-urban divide.

SRHR for all will remain a distant agenda if services and interventions are not equitably distributed and accessible for all women. Services and interventions wherever available also do not reach young people, especially those who are unmarried or do not adhere to the heteronormative. These services therefore remain discriminatory, endangering the lives of young women who remain vulnerable to gender-based violence, early and forced marriages, unwanted adolescent pregnancies, and sexually transmitted infections including HIV and AIDS. There is a need therefore to reach out to young people; this can be partly achieved through the availability and accessibility of youth-friendly services that can provide safe and non-judgmental spaces for young people.

Sexual and reproductive health and rights are at the core of all human beings. It is about the freedom to choose who we are, how we define ourselves, who we relate to, and whether or not we choose to have children. It is also about one's identity, one's life choices, and therefore one's very being. We must also accept and address the reality that issues related to SRHR does not exist in a vacuum and is closely interlinked and influenced by other aspects such as culture, religion, and socio-economic institutions. This report highlights the significance of addressing the gaps in the SRHR agenda in the 2030 Agenda world where many countries remain far from achieving the goals that they had initially set out during ICPD as well as the Beijing Platform for Action. It also highlights the moral imperative that all state governments reassess and recognise the status and the contexts in which marginalised communities, including women and young people, still remain deprived of their rights.

Endnotes

1 UNESCAP, "Population," in *Statistical Yearbook for Asia and the Pacific* 2014, n.d., http://www.unescap.org/sites/default/files/01-Population-SYB2014.pdf.

2 The 15-country project by ARROW and its partners is titled "Strengthening the networking, knowledge management and advocacy capacities of an Asian network for sexual and reproductive health and rights (SRHR)." It aims to strengthen the network's advocacy function to contribute to improved SRHR of marginalised women and girls in Asia-Pacific and to the increased effectiveness of SRHR policies in achieving relevant MDG and ICPD goals while ensuring universal access to SRHR services in the region remain high on the development agenda in the future and that national and international policy- and decision-makers are improving SRHR policies. http://www.srhrforall.org/.

3 "Country Profiles: Highlighting Contraception Needs During ICFP 2016," SRHR for All, February 8, 2016, http://www.srhrforall.org/category/country-profiles/.

4 David B. Evans, Justine Hsu, and Ties Boerma, "Universal Health Coverage and Universal Access," *Bulletin of the World Health Organization* 91 (2013): 546-546A. doi: http://dx.doi.org/10.2471/BLT.13.125450.

5 "China: Ratify Key International Human Rights Treaty," Human Rights Watch, October 8, 2013, https://www.hrw.org/news/2013/10/08/china-ratify-key-international-human-rights-treaty.

6 "China Ratifies ICESCR: A Change in Sight or More of the Same?" China Labour Bulletin, March 1, 2000, http://www.clb.org.hk/content/china-ratifies-icescr-change-sight-or-more-same.

7 Women's Aid Organisation, ed., *CEDAW and Malaysia: Malaysian Non-Government Organisations' Alternative Report* (Kuala Lumpur: WAO, 2012), http://wao.org.my/file/file/Malaysian%20NGO%20CEDAW%20Alternative%20Report%202012%206MB.pdf.

8 United Nations Treaty Collection, "Chapter IV: Human Rights," United Nations, n.d., https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&clang=_en

9 United Nations, *The Millennium Development Goals Report 2014* (NY: United Nations, 2014), http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf.

10 Ibid.

11 Ibid.

12 Asian Development Bank, "Millennium Development Goals: Trends and Tables," in *Key Indicators for Asia and the Pacific 2014* (Metro Manila: ADB, 2014): 53-59, http://www.adb.org/sites/default/files/publication/43030/ki2014-mdg-introduction.pdf.

13 Ibid.

14 Ibid.

15 World Health Organisation, "Births Attended by Skilled Health Personnel (%)," WHO, n.d., http://www.who.int/whosis/whostat2006BirthsAttendedBySkilledHealthPersonnel.pdf.

16 Asian Development Bank, "Millennium Development Goals: Trends and Tables."

17 Ibid.

18 Ibid.

19 Ibid.

20 Ministry of Health and Population (MOHP) Nepal, New ERA, and ICF International, *Nepal Demographic Health Survey 2011* (Kathmandu: MOHP): 119, http://www.measuredhs.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf.

21 United Nations Children's Fund (UNICEF), *A Continuum of Care for Adolescent Girls in South Asia: Defining the Issues, Synthesising Evidence, and Working Towards a Policy Agenda* (Dhaka, Bangladesh: UNICEF, 2010), http://www.whrap.org/wp-content/uploads/2011/12/adolescent_health_SA-_COC_Unicef-1.pdf.

22 Rafiqul Huda Chaudhury and Zafrullah Chowdhury, "Maternal Mortality in Rural Bangladesh: Lessons Learned from Gonoshasthaya Kendra Programme Villages," *Asia-Pacific Population Journal* 23, no. 1 (2008): 55.

23 World Health Organisation,"Antenatal Care Coverage (%)," WHO, n.d., http://www.who.int/whosis/whostat2006AntenatalCareCoverage.pdf.

24 United Nations, *The Millennium Development Goals Report 2014*.

25 Ibid.

26 Ibid.

27 Asian Development Bank, "Millennium Development Goals: Trends and Tables."

28 Ibid.

29 Ibid.

30 Michael Seear, *An Introduction to International Health* (Toronto: Canadian Scholars' Press, 2007).

31 World Health Organisation, *Monitoring Emergency Obstetric Care: A Handbook* (Geneva: WHO, 2009): 1-164, http://apps.who.int/iris/bitstream/10665/44121/1/9789241547734_eng.pdf.

32 Charles Ameh, Sia Msuya, Jan Hofman, Joanna Raven, Matthews Mathai, and Nynke van den Broek, "Status of Emergency Obstetric Care in Six Developing Countries Five Years before the MDG Targets for Maternal and Newborn Health," *PLoS ONE* 7, no. 12 (Dec 2012): e49938. doi:10.1371/journal.pone.

33 Ibid.

34 Xaysomphou Douangphachanh, Moazzam Ali, Phathammavong Outavong, Phengsavanh Alongkon, Menorath Sing, Kuroiwa Chushi, "Availability and use of emergency obstetric care services in public hospitals in Laos PDR: A systems analysis," *BioScience Trends* 4, no. 6 (Dec 2010): 318, http://www.ncbi.nlm.nih.gov/pubmed/21248430.

35 Zumrotin K. Susilo, "Country Profile Universal Access to Sexual and Reproductive Health: Indonesia," ARROW, 2014, http://arrow.org.my/publication/country-profile-universal-access-to-sexual-and-reproductive-health-services-profile-on-indonesia/.

36 Ministry of Health (Lao PDR) and Lao Statistics Bureau, *Lao Social Indicator Survey*, 2012 (Lao PDR: Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment, 2012).

37 Maryum Siddiqui, Samreen Shahbaz, and Tabinda Sarosh, "Country Profile on Universal Access to Sexual and Reproductive Health: Pakistan," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-pakistan/.

38 Ruby Shakya, Laxmi Prabha Shrestha, and Honey Gurung, "Country Profile on Universal Access to Sexual and Reproductive Health: Nepal," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-nepal/.

39 Sai Jyothirmai Racherla, Suon Bophea, and Sek Sisokhom, "Country Profile Universal Access to Sexual and Reproductive Health: Cambodia," ARROW, 2015, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-cambodia/.

40 Evangeline De Silva, "Country Profile on Universal Access to Sexual and Reproductive Health: Sri Lanka," ARROW, 2015, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-sri-lanka/.

41 UNESCAP, "Population," in *Statistical Yearbook for Asia and the Pacific 2014*.

42 Ibid.

43 Ibid.

44 World Health Organisation Statistical Information System, "Contraceptive Prevalence Rate (%)," WHO, 2008, http://www.who.int/whosis/whostat2006ContraceptivePrevalenceRate.pdf.

45 United Nations Department of Economic and Social Affairs (UNDESA) Population Division, *World Contraceptive Use 2011* (New York: UNDESA, 2011), http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm.

46 Sivananthi Thanenthiran and Sai Jyothirmai Racherla, *Reclaiming & Redefining Rights ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia* (Malaysia: The Asian-Pacific Resource & Research Centre for Women, 2009), http://arrow.org.my/wp-content/uploads/2015/04/Reclaiming-Redefining-Rights_-ICPD-15_Monitoring-Report_Asia_2011.pdf.

47 Ibid.

48 Mohamed Najimudeen and Kanagasabai Sachchithanantham, "An Insight into Low Contraceptive Prevalence in Malaysia and its Probable Consequences," *International Journal of Reproduction, Contraception, Obstetrics and Gynecology* 3, no. 3 (2014), 493-496. doi:10.5455/2320-1770.ijrcog20140943.

49 Government of the People's Republic of Bangladesh, "Memo No. 5-14/MCH-FP/Trg.79," Dhaka, Bangladesh: Population Control and Family Planning Division, 1979.

50 Heidi Bart Johnston, Anna Schurmann, Elizabeth Oliveras, and Halida Hanum Akhter, "Scaled Up and Marginalised: A Review of Bangladesh's Menstrual Regulation Programme and its Impact," in Erik Blas, Johannes Sommerfeld, and Anand Sivasankara Kurup, eds., *Social Determinants Approaches to Public Health: From Concept to Practice* (Geneva: WHO, 2011): 9-24, http://www.who.int/social_determinants/tools/SD_Publichealth_eng.pdf.

51 Erin Biel, "Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand" (Chiang Mai: MAP Foundation, n.d.), http://arrow.org.my/wp-content/uploads/2015/04/Country-Profile-Thailand.pdf.

52 Lao PDR Ministry of Public Health, *A Strategic Assessment of Reproductive Health in the Lao People's Democratic Republic* (Geneva: World Health Organisation, 2000), http://whqlibdoc.who.int/hq/2000/WHO_RHR_00.3.pdf?ua=1.

53 Ministry of Health Malaysia, "Guidelines on Termination of Pregnancy (TOP) for Hospitals in the Ministry of Health," September 19, 2012, http://www.moh.gov.my/images/gallery/Garispanduan/Guideline%20On%20TOP%20for%20Hospitals%20in%20MOH.pdf.

54 Erin Biel, "Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand."

55 In 2013, the one-child policy in China has been relaxed to allow couples to have two children if either the husband or wife comes from a one-child family.

56 Solongo Algaa, "Country Profile on Universal Access to Sexual and Reproductive Health: Mongolia," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-mongolia/.

57 Centre for Reproductive Rights, "The World's Abortion Laws 2014: Thailand's Abortion Provisions," Reproductive Rights, n.d., http://reproductiverights.org/en/node/2721/map_popup.

58 UNAIDS, *The Gap Report* (Geneva: UNAIDS, 2014), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.

59 Ibid.

60 Ibid.

61 Ibid.

62 Ibid.

63 Ibid.

64 Ibid.

65 Ibid.

66 Ibid.

67 Ibid.

68 Ibid.

69 UNAIDS, *HIV in Asia and the Pacific: UNAIDS Report 2013* (Bangkok: UNAIDS, 2013), http://www.unaids.org/sites/default/files/media_asset/2013_HIV-Asia-Pacific_en_0.pdf.

70 Ibid.

71 Ibid.

72 Erin Biel, "Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand."

73 Ibid.

74 UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (Bangkok: UNAIDS, 2011), http://www.unaids.org/sites/default/files/media_asset/20110826_APGettingToZero_en_1.pdf.

75 UNAIDS, *GLOBAL REPORT: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva: UNAIDS, 2013), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf.

76 Sivananthi Thanenthiran, Sai Jyothirmai Racherla, and Suloshini Jahanath, *Reclaiming & Redefining Rights ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia Pacific* (Malaysia: The Asian-Pacific Resource & Research Centre for Women, 2013), http://arrow.org.my/wp-content/uploads/2015/04/ICPD-20-Asia-Pacific_Monitoring-Report_2013.pdf.

77 Nirantar Trust, *Early and Child Marriage in India: A Landscape Analysis* (New Delhi: Nirantar Trust, 2015), http://www.nirantar.net/public/site/files/EM_Report_30-4-15.pdf.

78 Mohammad Zia-ur-Rahman, "Pakistan's Slow but Steady Progress on Ending Child Marriage," *The Guardian*, June 2, 2014, https://www.theguardian.com/global-development/2014/jun/02/pakistan-progress-ending-child-marriage.

79 Ibid.

80 Government of Lao PDR,"Decree of the President of the Lao PDR On the Promulgation of the Family Law. No 97/PO," Vientiane, Lao PDR, December 24, 1990.

81 "Family Code of the Philippines, Executive Order No. 209. (1987, July 6)," Official Gazette, http://www.gov.ph/downloads/1987/07jul/19870706-EO-0209-CCA.pdf.

82 Attorney General's Chambers, Islamic Family Law (Federal Territories) Act 1984 (as at 1 January 2006) (Kuala Lumpur, Malaysia: The Commissioner of Law Revision and Percetakan Nasional Malaysia Bhd., 2006a).

83 Hariati Azizan, "Child Marriages on the Rise," *The Star Online*, October 6, 2013, http://www.thestar.com.my/news/nation/2013/10/06/child-marriages-on-the-rise-1022-applications-approved-in-2012-compared-to-900-in-2011/.
84 Attorney General's Chambers, Law Reform (Marriage and Divorce) Act 1976 (as at 1 January 2006) (Kuala Lumpur, Malaysia: The Commissioner of Law Revision and Percetakan Nasional Malaysia Bhd., 2006b).
85 "Presidential Decree no. 1083. A Decree to Ordain and Promulgate a Code Recognizing the System of Filipino Muslim Laws, Codifying Muslim Personal Laws, and Providing for its Administration and for Other Purposes." http://library.pcw.gov.ph/sites/default/files/presidential-decree-1083.pdf
86 Gender Resource Information and Development Centre (GRID), "Lao PDR Gender Profile," Vientiane, GRID, Lao PDR.
87 PPI, "Sindh Assembly passes domestic violence bill," *The Express Tribune*, March 8, 2013, http://tribune.com.pk/story/517722/sindh-assembly-passes-domesticviolence-bill/.
88 Naziha Syed Ali, "Tackling Domestic Violence," Dawn, February 11, 2014, http://www.dawn.com/news/1086246.
89 Imran Gabol, "Punjab Assembly passes Protection of Women Against Violence Bill," Dawn, February 24, 2016, http://www.dawn.com/news/1241626.
90 So Sokbunthoeun, Kim Sedara, and Doung Virorth, "Exploring the Implementation of Policies to Address Violence Against Women in Cambodia," Working Paper, Bangkok: Partners for Prevention, 2013, http://www.partners4prevention.org/sites/default/files/resources/p4p_working_paper_vaw_policies_cambodia.pdf.
91 Yunmei Wu, Rui Deng, and Chaofang Yan, "Country Profile on Universal Access to Sexual and Reproductive Rights: China," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-china/.
92 The Advocates for Human Rights and Mongolia National Center Against Violence, *Implementation of Mongolia's Domestic Violence Legislation: A Human Rights Report* (Minneapolis: The Advocates for Human Rights, 2013), http://www.theadvocatesforhumanrights.org/uploads/mongolia_report_final.pdf.
93 Mizna Shareef, trans., "Unofficial Translation of the Domestic Violence Act Number 3/2012," n.d., http://countryoffice.unfpa.org/filemanager/files/maldives/the_domestic_violence_act_2012_maldives_english_translation_unofficial.pdf.
94 "Domestic Violence Victim Protection Act, B.E. 2550," Thailand, 2007, http://thailaws.com/law/t_laws/tlaw0403.pdf.
95 ARROW, "Country Profile on Universal Access to Sexual and Reproductive Rights: India," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-india/.
96 J.S. Verma, Leila Seth, Gopal Subramanium, "Report of the Committee on Amendments to Criminal Law," New Delhi, India, 2013, http://www.prsindia.org/uploads/media/Justice%20verma%20committee/js%20verma%20committe%20report.pdf.
97 UNESCAP, *Asia-Pacific Migration Report 2015: Migrants' Contribution to Development* (Bangkok: UNESCAP, 2015), http://www.unescap.org/sites/default/files/SDD%20AP%20Migration%20Report%20report%20v6-1-E.pdf.
98 Ibid.
99 Ibid.
100 Ibid.
101 Ibid.
102 Ibid.
103 IOM, "Migrant Information Note," no. 20 (June 2013), http://www.burmalibrary.org/docs15/IOM-Migrant_Info_Note_No_20-en.pdf.
104 Ibid.
105 UNESCAP, *Asia-Pacific Migration Report 2015: Migrants' Contribution to Development*.
106 United Nations High Commissioner for Refugees, "States Parties to the 1951 Convention relating to the Status of Refugees and the 1967 Protocol," UNHCR, n.d., http://www.unhcr.org/3b73b0d63.html.
107 Women's Aid Organisation, *CEDAW and Malaysia: Malaysian Non-Government Organisations' Alternative Report*.
108 Cecilia Ng, *Gender and Rights: Analysis for Action* (Penang: Good Governance and Gender Equality Society and Women's Development Research Centre, 2011).
109 Adrienne Millbank, "The Problem with the 1951 Refugee Convention," Research Paper 5: Social Policy Group, Parliament of Australia, September 5, 2000, http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp0001/01RP05.
110 "Republic Act No. 8353 [The Anti-Rape Law of 1997]," Chan Robles Virtual Law Library, n.d., http://www.chanrobles.com/republicactno8353.htm.
111 Tengku Noor Azira Tengku Zainudin and Anita Abdul Rahim, "Child Patient and Consent to Medical Treatment in Malaysia: A Legal Perspective," *Journal of Global Peace and Conflict* 1, no. 1 (June 2013), 41-48, http://jgpcnet.com/journals/jgpc/Vol_1_No_1_June_2013/4.pdf.
112 Yunmei Wu, Rui Deng, and Chaofang Yan, "Country Profile on Universal Access to Sexual and Reproductive Rights: China."
113 Sychareun Vanphanom, Phengsavanh Alongkone, and Hansana Visanou, "Country Profile on Universal Access to Sexual and Reproductive Rights: Lao PDR," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-lao-pdr/.
114 "Rape Laws in Thailand," Thailand Law, June 16, 2013, http://www.thailandlaw.org/rape-laws-in-thailand.html.
115 Cambodian Committee of Women, *Violence Against Women: How Cambodian Laws Discriminate Against Women* (Phnom Penh, Cambodia: CAMBOW, 2007), http://www.licadho-cambodia.org/reports/files/112CAMBOWViolenceWomenReport2007_ENG.pdf.
116 Junice L.D. Melgar, Alfredo R. Melgar, and Joy Salgado, "Country Profile on Universal Access to Sexual and Reproductive Rights: Philippines," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-philippines/.
117 Hwei Mian Lim, "Country Profile on Universal Access to Sexual and Reproductive Rights: Malaysia," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-malaysia/.
118 Irene Putrie, "Participants' Papers: Country Report - Indonesia," UNAFEI, http://www.unafei.or.jp/english/pdf/RS_No69/No69_14PA_Putrie.pdf.
119 Isabel Marler, "Maldives: Sex Without Consent is Always Rape," WLUML, February 6, 2014, http://www.wluml.org/action/urgent-maldives-sex-without-consent-always-rape.
120 Mst. Taslima Khatun and Khandaker Farzana Rahman, "Domestic Violence Against Women in Bangladesh: Analysis from a Socio-Legal Perspective," *Bangladesh e-Journal of Sociology* 9, no. 2: 19-30.

121 ARROW, "Arrow for Change -- Health Sector Response to Gender-Based Violence and SRHR," ARROW, 2011, http://arrow.org.my/publication/gender-based-violence-and-sexual-and-reproductive-health-and-rights-looking-at-the-health-sector-response-in-the-asia-pacific-region/.
122 The Commissioner of Law Revision (Malaysia), "Penal Code: Act 574," UNODC, 2006, https://www.unodc.org/tldb/pdf/Malaysia_Penal_Code_Act_574_Full_text.pdf.
123 International Gay and Lesbian Human Rights Commission, "Human Rights Violations on the Basis of Sexual Orientation, Gender Identity, and Homosexuality in the Philippines: Submitted for consideration at the 106th session of the human rights committee for the fourth periodic review of the Philippines," IGLHRC, October 2012, https://www.outrightinternational.org/sites/default/files/philippines_report.pdf.
124 Ibid.
125 Sai Jyothirmai Racherla, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: Cambodia."
126 Yunmei Wu, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: China."
127 Sai Jyothirmai Racherla, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: Cambodia."
128 Sychareun Vanphanom, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: Lao PDR."
129 Manesh Shrestha, "Nepal Court Allows Lesbian Live-In Relationship," *The Times of India*, November 6, 2012, http://timesofindia.indiatimes.com/world/south-asia/Nepal-court-allows-lesbian-live-in-relationship/articleshow/17116724.cms.
130 Philippine Supreme Court , "Silverio v. Republic of the Philippines, G.R. No. 174689," October 22, 2007, http://sc.judiciary.gov.ph/jurisprudence/2007/october2007/174689.htm.
131 Jason Armbrecht, "Transsexuals and Thai Law," Thailand Law Forum, April 11, 2008, http://www.thailawforum.com/Transsexuals-and-Thai-Law.html.
132 Women's Aid Organisation, *CEDAW and Malaysia: Malaysian Non-Government Organisations' Alternative Report*.
133 Solongo Algaa, "Country Profile on Universal Access to Sexual and Reproductive Health: Mongolia."
134 Angel L. Martinez Cantera, "Nepal's 'Third Gender,'" *Aljazeera*, March 12, 2014, http://www.aljazeera.com/indepth/features/2014/03/nepal-third-gender-201431181229222617.html.
135 Maryum Siddiqui, Samreen Shahbaz, and Tabinda Sarosh, "Country Profile on Universal Access to Sexual and Reproductive Rights: Pakistan."
136 "India Court Recognises Transgender People as Third Gender," *BBC News*, April 15, 2014, http://www.bbc.com/news/world-asia-india-27031180.
137 Women's Aid Organisation, *CEDAW and Malaysia: Malaysian Non-Government Organisations' Alternative Report*.
138 Yunmei Wu, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: China."
139 Yunmei Wu, Rui Deng, and Chaofang Yan, "Country Profile on Universal Access to Sexual and Reproductive Rights: China," ARROW, 2014, http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-china/
140 Yunmei Wu, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: China."
141 Ibid.
142 Zumrotin K. Susilo, "Country Profile Universal Access to Sexual and Reproductive Rights: Indonesia."
143 Sai Jyothirmai Racherla, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: Cambodia."
144 Ibid.
145 Kamol Saejeng, "Thailand Country Report," presented at the Expert Group Meeting to Assess the Progress in the Implementation of the Plan of Action on Population and Poverty Adopted at the Fifth Asian and Pacific Conference, February 2009, Bangkok.
146 Executive Board of the United Nations Development Programme, the United Nations Population Fund, and the United Nations Office for Project Services, "Final Country Programme Document for Thailand," UNFPA, February 2012, http://countryoffice.unfpa.org/thailand/drive/FINALCPDforThailandCycle10asof29September2011.pdf
147 Sychareun Vanphanom, et al., "Country Profile on Universal Access to Sexual and Reproductive Rights: Lao PDR."
148 Supreme Court of the Philippines, "Imbong, et al. v. Ochoa, et al, G.R. Nos. 204819, 204934, 204957, 204988, 205003, 205043, 205138, 205478, 205491, 205720, 206355, 207111, 207172 & 207563," Philippine Supreme Court, April 8, 2014, http://sc.judiciary.gov.ph/jurisprudence/2014/toc/april.php
149 Hwei Mian Lim, "Country Profile on Universal Access to Sexual and Reproductive Rights: Malaysia."
150 Solongo Algaa, "Country Profile on Universal Access to Sexual and Reproductive Health: Mongolia."
151 Department of Health Services (DoHS), Department of Health Services: Annual Report 2068/69," Kathmandu: DoHS, 2013.
152 Ibid.
153 Vanphanom Sychareun, "Meeting the Contraceptive Needs of Unmarried Young People: Attitudes of Formal and Informal Sector Providers in Vientiane Municipality, Lao PDR," *Reproductive Health Matters* 12, no. 23 (2004): 155-165. doi: 10.1016/S0968-8080(04)23117-2.
154 World Health Organisation, *A Strategic Assessment of Reproductive Health in the Lao People'sDemocratic Republic* (Geneva: WHO, http://apps.who.int/iris/bitstream/10665/66371/1/WHO_RHR_00.3.pdf).

Bibliography

Algaa, Solongo. "Country Profile on Universal Access to Sexual and Reproductive Health: Mongolia." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-mongolia/.

Ali, Naziha Syed. "Tackling Domestic Violence." Dawn, February 11, 2014. http://www.dawn.com/news/1086246.

Ameh, Charles, Sia Msuya, Jan Hofman, Joanna Raven, Matthews Mathai, and Nynke van den Broek. "Status of Emergency Obstetric Care in Six Developing Countries Five Years before the MDG Targets for Maternal and Newborn Health." PLoS ONE 7, no. 12 (Dec 2012): e49938. doi:10.1371/journal.pone.

Armbrecht, Jason. "Transsexuals and Thai Law." Thailand Law Forum, April 11, 2008. http://www.thailawforum.com/Transsexuals-and-Thai-Law.html.

Asian Development Bank. "Millennium Development Goals: Trends and Tables." In Key Indicators for Asia and the Pacific 2014, 53-59. Metro Manila: ADB, 2014. http://www.adb.org/sites/default/files/publication/43030/ki2014-mdg-introduction.pdf.

Asian-Pacific Resource and Research Centre for Women. Reclaiming and Redefining Rights. ICPD +15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur: ARROW, 2009.

___. "Arrow for Change -- Health Sector Response to Gender Based Violence and SRHR." Kuala Lumpur: ARROW, 2011. http://arrow.org.my/publication/gender-based-violence-and-sexual-and-reproductive-health-and-rights-looking-at-the-health-sector-response-in-the-asia-pacific-region/.

___. "Thematic papers presented at Beyond ICPD and the MDGs: NGOs Strategizing for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional, and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO UNFPA Dialogue for Strategic Engagement." Kuala Lumpur: ARROW 2012.

___. "Country Profile on Universal Access to Sexual and Reproductive Rights: India." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-india/.

Attorney General's Chambers. "Islamic Family Law (Federal Territories) Act 1984 (as at 1 January 2006)." Kuala Lumpur: The Commissioner of Law Revision and Percetakan Nasional Malaysia Bhd., 2006a.

___. "Law Reform (Marriage and Divorce) Act 1976 (as at 1 January 2006)." Kuala Lumpur: The Commissioner of Law Revision and Percetakan Nasional Malaysia Bhd., 2006b.

Azizan, Hariati. "Child Marriages on the Rise." The Star Online, October 6, 2013. http://www.thestar.com.my/news/nation/2013/10/06/child-marriages-on-the-rise-1022-applications-approved-in-2012-compared-to-900-in-2011/.

Biel, Erin. "Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand." Chiang Mai: MAP Foundation, 2015. http://arrow.org.my/wp-content/uploads/2015/04/Country-Profile-Thailand.pdf.

Cambodian Centre for Human Rights. Coming Out in the Kingdom: Lesbian, Gay, Bisexual, and Transgender people in Cambodia. Phnom Penh: CCHR, 2010. http://cchrcambodia.org/index_old.php?url=project_page/project_page.php&p=report_detail.php&reid=8&id=3.

Cambodian Committee of Women. Violence Against Women: How Cambodian Laws Discriminate Against Women. Phnom Penh: CAMBOW, 2007. http://www.licadho-cambodia.org/reports/files/112CAMBOWViolenceWomenReport2007_ENG.pdf.

Centre for Reproductive Rights. "The World's Abortion Laws 2014: Thailand's Abortion Provisions." Reproductive Rights, n.d. http://reproductiverights.org/en/node/2721/map_popup.

Chaudhury, Rafiqul Huda, and Zafrullah Chowdhury. "Maternal Mortality in Rural Bangladesh: Lessons Learned from Gonoshasthaya Kendra Programme Villages." Asia-Pacific Population Journal 23, no. 1 (2008): 55.

"China Ratifies ICESCR: A Change in Sight or More of the Same?" China Labour Bulletin, March 1, 2000. http://www.clb.org.hk/en/content/china-ratifies-icescr-change-sight-or-more-same.

"China: Ratify Key International Human Rights Treaty." Human Rights Watch, October 8, 2013. https://www.hrw.org/news/2013/10/08/china-ratify-key-international-human-rights-treaty.

"Country Profiles: Highlighting Contraception Needs during ICFP 2016." SRHR for All, February 8, 2016. http://www.srhrforall.org/category/country-profiles/.

Department of Health Services (DoHS). Department of Health Services: Annual Report 2068/69. Kathmandu: DoHS, 2013.

De Silva, Evangeline. "Country Profile on Universal Access to Sexual and Reproductive Health: Sri Lanka." Kuala Lumpur: ARROW, 2015. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-sri-lanka/.

"Domestic Violence Victim Protection Act, B.E. 2550." Thai Laws, 2007. http://thailaws.com/law/t_laws/tlaw0403.pdf.

Douangphachanh, Xaysomphou, Moazzam Ali, Phathammavong Outavong, Phengsavanh Alongkon, Menorath Sing, and Kuroiwa Chushi. "Availability and Use of Emergency Obstetric Care Services in Public Hospitals in Laos PDR: A Systems Analysis." BioScience Trends 4, no. 6 (Dec 2010): 318. http://www.ncbi.nlm.nih.gov/pubmed/21248430.

Evans, David B., Justine Hsu, and Ties Boerma. "Universal Health Coverage and Universal Access." Bulletin of the World Health Organization 91 (2013): 546-546A. doi: http://dx.doi.org/10.2471/BLT.13.125450.

Executive Board of the United Nations Development Programme, the United Nations Population Fund, and the United Nations Office for Project Services. "Final Country Programme Document for Thailand." UNFPA, February 2012. http://countryoffice.unfpa.org/thailand/drive/FINALCPDforThailandCycle10asof29September2011.pdf.

"Family Code of the Philippines, Executive Order No. 209. (1987, July 6)." Official Gazette. http://www.gov.ph/downloads/1987/07jul/19870706-EO-0209-CCA.pdf.

Gabol, Imran. "Punjab Assembly Passes Protection of Women Against Violence Bill." Dawn, February 24, 2016. http://www.dawn.com/news/1241626.

Gender Resource Information and Development Centre (GRID). "Lao PDR Gender Profile." Vientiane: GRID, 2005.

Government of Lao PDR. "Decree of the President of the Lao PDR On the Promulgation of the Family Law. No 97/PO." Vientiane: Government of Lao PDR, December 24, 1990.

Government of the People's Republic of Bangladesh. "Memo No. 5-14/MCH-FP/Trg.79." Dhaka: Population Control and Family Planning Division, 1979.

"India Court Recognises Transgender People as Third Gender." BBC News, April 15, 2014. http://www.bbc.com/news/world-asia-india-27031180.

International Gay and Lesbian Human Rights Commission. "Human Rights Violations on the Basis of Sexual Orientation, Gender Identity, and Homosexuality in the Philippines: Submitted for consideration at the 106th session of the human rights committee for the fourth periodic review of the Philippines." Philippines: IGLHRC, October 2012. https://www.outrightinternational.org/sites/default/files/philippines_report.pdf.

IOM. "Migrant Information Note no. 20 (June 2013)." http://www.burmalibrary.org/docs15/IOM-Migrant_Info_Note_No_20-en.pdf.

Johnston, Heidi Bart, Anna Schurmann, Elizabeth Oliveras, and Halida Hanum Akhter. "Scaled Up and Marginalised: A Review of Bangladesh's Menstrual Regulation Programme and its Impact." In Social Determinants Approaches to Public Health: From Concept to Practice, edited by Erik Blas, Johannes Sommerfeld, and Anand Sivasankara Kurup, 9-24. Geneva: WHO, 2011. http://www.who.int/social_determinants/tools/SD_Publichealth_eng.pdf.

Khatun, Mst. Taslima, and Khandaker Farzana Rahman. "Domestic Violence Against Women in Bangladesh: Analysis from a Socio-Legal Perspective." Bangladesh e-Journal of Sociology 9, no. 2: 19-30.

Lao PDR Ministry of Public Health. A Strategic Assessment of Reproductive Health in the Lao People's Democratic Republic. Geneva: World Health Organisation, 2000. http://whqlibdoc.who.int/hq/2000/WHO_RHR_00.3.pdf.

Lim, Hwei Mian. "Country Profile on Universal Access to Sexual and Reproductive Rights: Malaysia." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-malaysia/.

Marler, Isabel. "Maldives: Sex Without Consent is Always Rape." WLUML, February 6, 2014. http://www.wluml.org/action/urgent-maldives-sex-without-consent-always-rape.

Martinez Cantera, Angel L. "Nepal's 'Third Gender.'" Aljazeera, March 12, 2014. http://www.aljazeera.com/indepth/features/2014/03/nepal-third-gender-201431181229222617.html.

Melgar, Junice L.D., Alfredo R. Melgar, and Joy Salgado. "Country Profile on Universal Access to Sexual and Reproductive Rights: Philippines." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-philippines/.

Millbank, Adrienne. "The Problem with the 1951 Refugee Convention." Research Paper 5: Social Policy Group, Parliament of Australia, September 5, 2000. http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp0001/01RP05.

Ministry of Health (Lao PDR) and Lao Statistics Bureau. Lao Social Indicator Survey, 2012. Lao PDR: Vientiane Statistics Division, Department of Planning and Finance, Ministry of Health, Lao Statistics Bureau, Ministry of Planning and Investment, 2012.

Ministry of Health Malaysia. "Guidelines on Termination of Pregnancy (TOP) for Hospitals in the Ministry of Health." September 19, 2012. http://www.moh.gov.my/images/gallery/Garispanduan/Guideline%20On%20TOP%20for%20Hospitals%20in%20MOH.pdf.

Ministry of Health and Population (MOHP) Nepal, New ERA, and ICF International. Nepal Demographic Health Survey 2011. Kathmandu: MOHP, 2011: 119. http://www.measuredhs.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf.

Najimudeen, Mohamed, and Kanagasabai Sachchithanantham. "An Insight into Low Contraceptive Prevalence in Malaysia and its Probable Consequences." International Journal of Reproduction, Contraception, Obstetrics and Gynecology 3, no. 3 (2014): 493-496. doi:10.5455/2320-1770.ijrcog20140943.

Ng, Cecilia. Gender and Rights: Analysis for Action. Penang: Good Governance and Gender Equality Society and Women's Development Research Centre, 2011.

Nirantar Trust. Early and Child Marriage in India: A Landscape Analysis. New Delhi: Nirantar Trust, 2015. http://www.nirantar.net/public/site/files/EM_Report_30-4-15.pdf.

Philippine Supreme Court. "Silverio v. Republic of the Philippines, G.R. No. 174689." October 22, 2007. http://sc.judiciary.gov.ph/jurisprudence/2007/october2007/174689.htm.

Population Reference Bureau. "2014 World Population Data Sheet." http://www.prb.org/pdf14/2014-world-population-data-sheet_eng.pdf.

PPI. "Sindh Assembly Passes Domestic Violence Bill." The Express Tribune, March 8, 2013. http://tribune.com.pk/story/517722/sindh-assembly-passes-domestic-violence-bill/.

"Presidential Decree no. 1083, A Decree to Ordain and Promulgate a Code Recognizing the System of Filipino Muslim Laws, Codifying Muslim Personal Laws, and Providing for its Administration and for Other Purposes." http://library.pcw.gov.ph/sites/default/files/presidential-decree-1083.pdf.

Putrie, Irene. "Participants' Papers: Country Report – Indonesia." Indonesia: UNAFEI, 2005. http://www.unafei.or.jp/english/pdf/RS_No69/No69_14PA_Putrie.pdf.

Racherla, Sai Jyothirmai, Suon Bophea, and Sek Sisokhom. "Country Profile Universal Access to Sexual and Reproductive Health: Cambodia." Kuala Lumpur: ARROW, 2015. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-cambodia/.

"Rape Laws in Thailand." Thailand Law, June 16, 2013. http://www.thailandlaw.org/rape-laws-in-thailand.html.

"Republic Act No. 8353 [The Anti-Rape Law of 1997]." Chan Robles Virtual Law Library, n.d. http://www.chanrobles.com/republicactno8353.htm.

Saejeng, Kamol. "Thailand Country Report." Presented at the Expert Group Meeting to Assess the Progress in the Implementation of the Plan of Action on Population and Poverty Adopted at the Fifth Asian and Pacific Conference. Bangkok, February 2009.

Seear, Michael. An Introduction to International Health. Toronto: Canadian Scholars' Press, 2007.

Shakya, Ruby, Laxmi Prabha Shrestha, and Honey Gurung. "Country Profile on Universal Access to Sexual and Reproductive Health: Nepal." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-nepal/.

Shareef, Mizna, trans. "Unofficial Translation of the Domestic Violence Act Number 3/2012." n.d. http://countryoffice.unfpa.org/filemanager/files/maldives/the_domestic_violence_act_2012_maldives_english_translation_unofficial.pdf.

Shrestha, Manesh. "Nepal Court Allows Lesbian Live-In Relationship." The Times of India, November 6, 2012. http://timesofindia.indiatimes.com/world/south-asia/Nepal-courtallows-lesbian-live-in-relationship/articleshow/17116724.cms.

Siddiqui, Maryum, Samreen Shahbaz, and Tabinda Sarosh. "Country Profile on Universal Access to Sexual and Reproductive Health: Pakistan." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-health-pakistan/.

"Sodomy Laws Around the World." GLAPN, November 24, 2007. http://www.glapn.org/sodomylaws/world/world.htm.

Sokbunthoeun, So, Kim Sedara, and Doung Virorth. "Exploring the Implementation of Policies to Address Violence Against Women in Cambodia." Working Paper. Bangkok: Partners for Prevention, 2013. http://www.partners4prevention.org/sites/default/files/resources/p4p_working_paper_vaw_policies_cambodia.pdf.

Supreme Court of the Philippines. "Imbong, et al. v. Ochoa, et al., G.R. Nos. 204819, 204934, 204957, 204988, 205003, 205043, 205138, 205478, 205491, 205720, 206355, 207111, 207172 & 207563." Philippine Supreme Court, April 8, 2014. http://sc.judiciary.gov.ph/jurisprudence/2014/toc/april.php.

Susilo, Zumrotin K. "Country Profile Universal Access to Sexual and Reproductive Health: Indonesia." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-universal-access-to-sexual-and-reproductive-health-services-profile-on-indonesia/.

Sychareun, Vanphanom. "Meeting the Contraceptive Needs of Unmarried Young People: Attitudes of Formal and Informal Sector Providers in Vientiane Municipality, Lao PDR." Reproductive Health Matters 12, no. 23 (2004): 155-165. doi:10.1016/S0968-8080(04)23117-2.

Thanenthiran, Sivananthi, and Sai Jyothirmai Racherla. Reclaiming & Redefining Rights ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur: ARROW, 2009. http://arrow.org.my/wp-content/uploads/2015/04/Reclaiming-Redefining-Rights_-ICPD-15_Monitoring-Report_Asia_2011.pdf.

Thanenthiran, Sivananthi, Sai Jyothirmai Racherla, and Suloshini Jahanath. Reclaiming & Redefining Rights ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia Pacific. Kuala Lumpur: ARROW, 2013. http://arrow.org.my/wp-content/uploads/2015/04/ICPD-20-Asia-Pacific_Monitoring-Report_2013.pdf.

The Advocates for Human Rights and Mongolia National Center Against Violence. Implementation of Mongolia's Domestic Violence Legislation: A Human Rights Report. Minneapolis: The Advocates for Human Rights, 2013. http://www.theadvocatesforhumanrights.org/uploads/mongolia_report_final.pdf.

The Commissioner of Law Revision (Malaysia). "Penal Code: Act 574."Kuala Lumpur: UNODC, 2006. https://www.unodc.org/tldb/pdf/Malaysia_Penal_Code_Act_574_Full_text.pdf.

Zainudin, Tengku Noor Azira Tengku, and Anita Abdul Rahim. "Child Patient and Consent to Medical Treatment in Malaysia: A Legal Perspective." Journal of Global Peace and Conflict 1, no. 1 (June 2013): 41-48. http://jgpcnet.com/journals/jgpc/Vol_1_No_1_June_2013/4.pdf.

UNAIDS. The Gap Report. Geneva: UNAIDS, 2014. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.

UNAIDS. Global Report: UNAIDS Report on the Global AIDS Epidemic 2013. Geneva: UNAIDS, 2013. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf.

UNAIDS. HIV in Asia and the Pacific: Getting to Zero. Bangkok: UNAIDS, 2011. http://www.unaids.org/sites/default/files/media_asset/20110826_APGettingToZero_en_1.pdf.

UNAIDS. HIV in Asia and the Pacific: UNAIDS Report 2013. Bangkok: UNAIDS, 2013. http://www.unaids.org/sites/default/files/media_asset/2013_HIV-Asia-Pacific_en_0.pdf.

UN Department of Economic and Social Affairs Population Division. Abortion Policies and Reproductive Health Around the World. New York: United Nations, 2014. http://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf.

UNESCAP. Asia-Pacific Migration Report 2015: Migrants' Contribution to Development. Bangkok: UNESCAP, 2015. http://www.unescap.org/sites/default/files/SDD%20AP%20Migration%20Report%20report%20v6-1-E.pdf.

____. "Population." In Statistical Yearbook for Asia and the Pacific, UNESCAP, 2014. http://www.unescap.org/sites/default/files/01-Population-SYB2014.pdf.

UNICEF. A Continuum of Care for Adolescent Girls in South Asia: Defining the Issues, Synthesising Evidence, and Working Towards a Policy Agenda. Dhaka: UNICEF, 2010. http://www.whrap.org/wp-content/uploads/2011/12/adolescent_health_SA-_COC_Unicef-1.pdf.

United Nations. The Millennium Development Goals Report 2014. New York: United Nations, 2014. http://www.un.org/millenniumgoals/2014%20MDG%20report/MDG%202014%20English%20web.pdf.

United Nations Department of Economic and Social Affairs Population Division. World Contraceptive Use 2011. New York: UNDESA, 2011. http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm.

United Nations High Commissioner for Refugees. "States Parties to the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol." UNHCR, n.d. http://www.unhcr.org/3b73b0d63.html.

United Nations Treaty Collection. "Chapter IV: Human Rights." United Nations, n.d. https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV13&chapter=4&clang=_en.

UN OHCHR. "Ratification of 18 International Human Rights Treaties." n.d. http://indicators.ohchr.org/.

Vanphanom, Sychareun, Phengsavanh Alongkone, and Hansana Visanou. "Country Profile on Universal Access to Sexual and Reproductive Rights: Lao PDR." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-lao-pdr/.

Verma, J.S., Leila Seth, and Gopal Subramanium. "Report of the Committee on Amendments to Criminal Law." New Delhi, 2013. http://www.prsindia.org/uploads/media/Justice%20verma%20committee/js%20verma%20committe%20report.pdf.

Women's Aid Organisation, ed. CEDAW and Malaysia: Malaysian Non-Government Organisations' Alternative Report. Kuala Lumpur: WAO, 2012. http://wao.org.my/file/file/Malaysian%20NGO%20CEDAW%20Alternative%20Report%202012%206MB.pdf.

Women's Research Institute. "Fact Sheet: Reproductive Information for Teens and Women Also Helps End Early Marriages." WRI, March 2013. http://wri.or.id/files/Factsheet_kespro_gunungkidul_march_2013_English.pdf.

World Health Organisation. "Antenatal Care Coverage (%)." WHO, n.d. http://www.who.int/whosis/whostat2006AntenatalCareCoverage.pdf.

____. "Births Attended by Skilled Health Personnel (%)." Geneva: WHO, 2006,. http://www.who.int/whosis/whostat2006BirthsAttendedBySkilledHealthPersonnel.pdf.

____. A Strategic Assessment of Reproductive Health in the Lao People's Democratic Republic. Geneva: WHO, 2000. http://apps.who.int/iris/bitstream/10665/66371/1/WHO_RHR_00.3.pdf.

____. Monitoring Emergency Obstetric Care: A Handbook. Geneva: WHO, 2009: 1-164. http://apps.who.int/iris/bitstream/10665/44121/1/9789241547734_eng.pdf.

World Health Organisation Statistical Information System. "Contraceptive Prevalence Rate (%)." Geneva: WHO, 2008. http://www.who.int/whosis/whostat2006ContraceptivePrevalenceRate.pdf.

Wu, Yunmei, Rui Deng, and Chaofang Yan. "Country Profile on Universal Access to Sexual and Reproductive Rights: China." Kuala Lumpur: ARROW, 2014. http://arrow.org.my/publication/country-profile-on-universal-access-to-sexual-and-reproductive-rights-china/.

Zia-ur-Rahman, Mohammad. "Pakistan's Slow but Steady Progress on Ending Child Marriage." The Guardian, June 2, 2014. https://www.theguardian.com/global-development/2014/jun/02/pakistan-progress-ending-child-marriage.

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, engagement, advocacy, and mobilisation.

ARROW envisions an equal, just and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

'Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asian Network for Sexual and Reproductive Health and Rights (SRHR)' is an ARROW-implemented project. The project brings together five implementing partners and ten associate partners from across Asia to advocate for universal access to SRHR as a key component of national and global policies and agendas; as well as to work on addressing the key challenge of religious fundamentalisms as experienced across the region.

This project is funded by the European Union.

ISBN 978-967-0339-27-6

Asian-Pacific Resource and Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields 50470, Kuala Lumpur, Malaysia

Telephone (603) 2273 9913/9914/9915
Fax (603) 2273 9916
E-mail arrow@arrow.org.my
Web www.arrow.org.my
Facebook The Asian-Pacific Resource & Research Centre for Women (ARROW)
Twitter @ARROW_Women
Youtube youtube.com/user/ARROWomen
Pinterest arrowomen

European Commission
EuropeAid Cooperation
Office Information
Communication and Front Office
Unit-04 L-41, Office 06/84
B-1049 Brussels, Belgium

Telephone 322 296 94 97
Fax 322 296 64 97
E-mail europeaid-info@ec.europa.eu
Web http://ec.europa.eu/europeaid