championing
women's sexual and
reproductive rights

COUNTDOWN TO 2030:

Are Countries in the Asia Pacific Region Honoring Their Commitments to SDG3 and SDG5 Towards the Fulfilment of Sexual and Reproductive Health and Rights for All?

arrow

briefs

2025

ASIAN-PACIFIC RESOURCE AND RESEARCH CENTRE FOR WOMEN (ARROW)

arrow.org.my

COUNTDOWN TO 2030:
ARE COUNTRIES IN THE ASIA PACIFIC REGION HONORING THEIR COMMITMENTS TO SDG 3 AND SDG 5 TOWARDS THE FULFILMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ALL?

2025

PUBLISHED BY

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

Telephone	+603 2273 9913/9914/9915
Fax	+603 2273 9916
Email	arrow@arrow.org.my
Web	arrow.org.my
Bluesky	arrowomen.bsky.social
Facebook	ARROW.Women
Instagram	arrow_women
YouTube	ARROW_Women
LinkedIn	arrowomen

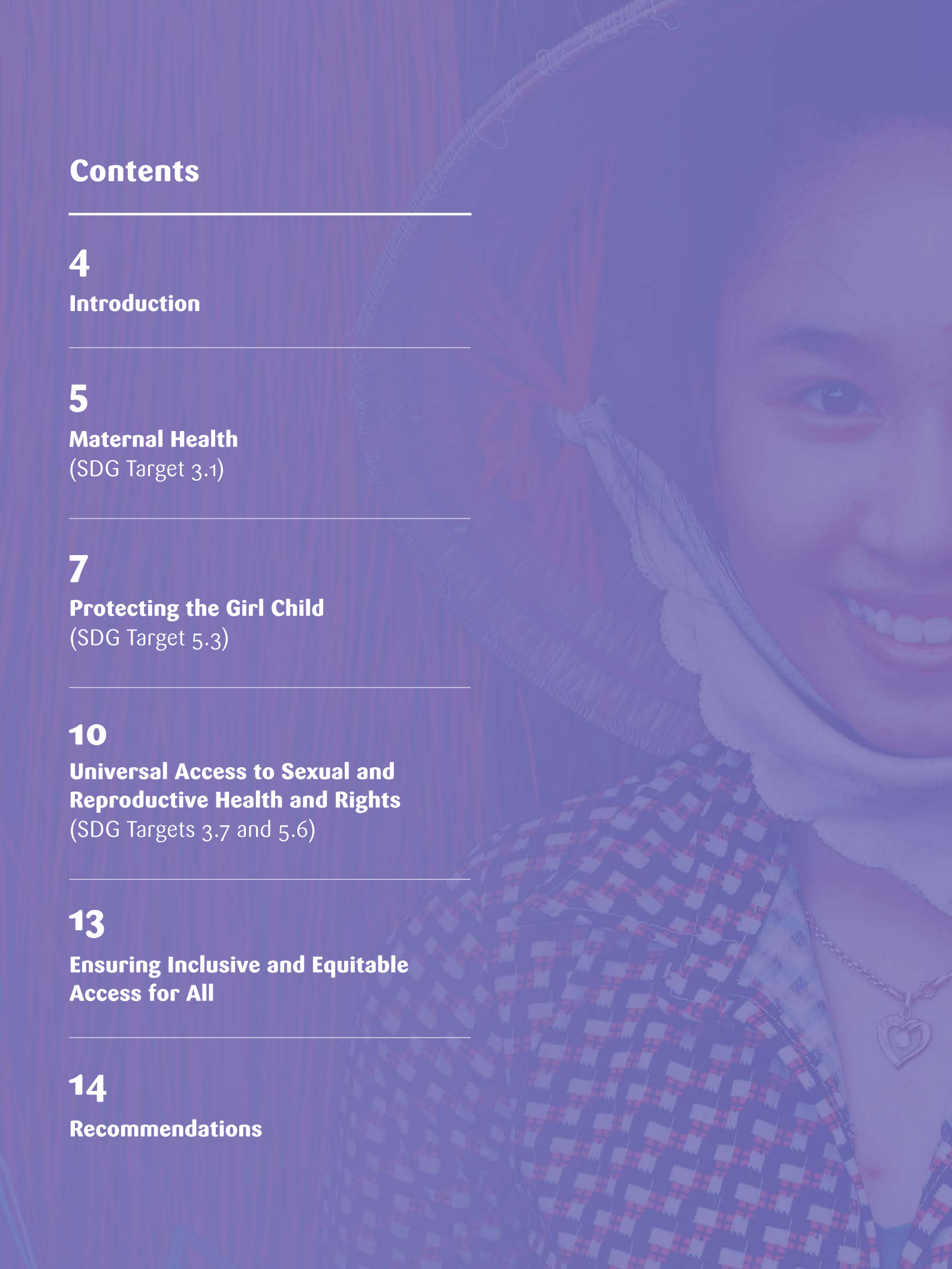
PUBLICATIONS TEAM

Author	Nadia Rajaram
Reviewers	Sivananthi Thanenthiran and Anjali Shenoi
Graphic Design	Nicolette Mallari
Cover Photo	R7 Photo/Shutterstock.com

ACKNOWLEDGEMENT

This brief was developed based on publicly available secondary data as well as evidence generated at the national and/or community level by partners of ARROW, which have contributed tremendously to our understanding about the contextual factors that drive or hinder progress in the region towards SRHR within the SDG framework.

Contents



Introduction

The assurance of sexual and reproductive health and rights (SRHR) has been integrated into the Sustainable Development Goals (SDGs), particular in Goal 3 (Good Health and Wellbeing) and Goal 5 (Gender Equality), though there are cross-cutting implications for SRHR across all the SDGs. However, progress in the region towards these goals remains slow and uneven. In 2020, ARROW and her partners worked collaboratively to identify the key successes and gaps for the Asia Pacific region.[1, 2] There was a unified call for greater investment towards the development of legal and financial frameworks, and adequate, transparent monitoring of these frameworks, to ensure that no one is left behind. Large data gaps persist, particularly for the targets and indicators around SRHR that represent emerging threats to women's rights in this part of the world. From the national-level research conducted across the region, there was a clear call for improved accountability mechanisms to ensure that women and girls have access to a full range of quality services that meet their sexual and reproductive needs. Furthermore, the persistence of systemic barriers that perpetuate gender inequalities must be resolved.

Today, the review of progress made in these SDG targets and indicators are further complicated by global challenges that have led to the present "polycrisis." The COVID-19 pandemic acutely reduced the availability of SRH services in many countries in the region,[3] and in some cases, these disruptions have persisted to this day. Globally, the instability brought about by prolonged war and shifts in political power has led to dramatic declines in focus and funding for SRHR.[4] In some countries in Asia, increasing fundamentalism at the national level further impedes progress made towards the realization of SRHR for its women and girls. Worsening climate change unequally affects communities that are already at a social and economic disadvantage, leading to forced migration, disruption of access to health services and proper sanitation, worsening food insecurity, and increased exposure to environmental toxins, with women and girls bearing the brunt of these problems.[5] In a multidimensional index developed by EM2030 to benchmark gender equality within the SDG framework, most of the emerging economies in the region ranked poorly, indicating that the region still has a long road ahead towards gender equality and the fulfilment of SRHR (Figure 1).

FIGURE 1:
SDG GENDER INDEX FOR EMERGING ECONOMIES IN ASIA AND THE PACIFIC

VERY POOR
POOR
FAIR
GOOD
VERY GOOD
NO DATA

CENTRAL & EAST ASIA	SOUTH EAST ASIA	SOUTH ASIA	PACIFIC
Mongolia	Lao PDR	Pakistan	Tonga
Kyrgyzstan	Myanmar	Bangladesh	Papua New Guinea
Uzbekistan	Philippines	Afghanistan	Fiji
Tajikistan	Cambodia	Sri Lanka	Vanuatu
Kazakhstan	Indonesia	Nepal	Samoa
China	Thailand	India	Solomon Islands
Turkmenistan	Vietnam	Maldives	Kiribati
	Malaysia	Bhutan	Micronesai
	Timor Leste		Tuvalu
			Marshall Islands

Data source: *2024 SDG Gender Index, EM 2030, https://equalmeasures2030.org/2024-sdg-gender-index/ (accessed: 1 July 2025).*

In light of this year's focus on Goal 3 and Goal 5 in the High-Level Political Forum, ARROW and her partners have reviewed progress made towards SRHR for the Asia Pacific region in the face of these intersecting crises, both within the SDG framework, but also incorporating community and lived experiences of women and girls in all their diversities, from the region.

Maternal Health (SDG Target 3.1)

One third of countries in the region are not on track to reduce maternal mortality to below 70 deaths per 100,000 live births. A majority of countries are experiencing a decline in maternal mortality, but for many, the problem is too big and progress is not fast enough.

Maternal mortality is largely preventable. The primary cause of maternal mortality and morbidity is haemorrhage and eclampsia, suggesting that consistent access to quality healthcare is key to saving lives.[6, 7] In a regional analysis, we show that access to the full spectrum of maternity care, including antenatal care, skilled delivery services, and postpartum care, is correlated to lower maternal mortality ratios (Fig 2). The maternal mortality ratio is lowest in countries where these services are highly utilized. Delays in accessing maternal health services also increases the risk of maternal mortality. Research from our partners in the University of Health Sciences Lao PDR, shows that delays in seeking care and receiving care are the primary contributors of maternal mortality in the rural areas of Luang Prabang, and was attributed to 61% and over 80% of maternal deaths in the area, respectively.[8]

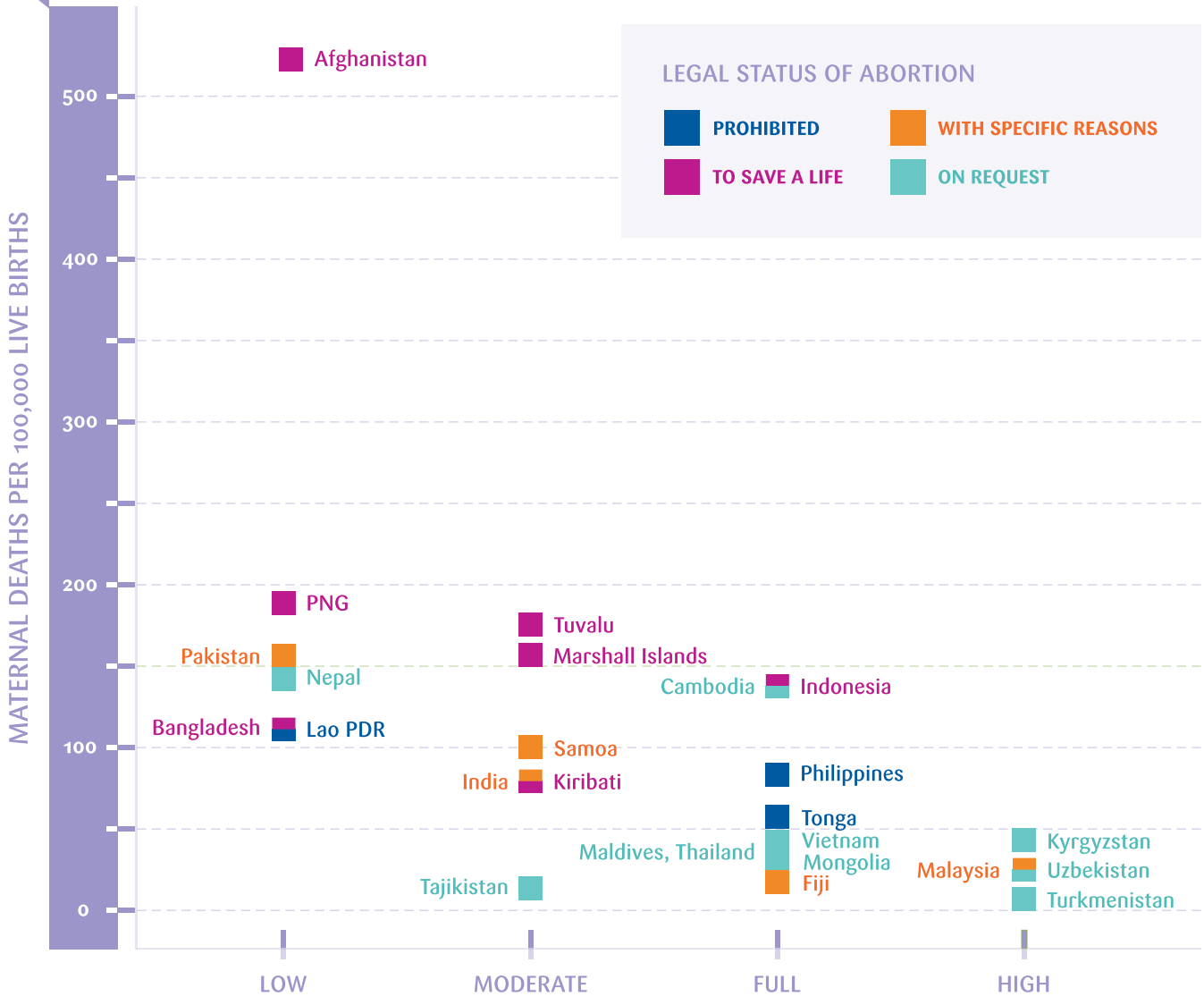
Unsafe abortion continues to be an important source of preventable maternal deaths. Regional data on unsafe abortion remain scarce and outdated. An estimation using 2010-2014 data showed that up to 38% of abortions in Asia were unsafe.[9] A smaller study from Nepal showed that the prevalence of abortion among women who ever had a terminated pregnancy was 21%, of which 16% had undergone an unsafe abortion.[10] The extent of unsafe abortions in the Pacific is not documented.

Researchers estimate that the rates of abortion for this region are between 34-46 abortions per 1,000 women of reproductive age,[11] indicating that there is a dire need for safe abortion services in Asia and the Pacific, though this need is largely unmet by legislation. We (Figure 2) and others[12] demonstrate that in countries with the more restrictive legislation on abortion, the burden of maternal mortality is higher. This is likely explained by the higher prevalence of unsafe abortions in countries with the most legal restrictions on abortion.[13] Given the intricacies of death reporting for unsafe abortions in the presence of legal and social barriers in the region, the correlation we observe between restrictive legislation and maternal deaths is likely an underestimation. It proposes the removal of legal barriers to abortion as a critical intervention to reduce maternal mortality in the country whilst also ensuring reproductive justice for women and girls.

Let's acknowledge that these maternal mortality risk factors act in tandem for a young girl, exacerbating the risk to her physical and mental wellbeing. A pregnant adolescent is more likely to seek out unsafe abortion options,[14] because the legal pathway is often not available to her or is hindered by many barriers, including parental consent, affordability, and societal pressures. A pregnancy adolescent is also more likely to delay seeking help out of fear or lack of agency, especially when the healthcare services available to are not adolescent-friendly.[15] This is exemplified in recent research done in Nepal, where our partners report that pregnant adolescents face a multitude of structural and social barriers in access care, including stigma and taboo about SRHR issues, weak adolescent-friendly health service delivery, and inadequate training of health workers and teachers.[16]

Unsafe abortion continues to be an important source of **preventable maternal deaths**. Regional data on unsafe abortion remain scarce and outdated. Researchers estimate that the rates of abortion for this region are between 34-46 abortions per 1,000 women of reproductive age, indicating that there is a **dire need for safe abortion services in Asia and the Pacific, though this need is largely unmet by legislation.**

FIGURE 2:
CORRELATION BETWEEN MATERNAL DEATHS, COVERAGE OF MATERNAL HEALTH SERVICES, AND LEGAL STATUS OF ABORTION FOR COUNTRIES IN ASIA AND THE PACIFIC



Coverage of maternal services includes (1) Births attended by skilled health personnel (%), (2) Antenatal care coverage - at least four visits (%), and (3) Proportion of mothers who had postnatal contact with a health provider within 2 days of delivery (%). Low coverage corresponds to all services having less than 80% coverage. Full coverage corresponds to all services having greater than 80% coverage. High coverage corresponds to all services have greater than 90% coverage. Nine countries were excluded from analysis due to incomplete data. Most recent available data was used across indicators (not older than 2017).

Data sources: *Maternal health indicators, World Health Organization, https://www.who.int/data/gho/data/indicators/indicator-details/GHO; Abortion legislation, Centre for Reproductive Rights, https://reproductiverights.org/maps/worlds-abortion-laws/?country=KHM (accessed: 1 July 2025).*

Protecting the Girl Child (SDG Target 5.3)

Girls in the region face a multitude of challenges when it comes to their safety and well-being, including early and forced marriages, female genital mutilation or cutting (FGM/C), as well as sexual, physical, and psychological violence. In the SDG framework, the protection of girls is monitored through the assessment of two outcomes, prevalence of early marriages (SDG Indication 5.3.1) and prevalence of FGM/C.

Early and forced marriages are practiced in many countries in the region. Whilst there is a stated reasonable legal age of marriage in most countries in the region, there are often exceptions to the law (Table 1). For example, in the Philippines, the minimum legal age of marriage is 18 for both girls and boys, and parental consent is required up to 21 years of age. However, under the Muslim Law on Personal Status, girls can be married as early as 13 years old.[17] In Bangladesh, a loophole in the Child Marriage Restraint Act 2017 makes it possible for girls under 18 to be married in special cases and is open to interpretation.[18] Furthermore, some speculate that this loophole has increased the incidence of rape and sexual abuse of girls, allowing the perpetrator to marry the girl in the event of pregnancy.[19] The prevalence of child marriages in Bangladesh has increased by 13% since the COVID-19 pandemic, and was reported to have been exacerbated by the financial and social insecurities in those times.[20]

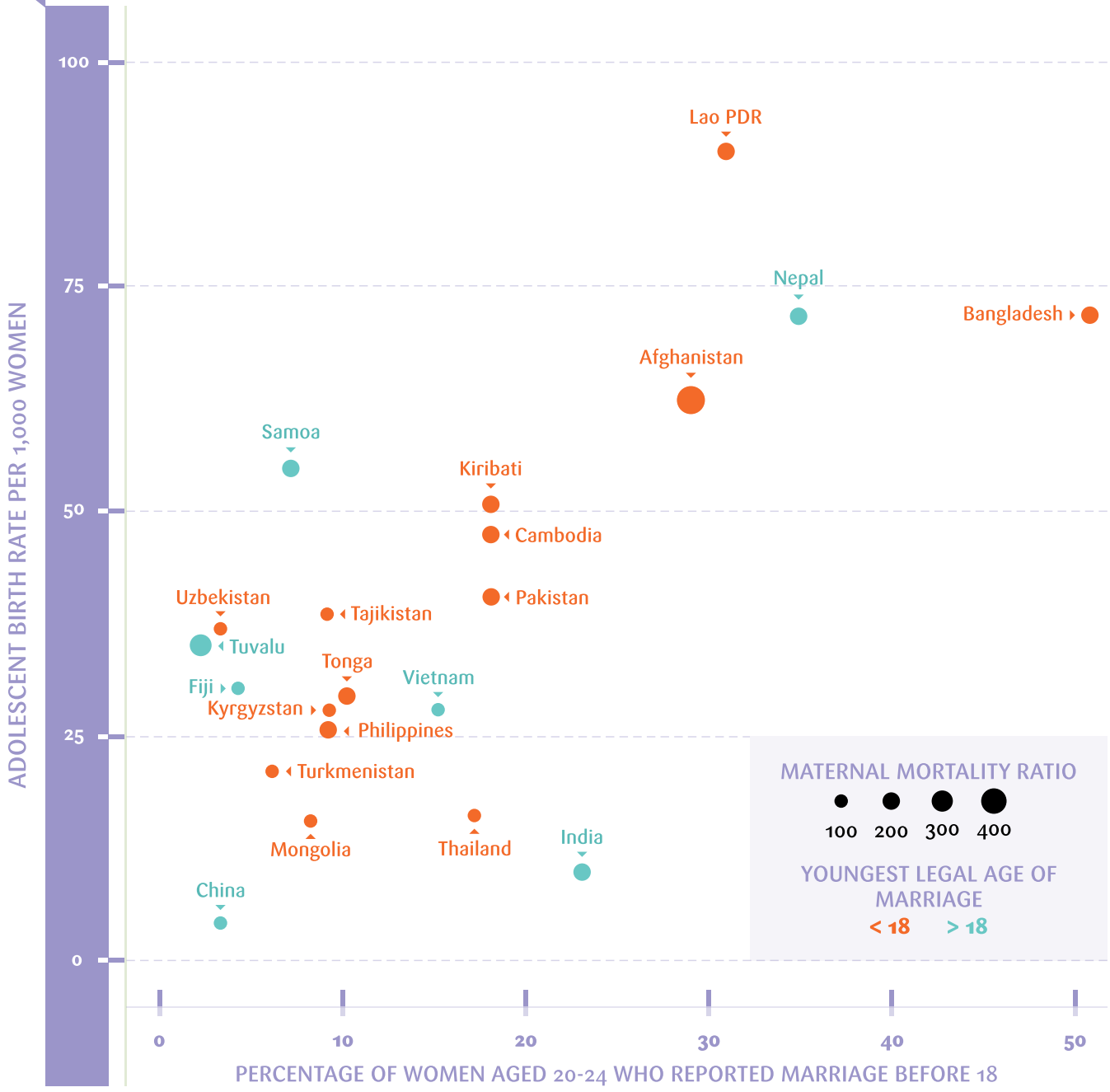
Even when appropriate legal protections are in place, early and forced marriages still occur through customary practices. In Kyrgyzstan, our partners report that despite the criminalization of forced marriage, there is poor implementation at local levels, and in many cases, these marriages are held within the family or religious institutions and go unregistered.[21] Furthermore, health workers, teachers, and law enforcement often lack the capacity to act on early or forced marriages. In this region, forced marriage is just the start to various forms of control over the girl or women, leaving her unprotected from physical, sexual, and psychological violence, particularly in cases of inter-caste or inter-religious couples or in emergency settings.

Data on female genital mutilation or cutting (FGM/C) remain scarce, though the practice are widespread in the region. In many of these countries, **there is little-to-no legal framework that protects girls from FGM/C and the procedure is routinely performed under medical care.** It is evident that Asia Pacific countries are far from achieving the SDG 5.3 target to eliminate these harmful practices, which results in irreparable physical and psychological damage amongst girls, even death.

Marriage at a young age exposes a girl to many challenges that she should not have to deal with. Child brides are discouraged or not allowed to complete their education. We demonstrate that early marriage is correlated to higher rates of adolescent pregnancies, and correspondingly higher rates of maternal mortality (Fig 3). It is of particular concern for countries such as Lao PDR, Bangladesh, Nepal, and Afghanistan, which carry a heavy burden of both early marriages and adolescent pregnancies, but low access and/or availability of maternal health services (Fig 2). Also, young girls are less likely to seek help when they are exposed to violence in the household. A study form Turkey showed that early marriage and adolescent pregnancy were both associated with an increase in risk for intimate partner violence.[22] A study of South Asia shows that early marriages and early pregnancy occurs most often in rural areas, at the intersection of poverty and lack of access to education.[23]

Data on female genital mutilation or cutting (FGM/C) remain scarce, though the practice are widespread in the region. UNICEF reports that in Indonesia, half of women aged 15-49 years old have reported experiencing FGM/C.[24] FGM/C is also practiced in India, Sri Lanka, Bangladesh, Thailand, Malaysia, Cambodia, Vietnam, Lao PDR, and the Philippines, as part of religious practice, as a means to control women's sexuality.[25] In many of these countries, there is little-to-no legal framework that protects girls from FGM/C (Table 2) and the procedure is routinely performed under medical care.[26, 27] It is evident that Asia Pacific countries are far from achieving the SDG 5.3 target to eliminate these harmful practices, which results in irreparable physical and psychological damage amongst girls, even death.

FIGURE 3:
CCORRELATION BETWEEN ADOLESCENT PREGNANCY, CHILD MARRIAGES, LEGAL AGE OF MARRIAGE, AND MATERNAL MORTALITY FOR COUNTRIES IN ASIA AND THE PACIFIC.



Youngest legal age of marriage for women is defined not just as the stated legal age of marriage in the law, but also considers any exceptions to the legal age that can be lawfully applied. Most recent available data was used across indicators (not older than 2017).

Data sources: *Adolescent birth rate per 1000 women & maternal mortality ratio per 100,000 live births, World Health Organization, https://www.who.int/data/gho/data/indicators/indicator-details/GHO; Percent of women aged 20-24 who reported marriage before age 18 & legal age of marriage, Girls Not Brides, https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/atlas/ (accessed: 1 July 2025).*

TABLE 1:
LEGAL STATUS FOR AGE AT MARRIAGE

Data sources: *Legal age of marriage, Girls Not Brides, https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/atlas/ (accessed: 1 July 2025).*

COUNTRY	LEGAL MINIMUM AGE OF MARRIAGE FOR WOMEN
CENTRAL & EAST ASIA	
China	20 years old, no exceptions
Kyrgyzstan	18 years old, with possibility of reducing by 1 year under special circumstances
Tajikistan	18 years old, with possibility of reducing by 1 year under special circumstances
Turkmenistan	18 years old, with possibility of reducing by 1 year with parental consent
Kazakhstan	18 years old, with possibility of reducing to 16 years old in case of pregnancy or parental consent
Mongolia	18 years old, with exceptions allowed for those 16-18 years old
Uzbekistan	17 years old, with possibility of reducing by 1 year under special circumstances
SOUTH EAST ASIA	
Indonesia	21 years old, with possibility of reducing by 17 years old with parental consent
Myanmar	18 years old
Vietnam	18 years old, no exceptions
Cambodia	18 years old, with possibility of reducing to 16 years old in case of pregnancy or parental consent
Lao PDR	18 years old, with exceptions allowed as low as 15 years old under special circumstances
Timor-Leste	17 years old, with possibility of reducing by 1 year with parental consent
Malaysia	18 years old for non-Muslims, but 16 years old for Muslims, with possibility of exceptions at younger ages
Philippines	18 years old, but religious law allows for marriage as young as 12 years old
Thailand	18 years old, with possibility of reducing to 17 years old with parental consent; no stated minimum under religious law
SOUTH ASIA	
Bhutan	18 years old, no exceptions
India	18 years old, no exceptions
Maldives	18 years old, no exceptions
Nepal	20 years old, no exceptions
Pakistan	18 years old, but in some provinces, it is still 16 years old
Afghanistan	No stated minimum under religious law
Bangladesh	18 years old, but allows for younger age in special circumstances with no stated minimum age
Sri Lanka	18 years old, but there is no stated minimum under religious law
PACIFIC	
Fiji	18 years old, no exceptions
Marshall Islands	18 years old, no exceptions
Samoa	21 years old, but girls between 18-20 years old require parental consent
Tuvalu	18 years old, no exceptions
Kiribati	21 years old, with possibility of reducing to 17 years old with parental consent; no stated minimum age under customary law
Micronesia	No stated minimum under customary law
Papua New Guinea	16 years old, with possibility of reducing to 14 years old with judicial consent; no stated minimum age under customary law
Solomon Islands	18 years old, with possibility of reducing to 15 years old with parental consent; no stated minimum age under customary law
Tonga	15 years old, but girls between 15-17 years old require parental consent
Vanuatu	21 years old, with possibility of reducing to 16 years old with parental consent; no stated minimum age under customary law

TABLE 2:
LEGAL STATUS FOR AGE AT MARRIAGE

Data sources: *Country profiles for FGM/C, Orchid Project, https://www.fgmcri.org/continent/asia/ (accessed: 9 July 2025).*

COUNTRY	ANALYSIS OF LEGAL FRAMEWORK
Indonesia	Legal restrictions for infants and children under 5 years old (article signed in 2024), though this may be restricted to circumcision that endangers the reproductive system
Sri Lanka	No law against FGM/C, though a circular issued in 2018 by the Ministry of Health prohibited medical practitioners from carrying it out
Thailand	No law against FGM/C, however, it could fall under Section 295 of Thailand's Criminal Code
India	No law against FGM/C
Malaysia	No law against FGM/C
Maldives	No law against FGM/C
Philippines	No law against FGM/C

Universal Access to Sexual and Reproductive Health and Rights (SDG Targets 3.7 and 5.6)

Universal access to sexual and reproductive health (SRH) reflects the availability, access, affordability, and utilization of a comprehensive range of services over the life cycle. This includes access for all, without bias or prejudice, to maternal health services, general reproductive and sexual health services, safe abortion services, HIV screening and treatment, and comprehensive sexuality education, among others. It also must incorporate the recognition of sexual and reproductive rights (SRR), which encompasses bodily integrity, autonomy, agency, and choice.

The most recent data shows that **most countries in the region have moderate to poor legal frameworks for SRH**. Only a few countries have reported strong legal frameworks to support universal access to sexual and reproductive health.

In the SDG framework, universal access to SRHR is monitored within national legal frameworks for 13 SRH areas, encompassing maternal services, life-saving commodities, abortion and post-abortion care, contraceptive services and consent, CSE, HIV testing and treatment, and HPV vaccination. The most recent data shows that, based on the above assessment, most countries in the region have moderate to poor legal frameworks for SRH. Only a few countries have reported strong legal frameworks to support universal access to sexual and reproductive health, namely Lao PDR, Philippines, Cambodia, Myanmar, Turkmenistan, and the Maldives. Data is largely missing from the Pacific.

Strong legal frameworks are important to improve the lives of women and girls in the region. For example, countries that have stronger legal framework for universal access to SRH are more likely to observe an increase in contraception prevalence (Fig 3). In the Philippines, for example, the increase in contraception prevalence has been attributed to the implementation of the Responsible Parenthood and Reproductive Health Law, which was fully implemented in 2017.[28] Our partners in Pakistan report that recent advancement in strengthening accountability within legal frameworks have resulted in important improvements in the provision of SRHR, such as through availability of digital SRHR education in local languages, trans- and women-friendly clinics, and inclusivity in legal aid and protections.[29] It was further noted that law enforcement is now more inclusive to trans persons, illuminating the impact that legal frameworks can have in changing norms and behaviour.

Furthermore, countries with stronger legal frameworks for SRH also report higher autonomy among women regarding their reproductive health (86-96%) compared to countries with moderate or poor frameworks (52-82%).[30] By integrating the importance of increasing knowledge, agency, and autonomy, legal frameworks can lead to greater improvements in a women's autonomy to make decisions about her own SRHR.[31]

Countries with moderate or poor frameworks observing smaller increases or even large decreases in contraception prevalence in the past decade. In Nepal, for example, weaker legal frameworks and a lack of resources have led to poor provision of maternal health services, inconsistent implementation of CSE, and weak adolescent-friendly health services.[32] Coupled with social barriers, such as stigma and taboo around SRHR issues and high prevalence of child marriages, it explains much of the poor SRHR outcomes for the country, including its high rates of maternal mortality, adolescent pregnancies, and declining prevalence of contraceptive use.

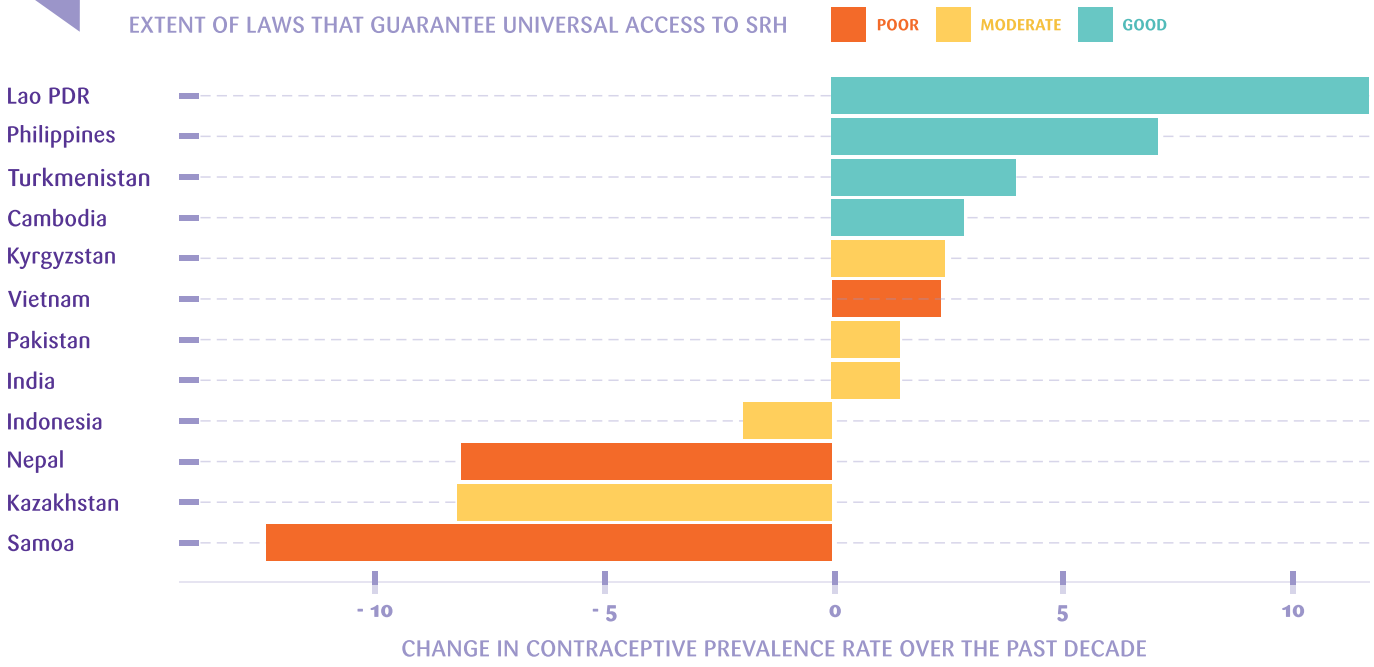
What is not adequately captured within the SDG monitoring framework is the investment in health as an integral element to translate legal frameworks into actionable and effective policy and programming. Many countries in the region have reported some increases in health expenditure as a percentage of the Gross Domestic Product (GDP), though these increases are often less than 1% over the past decade.[35] There appears to be a stagnation or regression in South East Asia, where government investment in healthcare is already low, averaging between 3-5% of GDP. Few countries in the Pacific, such as Micronesia and Marshall Islands, have reduced healthcare investment by 2-3% of GDP, a significant drop of resources allocated to the health of the population. Correspondingly, countries in Asia and the Pacific observe a high burden in household out-of-pocket costs for healthcare, which was estimated to be almost half of the region's total health expenditure.[36]

What is not adequately captured within the SDG monitoring framework is the **investment in health as an integral element to translate legal frameworks into actionable and effective policy and programming**. Many countries in the region have reported some increases in health expenditure as a percentage of the Gross Domestic Product (GDP), though these increases are often less than 1% over the past decade.

BOX 1:
YOUNG PEOPLE AND ACCESS TO YOUTH-FRIENDLY SERVICES IN THE PACIFIC

Our regional analysis also suggests that in the Pacific, such as in Tuvalu, Fiji, and Samoa, the high rates of adolescent pregnancies are not driven by early marriages (Fig 3), but rather a lack of access to youth-friend services. Lack of information and awareness of SRH services, bias and judgement from healthcare provider, and lack of intergenerational dialogue about sex all contribute to the high rates on unmet need for contraception among young people in the Pacific.[33] In light of these social barriers to contraception, young people in rural communities prefer to access SRH services in more urban areas that are perceived to offer more confidentiality, but the cost of travel and services hinder this option.[34]

FIGURE 4:
ABSOLUTE CHANGE IN CONTRACEPTIVE PREVALENCE RATES (%) COMPARING CURRENT PREVALENCE RATES (2017-2023 DATA) TO PRE-SDG RATES (2010-2016 DATA)



Note: *Data was only complete for 12 countries in the region.*
Data sources: *Women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (%), World Health Organization, https://www.who.int/data/gho/data/indicators/indicator-details/GHO (accessed: 1 July 2025).*

FIGURE 5:
INCLUSION OF COMPREHENSIVE SEXUALITY EDUCATION IN NATIONAL LEGAL FRAMEWORKS & POLICIES

Data sources: *Laws and policies related to sexuality education, defined as life skills-based HIV and sexuality education, 2017-2020, UNESCO, https://education-profiles.org/themes/~comprehensive-sexuality-education (accessed: 1 July 2025).*

Ensuring Inclusive and Equitable Access for All

The core principle of universal access to SRHR is that it must be available and accessible by all. While many countries have made progress on strengthening their provision of SRH through legal frameworks and national programmes, as monitored in SDG target 5.6, there remains glaring inequities to even the most basic health care services. These inequities are most often felt by marginalized populations, such as individuals with disabilities, those living in rural or geographically isolated areas, indigenous communities, communities living in climate-affected areas, migrant groups, older women and other diversities in the population.

In rural or remote areas, the fulfilment of SRHR is hindered by the distance to health facilities, poor coverage of services and equipment at these facilities, lack of capacity to make informed decisions, stigma and cultural norms, and also past negative experiences with formal health care systems.[37] Data collected by the University of Health Sciences Lao PDR show that up to 17% of rural women face geographical and logistical challenges to access timely maternal health services and even emergency or rescue services, leading to poor outcomes and death for these women.[38] In Bhutan, our partners from YPEER highlights the progress made in providing Universal Health Care and a comprehensive range of services for its citizens, but these necessities are not always accessible by persons with diverse disabilities, particularly in rural or geographically remote areas.[39] Basic accessibility facilities, such as ramps, lifts, and handicap-accessible toilets, are often not available in the primary health units that serve these populations. In Fiji, recent research shows that women, especially those in rural communities, lack awareness, understanding, and support for menopause, a natural biological process but one with important health and wellbeing outcomes, leaving women to deal with her symptoms alone and in the dark.[40]

Similarly, in Malaysia, Datum Initiative Malaysia have reported that women with disabilities face limited or no access to SRHR education, discrimination or condescension when accessing healthcare services, social stigma, and marginalization in the workplace.[41] Through their research, they discovered that current SRH services and information, even when accessible to persons with disabilities, may not adequately fulfilled their needs.

An important example from an interview done by Datum Initiative Malaysia:

Lakshmi, a blind woman in her 30s, emphasised the absence of accessible guidance on breastfeeding or protecting herself from sexual harassment. She also expressed her struggles with menstruation management, particularly the difficulty of determining whether she was bleeding, a task complicated by the lack of tactile or sensory-friendly aids. Her testimony highlights how basic aspects of reproductive health are made more challenging by the invisibility of disability within healthcare systems.

These examples showcase that current healthcare systems in the region have failed to fulfil the basic rights to health for people whose needs differ from the majority; the ones who carry the weight of this injustice. Most often, the national-level aggregated statistics do not reflect the lived experiences of the marginalized. The true extent of these inequities is not known given the lack of data from these parts of the population

Recommendations

In view of these findings for the region, we recommend the following:

1. Universal access to sexual and reproductive health and rights (SRHR) must be defined comprehensively to include the full spectrum of SRHR services and rights across the life cycle and be positioned within legal frameworks and implemented through adequate policy and resource allocation that can be translated into effective services and programmes that not only meets the needs of women and girls, but also empowers them to action.

2. Increase government investment in health, including increasing government budgets and the allocation of a greater share of public funds for the health sector, with periodic review of health financing policies to ensure that the needs of marginalized and vulnerable groups are not left out. Ensure the integration of Universal Health Coverage and SRHR into national strategies and health policies.

3. Remove the legal, structural, social, geographical barriers to timely access of maternal health services, including pre-natal care, safe delivery services, post-partum care, adolescent-friendly services, and safe abortion services in order to prevent unnecessary morbidity and mortality among women and girls in the region.

4. Review and redesign health care services and delivery, including for sexual and reproductive health, into cohesive systems that are inclusive and accessible to people in all their diversities. These systems must provide equitable access the marginalized, including young people, persons with disabilities, rural or remote communities – particularly in climate affected areas, and people of diverse sexual orientations, gender identities and expressions, among others.

5. Strengthen the provision of sexual and reproductive health services, including postabortion healthcare in all circumstances on a confidential basis, especially for rural women, women living in poverty, women with disabilities and women from ethnic or religious minorities.

6. Strengthen legal frameworks to eliminate child, early, and forced marriages and female genital mutilation or cutting, and ensure that accountability mechanisms are in place to support this legal framework, be regularly monitored and informed by evidence and outcomes to protect the lives and wellbeing of girls in the region.

7. Ensure that equality interventions address the structural barriers embedded in norms, laws, and policies that contribute to inequality and injustice. This is in addition to addressing the structural and systemic factors including repealing and abolishing discriminatory practices, laws, and policies that exacerbate gender inequality. This includes recognising the needs of gender diverse people and providing SRH service and facilities that cater to them.

8. Ensure high-quality, timely, reliable data is available, disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location, and other characteristics relevant in national and local settings. Monitoring should extend beyond the SDG indicators to capture progress made within legal frameworks, policy and programming, as well as health, rights, and justice outcomes.

Endnotes

1 ARROW. Affirming Rights, Accelerating Progress and Amplifying Action: Monitoring SDG3 in Asia-Pacific. https://arrow.org.my/publication/affirming-rights-accelerating-progress-and-amplifying-action-monitoring-sdg3-in-asia-pacific/ (2020).

2 ARROW. Affirming Rights, Accelerating Progress and Amplifying Action: Monitoring SDG5 in Asia-Pacific. https://arrow.org.my/publication/affirming-rights-accelerating-progress-and-amplifying-action-monitoring-sdg5-in-asia-pacific/ (2020).

3 Marzouk, M. et al. Effects of COVID-19 on sexual and reproductive health services access in the Asia-Pacific region: a qualitative study of expert and policymaker perspectives. *Sex Reprod Health Matters* 31, 2247237.

4 Pugh, S. Politics, power, and sexual and reproductive health and rights: impacts and opportunities. *Sexual and Reproductive Health Matters* 27, 1–5 (2019).

5 Climate Justice, Environmental Justice, and Sexual and Reproductive Health and Rights | Center for Reproductive Rights. https://reproductiverights.org/environmental-justice-reproductive-rights/ (2024).

6 De Silva, M. et al. Severe maternal morbidity in the Asia Pacific: A systematic review and meta-analysis. *The Lancet Regional Health - Western Pacific* 14, 100217 (2021).

7 Cresswell, J. A. et al. Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis. *The Lancet Global Health* 13, e626–e634 (2025).

8 Bridging the gap of preventable maternal mortality and morbidity (PMMM) in Lao PDR (unpublished report by University of Health Sciences, Lao PDR).

9. Ganatra, B. et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet 390, 2372–2381 (2017).

10. Yogi, A., K C, P. & Neupane, S. Prevalence and factors associated with abortion and unsafe abortion in Nepal: a nationwide cross-sectional study. *BMC Pregnancy Childbirth* 18, 376 (2018).

11 Bearak, J. et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019. *Lancet Glob Health* 8, e1152–e1161 (2020).

12 Latt, S. M., Milner, A. & Kavanagh, A. Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries. *BMC Women's Health* 19, 1 (2019).

13 Ganatra, B. et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *The Lancet* 390, 2372–2381 (2017).

14 Shah, I. H. & Ahman, E. Unsafe abortion differentials in 2008 by age and developing country region: high burden among young women. *Reproductive Health Matters* 20, 169–173 (2012).

15 Espinoza, C., Samandari, G. & Andersen, K. Abortion knowledge, attitudes and experiences among adolescent girls: a review of the literature. *Sex Reprod Health Matters* 28, 1744225.

16 Towards 2030: Monitoring Maternal Mortality and Reproductive Health in Nepal (unpublished report by YUWA, Nepal).

17 Child marriage atlas. *Girls Not Brides*. https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/.

18 Child marriage atlas. *Girls Not Brides*. https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/.

19 Bangladesh: Child Marriage Act has led to increase in rape of minor girls. *SabrangIndia.* https://sabrangindia.in/article/bangladesh-child-marriage-act-has-led-increase-rape-minor-girls/ (2017).

20 Hossain, M. J., Soma, M. A., Bari, M. S., Emran, T. B. & Islam, M. R. COVID-19 and child marriage in Bangladesh: emergency call to action. *BMJ Paediatr Open* 5, e001328 (2021).

21 Rural girls and their rights in Kyrgyzstan: early/child marriage and access to SRHR (unpublished report by ALGA, Kyrgyzstan).

22 Sezgin, A. U. & Punamäki, R.-L. Impacts of early marriage and adolescent pregnancy on mental and somatic health: the role of partner violence. *Arch Womens Ment Health* 23, 155–166 (2020).

23 Scott, S. et al. Early marriage and early childbearing in South Asia: Trends, inequalities, and drivers from 2005 to 2018. *Ann N Y Acad Sci* 1491, 60–73 (2021).

24 Female Genital Mutilation (FGM) Statistics. *UNICEF DATA.* https://data.unicef.org/topic/child-protection/female-genital-mutilation/.

25 Dawson, A. et al. Addressing female genital mutilation in the Asia Pacific: The neglected sustainable development target. *Australian and New Zealand Journal of Public Health* 44, 8–10 (2020).

26 Rashid, A., Iguchi, Y. & Afiqah, S. N. Medicalization of female genital cutting in Malaysia: A mixed methods study. *PLoS Med* 17, e1003303 (2020).

27 Jaya, V. A. F. T., Kim, Y. & Kang, M. Cutting through complexity: An intersectional analysis of female genital cutting in Indonesia. *Women's Studies International Forum* 104, 102906 (2024).

28 Estrada, M. A. G., Cheng, K. J. G. & Lacaza, R. M. Legal changes and evidence on unmet need for contraception, Philippines. *Bull World Health Organ* 102, 778–785 (2024).

29 Unpublished report by DASTAK, Pakistan.

30 UN Department of Economic and Social Affairs. SDG Indicators Database. https://unstats.un.org/sdgs/dataportal.

31 Liang, M., Katz, L., Filmer-Wilson, E. & Idele, P. Accelerating Progress in Women's Sexual and Reproductive Health and Rights Decision-Making: Trends in 32 Low- and Middle-Income Countries and Future Perspectives. *Glob Health Sci Pract* 12, e2400228 (2024).

32 Towards 2030: Monitoring Maternal Mortality and Reproductive Health in Nepal (unpublished report by YUWA, Nepal).

33 Baigry, M. I., Ray, R., Lindsay, D., Kelly-Hanku, A. & Redman-MacLaren, M. Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island Countries and Territories: A scoping review. PLoS One 18, e0280667 (2023).

34 Baigry, M. I., Ray, R., Lindsay, D., Kelly-Hanku, A. & Redman-MacLaren, M. Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island Countries and Territories: A scoping review. *PLoS One* 18, e0280667 (2023).

35 World Bank Open Data. *World Bank Open Data*. https://data.worldbank.org.

36 Health at a Glance: Asia/Pacific 2022. *OECD*. https://www.oecd.org/en/publications/health-at-a-glance-asia-pacific-2022_c7467f62-en.html (2022).

37 Wahyuningsih, S., Widati, S., Praveena, S. M. & Azkiya, M. W. Unveiling barriers to reproductive health awareness among rural adolescents: A systematic review. *Front Reprod Health* 6, 1444111 (2024).

38 Bridging the gap of preventable maternal mortality and morbidity (PMMM) in Lao PDR (unpublished report by University of Health Sciences, Lao PDR).

39 A Comprehensive Review of Bhutan's Progress on SDG 3 (unpublished report from YPEER-Bhutan).

40 Fiji Women's Rights Movement. *The 'M' Word: Ending the Silence! Fijian Women's Perceptions and Experiences, Journey to and During Menopause*. (2025).

41 Monitoring the SDGs at 10 Years: Sexual and Reproductive Health and the Lived Experiences of Women and Individuals Assigned Female at Birth with Disabilities in Malaysia (unpublished report from Malaysia).

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. Established in 1993, it 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.

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

Telephone	+603 2273 9913/9914/9915
Fax	+603 2273 9916
Email	arrow@arrow.org.my
Web	arrow.org.my
Bluesky	arrowomen.bsky.social
Facebook	ARROW.Women
Instagram	arrow_women
YouTube	ARROW_Women
LinkedIn	arrowomen