2020

SDG MONITORING REPORT

AFFIRMING RIGHTS, ACCELERATING PROGRESS AND AMPLIFYING ACTION:

Monitoring SDG3 in Asia-Pacific

About ARROW

Asian-Pacific Resource and Research Centre for Women (ARROW) is a regional, feminist, global-south non-profit organisation based in Malaysia with a consultative status with the Economic and Social Council of the United Nations. ARROW works towards an equal, just and equitable world that enables all women and young people to be equal citizens in all aspects of their lives, and that protects and advances their sexual and reproductive health and rights. For more details: https://arrow.org.my/.

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Introduction

Commitments made by governments towards the 2030 Agenda for Sustainable Development reached its fifth year of implementation in 2020. With just under 10 years to fulfil the mandate set by the Sustainable Development Goals (SDGs), 2020 marks a critical time to take stock of progress and short falls towards Agenda 2030. On January 22, 2020, the United Nations Secretary-General announced the "Decade of Action" campaign with the aims to 1) mobilise everyone, everywhere, 2) demand urgency and ambition, and 3) supercharge ideas and solutions.[1] Women's inclusion is crucial towards delivering the "Decade of Action" and progressing towards their health and rights, including sexual and reproductive health and rights (SRHR), which should be prioritised if we truly are to transform the world by 2030.

This brief is part of ARROW's mission may be towards monitoring the progress of government commitments towards Agenda 2030 in relation to women's health and wellbeing, in particular around universal access to sexual and reproductive health and rights. It draws on secondary data to provide a comparison and measure progress pertaining to women's health across 19 countries in the Asia-Pacific region. It will primarily focus its analysis around indicators from ARROW's publication, *An Advocate's Guide: Monitoring Universal Access to Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals*, with a focus on Goal 3 of the SDGs but it will also include additional indicators to elucidate a more detailed perspective of the on-the-ground realities women face in relation to their health. With this brief being written in the midst of the global COVID-19 pandemic, it would be fatuous to not include the implication of the crisis on women's health. This will be done through expanding the scope of the analysis to include the likely effects of COVID-19 on health indicators chosen in this brief. As Universal Health Coverage (UHC) remains a critical means of ensuring women's health under Sustainable Development Goal 3, this brief will also include analysis for national and global UHC frameworks.

WOMEN'S HEALTH IN UNIVERSAL HEALTH COVERAGE

Health is a central component of sustainable development. The best framework that countries have in ensuring people's health and wellbeing is through Universal Health Coverage (UHC), which the World Health Organization (WHO) describes to mean that "all individuals and communities receive the health services they need without suffering financial hardship."[2] This means enlisting all components of a health system including health delivery systems, the health workforce, health facilities, health technologies, information systems, quality assurance mechanisms, and governance and legislation to enable everyone to access services that address the most significant causes of disease and death and ensure quality of those services.[3]

BOX 1: Key Factors that Need to be in Place for UHC

- A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care
- Affordability – a system for financing health services so people do not suffer financial hardship when using them
- Availability of essential medicines and technologies to diagnose and treat medical problems
- A sufficient capacity of well-trained, motivated health workers to provide services to meet patients' needs based on the best available evidence
- Actions to address social determinants of health such as education, living conditions and household income, which affect people's health and their access to services

Source: WHO, Questions and Answers on Universal Health Coverage, p.1.[4]

Unexpected or long-term illness often requires people to use their life savings, sell assets or borrow funds which have short and long term implications on other aspects of wellbeing.[5] Reducing out-of-pocket costs for patients is a central goal of UHC as the need to pay for care discourages usage if it is going to cause financial hardship,[6] which consequently leads to poorer health outcomes particularly amongst marginalised groups such as people with lower socio-economic status, indigenous communities and undocumented migrants and refugees. UHC works towards covering essential health services that are most pertinent to a particular country and includes services for HIV and/or AIDS, tuberculosis, malaria, non-communicable diseases, mental health, sexual and reproductive health, and child health, which are made available to all who need them.

Biological and gender-based differences between women and men result in differences in health risks, disease incidences and health service needs.[7] For example, women are 1.2 times more susceptible to the human immunodeficiency virus (HIV) than men.[8] Gender-based differences in terms of access to and control of household resources, decision making within and outside the home, and roles and responsibilities within the family, all culminate and have decisive influence on health-seeking behaviour, health status and access to health services.[9] These gendered factors result in unequal accessibility of health systems and lead to shortcomings in women's health at all ages.

UHC is highly political and part of an ongoing global debate about the relative importance of 'vertical' priorities such as disease eradication and broader 'horizontal' system-strengthening proposals.[10] "Middle income countries can broadly afford to aim for UHC, but they are more likely to enact access expansions when they have governments that are accountable to the population."[11] There is a tendency to silo UHC as though it were a settled goal that only requires technical follow up which underplays its dependence on features on a country's governance. Additionally, without political support in the international arena, UHC may be undermined by advocates of other goals such as programmes focused on single diseases.[12]

Studies indicate that UHC is "likely to exclude more women than men, and even when achieved, it is unlikely to translate into universal access to health care for women unless factors contributing to inequalities in affordability, availability, and access of health care by women are systemically addressed."[13] This is grounded in gender-power inequalities, which underlie women's limited access to resources and lack of decision-making power. For instance, a WHO study across 6 countries including Cambodia, Nauru, Philippines, Samoa, Solomon Islands, and Tuvalu found that 78-97% of women aged 15-19 years had one or more problems accessing health care when they needed it, many of which were not related to affordability.[14] Moving from a universal coverage framework towards a universal access framework is critical in ensuring barriers faced by marginalised populations including women are adequately addressed.

UHC is recognised as a unifying platform for making progress on Sustainable Development Goal 3 and it is essential that women's rights advocates use the momentum around UHC and the SDGs to ensure that women are not left behind. Well-designed UHC programmes, which consider accessibility barriers, have shown positive impacts on women's access to needed health services, however, several challenges still remain.[15] For example, service packages often lack elements essential for women's health including maternal and reproductive services.[16]

UNIVERSAL HEALTH COVERAGE

Although out-of-pocket payments for healthcare have been falling globally, out-of-pocket spending as a share of income has not been declining. This concerns two aspects of UHC, 1) that everyone should receive needed health care (service coverage) and 2) families who do receive needed care do not suffer financial hardship. Strong performance in one dimension does not guarantee strong performance in the other.[17] Case in point, a low incidence of catastrophic payments that are especially large, relative to a family's income, might reflect getting needed care, being protected from out-of-pocket costs, however, a low incidence of catastrophic payments could also mean people are not getting needed care because they don't want to pay for it.[18] Both aspects need to be looked at together.

Just increasing the share of GDP spent on health does not seem to be sufficient in providing financial protection, with studies finding only a partial positive correlation between catastrophic spending and share of GDP spent on health. This could reflect spending on

TABLE 1: Coverage of Essential Services (SDG indicator 3.8.1) and Proportion of the Population with Large Household Expenditure on Health as a Share of Total Household Expenditure (Greater than 25%) (SDG Indicator 3.8.2)

	Coverage of Essential Services (2017)	Proportion of the Population with Large Household Expenditure on Health as a Share of Total Household Eexpenditure (Greater Than 25%)
EAST ASIA		
China	79	54 (2013)
Mongolia	62	0.45 (2014)
SOUTH ASIA		
Bangladesh	48	9.53 (2016)
India	55	3.9 (2011)
Maldives	62	6.17 (2009)
Nepal	48	2.41 (2014)
Pakistan	45	0.5 (2015)
Sri Lanka	66	0.9 (2016)
SOUTH EAST ASIA		
Cambodia	60	5.24 (2014)
Indonesia	57	0.51 (2018)
Lao PDR	51	—
Malaysia	73	—
Myanmar	61	2.78 (2014)
Philippines	61	1.41 (2015)
Thailand	80	0.41 (2017)
Vietnam	75	1.9 (2016)
PACIFIC		
Fiji	64	—
Papua New Guinea	40	—
Samoa	58	—

Source: United Nations Statistics Division (UNSD), "Global SDG Indicator Database."[19]

greater service availability, more use of expensive technology, and higher prices—all of which are likely to correlate positively with the incidence of catastrophic expenditure.[20] "The out-of-pocket spending is higher in countries that spend a large share of their GDP on health and lower in countries that channel more of their total health spending through social health insurance schemes and non-profit schemes."[21]

Women could benefit from a few main strategies to reduce the consequences of out-of-pocket expenditure. These could include 1) abolishment of user fees and charges in public health facilities, 2) targeting and exemption of specific population groups such as the poor and vulnerable, including pregnant women, from official payments, and 3) ensuring that a range of health services such as maternal and child care are exempted from official payments and delivered free of charge.[22]

Key Service Delivery and Health SDG Indicators for Women's SRHR Across Selected Countries in the Asia-Pacific Region

MATERNAL MORTALITY RATIO (SDG INDICATOR 3.1.1)

The SDG health indicator 3.1 calls for a reduction in the global maternal mortality ratio to less than 70 per 100, 000 live births by 2030. Recent data on MMR across the 19 countries selected in this review (Table 1) point to high MMR (greater than 70) amongst Least Developed Countries (LDCs) including Cambodia, Bangladesh, Lao Myanmar, and Nepal. Developing countries including Indonesia, Philippines, and India still have MMR greater than 70. In the countries highlighted in Table 2, all have trended towards improving its MMR.

TABLE 2: Maternal Mortality Ratio (SDG Indicator 3.1.1)

	MMR Point Estimate 2000	MMR Point Estimate 2010	MMR Point Estimate 2017
EAST ASIA			
China	59	36	29 (UI 22-35)
Mongolia	155	66	45 (UI 36-56)
SOUTH ASIA			
Bangladesh	434	258	173 (UI 131-234)
India	370	210	145 (UI 117-177)
Maldives	125	67	53 (UI 35-84)
Nepal	553	305	186 (UI 135-267)
Pakistan	286	191	140 (UI 85-229)
Sri Lanka	56	38	36 (UI 31-41)
SOUTH EAST ASIA			
Cambodia	488	248	160 (UI 116-221)
Indonesia	272	228	177 (UI 127-254)
Lao PDR	544	292	185 (UI 139-253)
Malaysia	38	30	29 (UI 24-36)
Myanmar	340	265	250 (UI 183-351)
Philippines	160	144	121 (UI 91-168)
Thailand	43	42	250 (UI 183-351)
Vietnam	68	47	121 (UI 91-168)
PACIFIC			
Fiji	51	39	34 (UI 27-43)
Papua New Guinea	249	168	145 (UI 67-318)
Samoa	88	58	43 (UI 20-97)

Source: WHO et al., Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.[23]

It is important to note that the majority of maternal deaths are preventable with three quarters of all deaths caused by postpartum haemorrhage, hypertensive disorders such as pre-eclampsia/eclampsia, infections, unsafe abortion, and other delivery-related complications.[24] Targeting both poverty and gender inequality, which affect the demand and supply of maternal health care services, is essential. Virtually, all deaths that occur from childbirth or from pregnancy related causes happen in low-income countries. There is also a significant disparity among the richest and poorest income quintiles within countries. Such is the case in Indonesia, the risk of maternal death is three to four times greater in the poorest than the richest group.[25]

According to WHO, "each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion."[26] Deaths attributed to unsafe abortion are predominantly caused by severe infections or bleeding that resulted from unsafe abortion procedures, or due to organ damage. Some women suffer long-term health consequences including infertility, while many more have a short-term illness or injury.[27]

The lack of availability of emergency obstetric care (EmOC) is another major contributor to maternal mortality, and "evidence notes that approximately 15% of all expected births result in life-threatening complications during pregnancy, delivery, or postpartum period. Universal access to EmOC is essential to reducing maternal mortality and this requires all pregnant women to have universal access to well-functioning EmOC facilities including skilled health personnel."[28]

Gender inequality and women's low social status and disempowerment can have significant impact on women's maternal health and overall demand for maternal health services.[29] Gender-based violence, intimate partner violence, and domestic violence are contributing factors to maternal deaths in the region. According to an ARROW study in 2010, "maternal deaths due to gender-based violence is equal to that of deaths from unsafe abortion in developing countries. It is estimated that the prevalence of violence a woman experiences during pregnancy is 4% to 32%."[30]

Gender inequality perpetuated through norms and practices are particularly detrimental for young women as they are placed at the bottom of the family and social hierarchy[31] and leave them vulnerable to early marriage and early pregnancy. Ensuring access, availability, and quality of reproductive health services can go a long way in preventing maternal deaths. "Governments need to put in place functional health systems as per the WHO criteria and ensure these services are available through primary health care and referral systems across countries to ensure reduction in maternal mortality."[32]

TABLE 3: Proportion of Births Attended by Skilled Health Personnel (SDG Indicator 3.1.2)

	2000	2010	2015-2018
EAST ASIA			
China	96.6	96.6	99.9 (2014)
Mongolia	96.6	98.8	98.9 (2013)
SOUTH ASIA			
Bangladesh	12.1	26.5	67.8 (2017)
India	42.5	52.3 (2008)	81.4 (2016)
Maldives	84 (2004)	98.2 (2010)	95.6 (2014)
Nepal	11.9	36 (2011)	58 (2016)
Pakistan	23 (2002)	43 (2011)	69.3 (2018)
Sri Lanka	96	98.6 (2007)	—

	2000	2010	2015-2018
SOUTH EAST ASIA			
Cambodia	31.8	71.0	89 (2014)
Indonesia	66.3 (2003)	83.1 (2012)	93.6 (2018)
Lao PDR	16.7	40.1 (2012)	64.4 (2017)
Malaysia	96.6	98.6	99.5 (2016)
Myanmar	57 (2001)	71	60.2 (2016)
Philippines	58	72.2 (2011)	84.4 (2017)
Thailand	99.3	99.6 (2012)	99.1 (2016)
Vietnam	58.8	91.9 (2011)	93.8 (2014)
PACIFIC			
Fiji	96.9	99.7	99.8 (2016)
Papua New Guinea	39 (2004)	53 (2006)	—
Samoa	80	80.8 (2009)	82.5 (2014)

Source: United Nations, "Indicator 3.1.2, Series: Proportion of Births Attended by Skilled Health Personnel (%) SH_STA_BRTC."[33]

BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL

Assistance by properly trained health personnel working within an enabling environment is key to lowering maternal deaths. Most countries in this review have met the target of >90% of births being attended by a skilled birth personnel with the exception of Cambodia, Lao PDR, Myanmar, Philippines, Bangladesh, Nepal, Pakistan, and Samoa. South Asian countries were least likely to have met the target. The Asia-Pacific was also the region which had the country with the least number of births attended by a skilled birth personnel: Nepal at only 58%). Current data on births attended by skilled personnel are currently not disaggregated by age or background characteristics making it difficult to ascertain access of services of marginalised populations.[34] Nevertheless, evidence suggests that coverage of SBA usually increases first among the urban rich, followed by the rural rich and then the urban poor, and the rural poor are the last to be reached.[35] Additionally, skilled health personnel should be able to connect to a robust referral system in order for their clients to be able to access EmoC services if necessary.

It is also important to note that the definition of skilled birth attendants (SBAs) varies between countries. Initially, WHO proposed SBA's definition, which includes doctors, nurses, and midwives, however, in many countries it also includes cadres such as auxiliary nurses, auxiliary midwives, community health workers, and even traditional birth attendants, who have received some degree of formal training.[36] Births can also occur in a range of possible settings from home to a tertiary referral centre, depending on availability and need. Home SBA deliveries are more common in rural than in urban areas of all locations.[37]

Gender inequality perpetuated through norms and practices are particularly detrimental for young women as they are placed at the bottom of the family and social hierarchy and leave them vulnerable to early marriage and early pregnancy. Ensuring access, availability, and quality of reproductive health services can go a long way in preventing maternal deaths.

TABLE 4: Adolescent Birth Rate (Per 1,000 Women Aged 15-19 Years)

	2000	2010	2016
EAST ASIA			
China	6	5.9	9.2 (2015)
Mongolia	27.3	18.9	26.7 (2014)
SOUTH ASIA			
Bangladesh	134	118	78
India	79.1	37.2	28.1 (2013)
Maldives	28.9	15.8	12.9 (2014)
Nepal	71	90	88 (2015)
Pakistan	60 (2002)	44 (2011)	46 (2016)
Sri Lanka	30.3	20.3 (2008)	21 (2015)
SOUTH EAST ASIA			
Cambodia	52 (2003)	46 (2009)	57 (2013)
Indonesia	54	48	—
Lao PDR	96	94	75.6 (2014)
Malaysia	12	13.9 (2011)	11.5 (2015)
Myanmar	22.7	16.7 (2007)	36 (2014)
Philippines	55 (2001)	59 (2011)	47
Thailand	31.1	50.1	42.5
Vietnam	24	38	30.1 (2014)
PACIFIC			
Fiji	34.8 (2002)	27.5 (2008)	40 (2014)
Papua New Guinea	70	65 (2004)	—
Samoa	33.6 (2001)	39.2 (2011)	40.8 (2016)

Source: UNSD, "Indicator 3.7.2: Adolescent Birth Rate (Aged 10-14 Years, Aged 15-19 Years) per 1,000 Women in that Age Group."[38]

Addressing adolescent pregnancy requires an intersectional approach that keeps the SRHR needs of young people at the centre. By strengthening comprehensive sexuality information, unmet need for contraception among young people and enabling stigma-free access to SRHR services, early pregnancies and its consequences can be prevented.

ADOLESCENT BIRTHS

Adolescence is a key transition in life that happens within a short period of time and for many girls, these transitions include the start of sexual activity, marriage, and childbearing.[39] Adolescent birth rate has increased in a number of countries in Asia and the Pacific, and countries chosen in this review include China, Mongolia, Sri Lanka, Myanmar, Fiji, and Samoa. In many of these countries, this is reflective of the need to overcome national, provincial, and local level barriers to the provision of sexual and reproductive health education and services to adolescents. Mongolia, which is driven by pro-natalist policies by the government, aims to rejuvenate the working sector with an increase in young people.[40] In most countries in the region, births occur within the context of marriage and seem to be higher in countries that do not strictly enforce the legal age of marriage.

Early pregnancies among adolescents have major health consequences with pregnancy and childbirth complications becoming the leading cause of death among girls aged 15-19 years old.[41] Adolescent mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20–24 years.4 Additionally, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to maternal mortality, morbidity, and lasting health problems.[42] In addition to the adverse impacts on young women's health, early childbearing also "greatly reduces the likelihood of a girl advancing her education, limits her opportunities for training and employment, and often confines her to the domestic sphere for a number of years."[43] Studies have shown that "girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership."[44] In most Asian societies, sex before marriage is not allowed and young women. who are sexually active, are not considered 'proper,' thus, in case of an unintended pregnancy, an unmarried young woman faces challenges in accessing safe abortion services due to stigma and shame associated with premarital sex and abortion.

Addressing early pregnancy would also lower child mortality as births to adolescent girls are more likely to lead to the death of children before their first birthday.[45] Despite maternal mortality being the highest for adolescent girls under 15 years of age, cross-country comparable birth rate data is only available for the 15-19 age group, invisibilising girls who are most vulnerable. Addressing adolescent pregnancy requires an intersectional approach that keeps the SRHR needs of young people at the centre. By strengthening comprehensive sexuality information, unmet need for contraception among young people and enabling stigma-free access to SRHR services, early pregnancies and its consequences can be prevented.

Early pregnancies among adolescents have major health consequences with pregnancy and childbirth complications becoming the leading cause of death among girls aged 15-19 years old. Adolescent mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20–24 years. Additionally, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to maternal mortality, morbidity, and lasting health problems.

TABLE 5: HIV Incidence Rate – Number of New HIV Infection per 1,000 Uninfected Population by Sex (SDG Indicator 3.3.1)

	Both Sexes	Male	Female
EAST ASIA			
China	—	—	—
Mongolia	0.01	0.02	0.01
SOUTH ASIA			
Bangladesh	0.01	0.01	0.01
India	—	—	—
Maldives	—	—	—
Nepal	0.03	0.04	0.02
Pakistan	0.11	0.15	0.07
Sri Lanka	0.01	0.01	< 0.01
SOUTH EAST ASIA			
Cambodia	0.05	0.06	0.05
Indonesia	0.17	0.22	0.13
Lao PDR	0.08	0.1	0.06
Malaysia	0.18	0.34	0.01
Myanmar	0.2	0.29	0.12
Philippines	0.13	0.24	0.02
Thailand	0.09	0.13	0.06
Vietnam	0.06	0.07	0.05
PACIFIC			
Fiji	—	—	—
Papua New Guinea	0.26	0.23	0.29
Samoa	—	—	—

Source: WHO, (2018), "New HIV Infections (per 1000 Uninfected Population).[46]

HIV INCIDENCE

In the early years of the HIV epidemic, HIV cases predominantly affected men, however, infection among women has since increased. In the recent decade, over half of all adults living with HIV are women.[47] "Similarly, of the total estimated new HIV infections among adults (15 and older) globally in 2018, 52% were among women with heightened differences between men and women at a younger age."[48]

The HIV epidemic in Asia varies between countries and sub-regions but are fuelled by unprotected paid sex, the sharing of contaminated injecting paraphernalia by people who inject drugs, and unprotected sex among men who have sex with men.[49] The largest infected population group are men who buy sex, with many who are either married or will get married, putting a significant number of women who are often perceived as "low risk," at risk of HIV infection. In fact, it is estimated that more than 90% of the 1.7 million women living with HIV in Asia were infected by their husbands or partners while in long-term relationships.[50]

Lack of access to sexual health and HIV services stemming from unaccommodating attitudes towards sex outside of marriage and restricted social autonomy of women and young girls also play a role in increasing the risk of HIV among women and young girls.

"The AIDS-related deaths among women is 27% lower among women and girls in 2016 than they are among men and boys owing to the higher treatment coverage and better treatment adherence among women.[51] However, for women of reproductive age, AIDS is the leading cause of death while for adolescents (10-19 years old), it is the second leading cause of death globally."[52]

Furthermore, gender inequality and denial of women's and girls' right to protect their sexual and reproductive health and bodily autonomy are the catalyst for this epidemic. "Closely related to the heightened risk of contracting HIV living in a patriarchal society, women who experience gender-based and intimate partner violence are also at a greater risk of becoming HIV positive."[53] Lack of access to sexual health and HIV services stemming from unaccommodating attitudes towards sex outside of marriage and restricted social autonomy of women and young girls also play a role in increasing the risk of HIV among women and young girls.[54]

TABLE 6: Proportion of Women Married or in a Union of Reproductive Age (Aged 15-49 Years) Who Have Had Their Need for Family Planning Satisfied with Modern Contraceptive Methods

	2018		2018
EAST ASIA		**SOUTH EAST ASIA**	
China	94.8	Cambodia	61.9
Mongolia	72.4	Indonesia	80.1
SOUTH ASIA		Lao PDR	68.4
Bangladesh	75.6	Malaysia	55.2
Bhutan	82.8	Myanmar	75.9
India	73.4	Philippines	56.4
Nepal	61.8	Thailand	90.0
Pakistan	52.7	Vietnam	77.0
Sri Lanka	73.8		

Source: Equal Measures 2030 (EM2030), Bending the Curve Towards Gender Equality by 2030.[55]

NEED FOR MODERN CONTRACEPTION

This indicator is relatively new. Unmet need for family planning is the usual indicator used for assessing the extent to which women's need for fertility control is met. This indicator is central to gender equality as it depicts access to safe and modern methods of contraception. It aims to show the degree to which the use of fertility control is keeping in pace with women's and couples' desires to prevent pregnancy and is useful for comparing populations with different fertility preferences across time and space.[56] Although "women of reproductive age" (15–49 years) refers to all women, data on modern contraceptive use is available only for women who are currently married or documented to be in a consensual union.[57] It is important to note that this indicator emphasises the use of "modern contraception" which may not be the method of preference for all women, especially for spacing between birth.[58]

UHC is recognized as a unifying platform for making progress on SDG Goal 3 *and it is essential that women's rights advocates use the momentum around UHC and the SDGs* **to ensure women are not left behind.**

TABLE 7: Proportion of Demand Satisfied (Contraception)

	Proportion of Demand Satisfied	Proportion of Demand Satisfied by Modern Methods	Sources
EAST ASIA			
China	—	—	China Sexual and Reproductive Health Rights Needs Assessment Report (2014)[59]
Mongolia	77%	68.3%	Situation Analysis of Family Planning in Mongolia (UNFPA 2016)[60]
SOUTH ASIA			
Bangladesh	83.9%	72.6%	BDHS 2014[61]
India	80%	72%	NFHS 4 2016[62]
Maldives	55%	42.7%	WCU 2018[63]
Nepal	69.1 %	56.3%	Nepal DHS 2016[64]
Pakistan	64%	47%	PDHS 2012-2013[65]
Sri Lanka	89%	74.1%	WCU 2018[66]
SOUTH EAST ASIA			
Cambodia	81%	56.4%	WCU 2018[67]
Indonesia	—	—	—
Lao PDR	71%	61.3%	DHS2011-12[68]
Malaysia	—	—	—
Myanmar	76%	75%	WCU 2018[69]
Philippines	75%	51.5%	DHS1998, 2008, 2013[70]
Thailand	92%	89.2%	WCU 2018[71]
Vietnam	—	—	DHS2002[72]
PACIFIC			
Fiji	—	—	—
Papua New Guinea	54%	40.6%	DHS2006-07[73]
Samoa	43%	39.4%	DHS2009[74]

DEMAND SATISFIED FOR CONTRACEPTION

Both the numbers of unmet need and current use (or contraceptive prevalence rate: CPR) make up the total demand for contraception, while demand satisfied is CPR divided by the total demand for contraception. It is also useful for us to look at these two indicators, as this is also a new indicator for the SDGs.

Analysis reveals that the largest gaps are amongst those in the "younger age groups of 15-19 years and 20-24 years, those with no education, and those in the lowest wealth quintile."[75] For married women, "[o]nly 21.9% with their demands satisfied, and only 18.8% was recorded for demand satisfied with modern methods. When examining sexually active, unmarried women in rural areas, however, they are particularly disadvantaged with only 16.8% of their demands satisfied by any

methods, and of that, 15.8% of demands satisfied are by modern methods."[76] A deep dive into DHS data shows that younger women belonging to the lowest wealth quintile and rural women have less access to their demands being met with modern methods.

These indicators are useful to add to the critical perspective of whether those who want a method of contraception are receiving what they need, and some hidden gaps that exist may be due to the providers themselves, social attitudes and/or taboos, as well as a lack of comprehensive service provision in certain areas and for certain groups. However, gaps remain within this indicator as well as it is a composite indicator. Who are the women affected, which methods are available to them, and what type of services are encapsulated, are still part of the problem with this indicator. The indicator also masks the numbers positively. For example, countries with overall low CPRs such as Pakistan, the Philippines, and Myanmar, which have real issues with service provision of a variety of modern methods reaching women at the local level, could be seen as having their demand satisfied. Hence, this is an indicator which should be presented along with other indicators in order to understand the picture more clearly.[77]

It is imperative to look at additional indicators such as 'informed choices' and availability of 'emergency contraception' to understand the 'goodness' of the numbers being presented. DHS data only looks at married women, even though it is common knowledge that unmarried young women between the age of 15 and24 are the most underserved group; contraceptive method mix at country level, and provision of counselling and services, which enable informed choices, help to better understand whether women have adequate choices around the method of contraception.

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Faultlines in Women's Health Exposed by the COVID-19 Pandemic

In the ongoing COVID-19 pandemic, sex disaggregated data suggest that fewer women are dying from this disease than men.[79] However, taking this at face value "over-simplifies the biological, behavioural, social, and systemic factors that may cause differences to emerge in regards to how women and men experience both the disease and its consequence."[80] The ripple effects caused by other factors put women at increased risk even if the disease itself does not. In the context of inequality, current national averages trend towards improvements over time and are important indicators of progress on a global and regional level, reporting inequalities within countries reveals the different experiences of rural and urban residents, the poor and the rich, the educated and the non-educated, and females and males.[81] Some of these factors will be discussed in this section.

CARE WORK

Caregiving is an under-resourced and largely unpaid activity that falls disproportionately on women and girls, worldwide. Unsurprisingly, the COVID-19 pandemic has put additional demands on women to care for children, the elderly, and those who suffer from disease or disability. The true extent of this burden is currently unknown but documented experiences from past outbreaks provide a fairly good understanding of what it will likely be for women. During the 2014-16 west African outbreak of the Ebola virus disease, gendered norms meant that women were more likely to be infected by the virus, given their predominate roles as caregivers within the family and as front-line care workers.[82] The pandemic has, in effect, magnified inequalities in care work distribution and will continue to do so unless governments allocate resources to help ease the burden faced by caregivers.

SEXUAL AND REPRODUCTIVE HEALTH

The adverse effects of the pandemic in relation to women's reproductive health are not limited to pregnancy or motherhood. Beyond the clinical scope of COVID-19 on pregnancy outcomes, which is currently unknown, health system level disruptions or interruptions in regular provision of SRH services such as pre- and postnatal checks, safe abortion, contraception, HIV/AIDS, and sexually transmitted infection[83] are already occurring in affected countries.

In countries with high maternal mortality rates (MMR), a strong indicator of weak health systems, the COVID-19 pandemic will likely severely impact health systems with worse outcomes in countries experiencing fragility and humanitarian crisis.[84] For instance in Nepal, the Family Division of the Department of Health services has already reported a 200% increase of MMR in the last two months when compared to figures from last year.[85] Nepal's maternal mortality is 239 deaths per 1,000,000 live births and has already missed its 2020 SDG target of reducing it to 125 deaths per 1,000,000 live births.[86] The complete halt to public transportation during the lockdown in Nepal, in addition to disruptions in antenatal and postnatal visits, and out-of-reach emergency obstetric care (EmOC) services have compelled more women to give birth at home.[87]

TABLE 8: Barriers to Accessing Healthcare Amongst Women

	Year	Problems Getting Permission to Go for Treatment	Problems Getting Money for Treatment	Problems with Distance to Health Facility	Problems Having to Take Transport	Not Wanting to Go Alone	Concern There Not be a Female Health Provider
SOUTH ASIA							
Bangladesh	2004[88]	17.4	14.0	8.4	12.4	19.1	17.4
India	2005-2006[89]	6.7	17.3	25.2	22.9	11.7	18.7
	2015-2016[90]	17.9	25.4	29.9	27.1	19.5	37.4
Maldives	2009[91]	2.3	11.4	26.0	28.2	23.7	57.0
Nepal	2001[92]	17.0	66.3	50.5	51.0	57.2	49.2
	2011[93]	12.6	46.8	46.6		60.2	
	2016[94]	23.5	54.9	53.0		67.8	66.9
Pakistan	2012-2013[95]	17.7	29.7	37.1	40.3	53.1	63.2
SOUTH EAST ASIA							
Cambodia	2000[96]	22.6	88.1	40.3	42.0	44.5	32.6
	2005[97]	14.3	74.1	38.7	38.7	45.0	36.9
	2014[98]	21.4	64.4	35.0		45.4	
Indonesia	2002-2003[99]	4.2	23.7	12.4	11.5	8.6	5.7
	2012[100]	5.1	15.2	10.5		22.8	
Myanmar	2015-2016[101]	4.3	34.0	23.4		31.4	
Philippines	2003[102]	10.7	67.4	27.2	25.6	28.1	20.5
	2013[103]	9.2	47.7	27.4		21.1	

Women in other COVID-19 affected countries with similar barriers to accessing health care will also bear similar consequences. Women from all countries reviewed in Table 6 are at risk of not being able to access care based on one or more barriers, pointing to the need of countries to contextualise gendered COVID-19 response based on existing weakness within its health system. Intersectional inequalities are likely to affect women in certain socio-demographics groups more such as poor, migrants, sexual and gender minorities, indigenous people, and those living with disabilities due to the marginalisation they already face and have likely and already make up a disproportionate number of women face barriers in accessing healthcare, which will be exacerbated in the COVID-19 pandemic.

Some countries have gone as far as using the pandemic to curtail women's access to SRH services. Case in point, some states in the United States of America moved to limit abortion as part of their response to coronavirus[104] by arguing that abortions are elective and therefore, non-essential. Across many developing countries, International Non-governmental Organisations (INGOs) who support access to SRH services such as IPPF had to close clinics as they were deemed non-essential while Marie Stopes experienced huge shortages in contraception due to supply chain disruptions.[105]

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SEXUAL AND REPRODUCTIVE RIGHTS

Women's access to justice is a significant issue, which needs to be addressed in the context of the COVID-19 pandemic due the consequential increased violence faced by women during the crisis. China's Hubei province, for instance, reported a jump in domestic violence reports in February from 47 last year to 162 this year during the lockdown. In Malaysia, the government reported a 57% increase in calls to its welfare hotline due to domestic violence and martial issues. As countries go into lockdown to curb the spread of COVID-19 for public safety, there is a need to recognise that homes are not safe spaces for many women and girls.

To make matters worse, in many countries across Asia, there is no specific law that regulates against sexual violence comprehensively, including Brunei, Cambodia, Myanmar, Philippines and Thailand.[106] In other countries including Afghanistan, Bangladesh, India, Nepal, Indonesia, and Malaysia, domestic violence legislation do not protect unmarried intimate partners.[107] However, many of the same countries including Afghanistan, Bangladesh and Malaysia, among other countries including Japan and Mongolia, do not criminalise martial rape.[108] Access to justice for women and girls in some countries is, therefore, completely impossible regardless of marital status, which is often a barrier to sexual and reproductive health services.

Sexual minorities have been unfairly targeted and accused of spreading COVID-19 in some countries, increasing the marginalisation and discrimination that they already face. To give an instance, South Korea had experienced a marked increase in online threats and discrimination against lesbian, gay, bisexual, and transgender (LGBT) people, when at least 100 infections were linked to a queer nightclub.[109] COVID-19 related disruptions to medical supplies and access to healthcare can also disrupt access to gender-affirming therapy and surgery, which can be a significant source of stress and anxiety in an already difficult time.[110]

As countries go into lockdown to curb the spread of COVID-19 for public safety, there is a need to recognise that homes are not safe spaces for many women and girls.

MENTAL HEALTH

The pandemic has exacerbated pre-existing gender inequalities; in a report published by UNFPA, "women and girls may be at a higher risk of intimate partner violence and other forms of domestic violence due to increased tensions in the household. As systems that protect women and girls, including community structures, may weaken or break down, hence, specific measures should be implemented to protect women and girls from the risk of intimate partner violence with the changing dynamics of risk imposed by COVID-19."[111]

Globally, women are the majority working in the informal sector and "[e]merging evidence on the impact of COVID-19 suggests that women's economic and productive lives will be affected disproportionately and differently from men. Across the globe, women earn less, save less, hold less secure jobs, and are more likely to be employed in the informal sector. They have less access to social protections and are the majority of single-parent households. Their capacity to absorb economic shocks is therefore less than that of men. As women take on greater care demands at home, their jobs will also be disproportionately affected by cuts and lay-offs."[112]

Closure of schools have added strain on women who are the primary care givers, as "women were doing three times as much unpaid care and domestic work as men. This unseen economy has real impacts on the formal economy, and women's lives."[113] SDG Goal 3 Target 3.4 focuses on promoting mental health and wellbeing, and "in the context of the pandemic, the increased demand for care work is deepening already existing inequalities in the gender division of labour. The less visible parts of the care economy are coming under increasing strain but remain unaccounted for in the economic response."[114]

"As access to formal and informal childcare alternatives declines, the rise in demand for unpaid childcare provision is likely to fall more heavily on women, not only because of the existing structure of the workforce but also because of social norms. This will constrain their ability to engage in paid work. Where remote working is possible, multitasking will likely increase, placing further burdens on women's physical and mental wellbeing."[115]

Recommendations

The Health and well-being goal 3 of SDGs should be located within the Universal Health Access framework and focus comprehensively on universal coverage of all people including marginalised groups, expanding the range of health services including SRH services, and should be provided to all without financial risk and hardship.

- Ensure and integrate a comprehensive definition of SRHR when conceptualising and progressively implementing UHC as well as in building collective health for all in all countries. Integrate UHC, including SRH into national strategies and related health policies ensuring that SRH services are made available at the primary, secondary and tertiary level along with other basic health care that can increase access to care and information, especially for disadvantaged populations, such as adolescents, people with disabilities and those living with HIV.

- Provide adequate financial, human and infrastructural resources towards implementing health policies, which ensures the highest attainable standard of sexual and reproductive health and mental health. Increase domestic financing to support UHC strategies, that include SRH and recognise intersectionality.

- Ensure that the most marginalised groups have access to health services, including sexual and reproductive health and rights. Ensure strong evidence bases that fill research gaps on SRHR that are used to inform decisions, policies and programmes on UHC.

- Ensure that access to safe abortion is part of the essential health services. In addition, ensure that often-neglected areas of SRHR are covered, such as safe abortion services, youth friendly SRH information and services, addressing sexual and gender based violence. Provide additional support to more marginalised groups, such as in humanitarian contexts and people of diverse sexual orientations, gender identities and expression, and sex characteristics

- Ensure the specific needs and priorities of women, adolescents, and other underserved populations, including their SRH needs are considered as a priority in the development and implementation of UHC policies, inclusive of resources allocation. Acknowledge the unique needs of population groups based on their circumstances, needs and lived realities.

- Ensure strengthened capacity of health workers at all levels and to include delivery of SRH services with recognition of the need to respect the human rights of women and girls in marginalised and stigmatised communities.

- Invest in strengthening and monitoring the public health sectors to ensure the provision of gender-sensitive, quality SRHR services with emphasis on dignity and respect, privacy and confidentiality and that these services meet public health and medical ethics standards.

- Ensure accountability mechanisms are in place, are operational, regularly monitored and informed by evidence and outcomes so they are able to prioritise services according to the needs of women and girls, how they can access services, supply of services and health and equity outcomes

- Ensure that systemic barriers that perpetuate gender inequalities, such as patriarchy and the influence of socio-cultural beliefs and practices on women and girls in society, and devaluing of girls are recognised in the design of UHC implementation.

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Asian-Pacific Resource and Research Centre for Women (ARROW) is a regional, feminist, global-south non-profit organisation based in Malaysia with a consultative status with the Economic and Social Council of the United Nations. ARROW works towards an equal, just and equitable world that enables all women and young people to be equal citizens in all aspects of their lives, and that protects and advances their sexual and reproductive health and rights.

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