

Women of the World:

Laws and Policies Affecting Their Reproductive Lives



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

**WOMEN OF THE WORLD: LAWS AND POLICIES
AFFECTING THEIR REPRODUCTIVE LIVES**

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Foreword

Imagine a world in which the laws and policies of every country allowed women to fully enjoy their reproductive rights. While this is still a distant goal, a confluence of factors has enabled women's health and rights advocates to bring it into focus. The 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW) were groundbreaking for so many reasons, among them that governments agreed that everyone *has* reproductive rights, and that they are an inalienable part of established international human rights. The recognition, long overdue, that the "traditional" human rights framework applies to women's unique human condition, including their reproductive and sexual lives, has inspired women around the world.

The ICPD and the FWCW also recognized that a legal and policy environment that ensures women's equality is necessary to ensure positive reproductive and sexual health outcomes. But to create that environment, advocates and policymakers need more information to support their efforts.

This series of reports, *Women of the World: Laws and Policies Affecting their Reproductive Lives*, is intended to give advocates and policymakers a more complete view of the laws and policies governing women's lives to better enable legal and policy reform, to speed the implementation of laws that will improve women's health and lives, and to assign accountability when governments fail to implement the laws designed to protect women. Initiated soon after the ICPD and the FWCW, the series to date has included reports covering Anglophone Africa, East Central Europe, Francophone Africa, Latin America and the Caribbean, and South Asia. The Center for Reproductive Rights and our collaborating organizations have raised awareness in each of the 35 countries covered by the series, and in many cases have contributed to improvements in laws and policies and their implementation.

We are very pleased to introduce the newest report in our series, *Women of the World: Laws and Policies Affecting their Reproductive Lives—East and Southeast Asia*, covering China, Malaysia, the Philippines, Thailand, and Vietnam. This report, the product of almost three years of work, represents a collaborative effort with nongovernmental organizations in the region. Its release comes just after the ten-year anniversary of the ICPD and coincides with the

ten-year anniversary of the FWCW; it also coincides with the five-year anniversary of the establishment of the Millennium Development Goals, through which world leaders reaffirmed their commitment to achieve universal access to reproductive health care by 2015 and to end discrimination against women. The situation in East and Southeast Asia is illustrative of that in many other regions: Despite some gains, the principles agreed to at the ICPD and the FWCW have not been translated into legislation and policy capable of transforming the lives of the vast majority of women; existing legislation and policy are not backed by sufficient political will and financial commitment. In many instances, enforcement is weak and accountability is lacking. Inherent discrimination persists as medical services required only by women continue to be criminalized.

We at the Center for Reproductive Rights want the law to work for women, ensuring their ability to exercise their reproductive rights and to enjoy full equality, no matter their country or community of origin. We hope our *Women of the World* publication will become a useful tool for improving women's reproductive lives in East and Southeast Asia through legal advocacy and reform.

Luisa Cabal, Director, International Legal Program

Melissa Upreti, Legal Adviser for Asia, International Legal Program

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Overview*

Governmental commitments at major international conferences such as the Fourth World Conference on Women (Beijing, 1995), the International Conference on Population and Development (ICPD, Cairo, 1994), and the World Conference on Human Rights (Vienna, 1993) have firmly established women's reproductive rights as human rights that must be enforced. More recently, with the reaffirmation of the Millennium Development Goals (2000), governments have agreed that addressing women's reproductive health as a fundamental human right is key to promoting gender equality and the right to development. This marks a distinct shift from the development trends of the 1970s and 1980s, which were dominated by population control programs that failed to recognize a woman's right to control her own fertility. There is no doubt that women's health and rights are now clearly included in the international political agenda. Governments today are legally obligated to uphold global commitments to women's health and human rights by introducing gender-sensitive laws and policies that guarantee and safeguard women's reproductive rights; allocating financial resources to implement existing laws, policies, and programs; and creating mechanisms to monitor and ensure their proper enforcement.

In recent years, the women of East and Southeast Asia have made progress on a number of fronts. One of the most laudable achievements has been an impressive female literacy rate that ranges from 82% to 96%. This reflects tremendous progress toward gender equality in education and women's empowerment. Literacy empowers women not only to proactively seek information about their health and make informed decisions about their reproductive lives, but also to speak out against injustice and hold their governments accountable for violations of their human rights. In addition, there has been a growing willingness in the region to address violence against women through legislation. Both Malaysia and the Philippines, for example, have introduced laws that enable women to confront domestic violence through legal measures and obtain protection orders against their abusers. This has led to a surge in reports of domestic violence, which is typically underreported because women fear retribution from their abusers. A deeper understanding of the impact of domestic violence on women's health is evident in Malaysia and China, where steps have been taken to integrate emergency medical care for victims of domestic violence with public health services, making it possible for victims to obtain emergency contraception.

Another promising development for women in the

region is that Thailand, Malaysia, and the Philippines have established human rights commissions to monitor, document, and report human rights violations. Their work can assist governments in fulfilling their obligations to protect human rights and can help raise awareness among the general public and the international community about violations of human rights.

The single most encouraging regional trend for reproductive rights, however, has been the general shift away from coercive population policies that focus upon targets to those that emphasize a woman's right to freely decide the number and spacing of her pregnancies. This shift reflects a growing international consensus that began in 1994 as a result of the International Conference on Population and Development.

Despite some of the positive developments in the region, a major concern is that as in most regions of the world, reproductive health is still largely confined to the realm of policy. Comprehensive laws that guarantee women reproductive rights and establish mechanisms for securing the enforcement of such laws do not exist, hence women remain vulnerable to abuse and exploitation. Where legislation does exist, it tends to be limited to certain aspects of women's reproductive rights, such as the right to family planning and

*The overview has been drafted in collaboration with ARROW

maternal health care; in some cases it tends to be problematic, as in the case of laws that criminalize abortion. Consequently, the promises made by governments to uphold and protect women's reproductive rights are still largely aspirational. This is not to suggest that existing laws and policies are irrelevant; on the contrary, existing legislative and policy barriers and gaps point to the need for reform in certain key areas and possibly the introduction of a comprehensive law that specifically addresses the gamut of women's reproductive health concerns from a human rights perspective. What follows is a reflection on the overarching challenges and a deeper discussion of some of the specific concerns that continue to keep women and girls in East and Southeast Asia from the enjoyment of reproductive freedom.

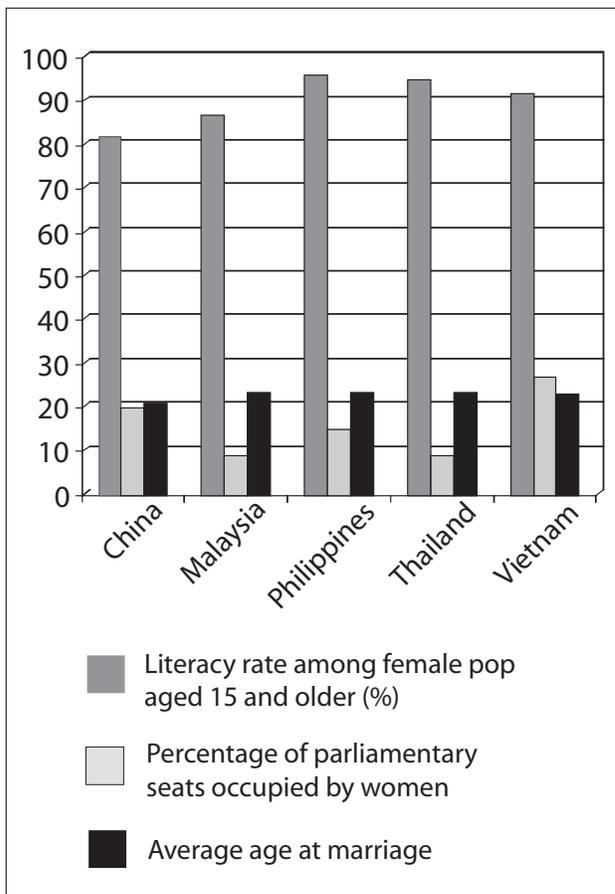
WHAT ARE REPRODUCTIVE RIGHTS?

A reproductive rights framework offers a powerful tool for advancing women's reproductive health and empowering women to address the social conditions that jeopardize their health and lives. Reproductive rights are founded on principles of human dignity and well-being. Broadly speaking, they include two key principles: that all persons have the right to reproductive health care and to make their own decisions about their reproductive lives. More specifically, they encompass a broad range of internationally and nationally recognized political, economic, social, and cultural rights that include the following:

- the right to life, liberty, and security
- the right to health, reproductive health, and family planning
- the right to decide the number, spacing, and timing of children
- the right to consent to marriage and to equality in marriage
- the right to privacy
- the right to be free from discrimination on specified grounds
- the right to be free from practices that harm women and girls
- the right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment
- the right to be free from sexual violence
- the right to enjoy scientific progress and to consent to experimentation

OVERARCHING CHALLENGES

Some of the major obstacles to the fulfillment of reproductive rights as human rights in the region include persistent gender inequality, insufficient data on women's health, religious fundamentalism, limited access to legal services, and the adverse impact of international policies.



Sources: United Nations Population Fund (UNFPA), Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2003. UNFPA, The State of the World Population 2005.

1. Persistent gender inequality

The ability of women to exercise their reproductive rights is greatly influenced by the extent to which they enjoy equal rights in education, marriage, citizenship, employment, property, and political participation. Women have made significant gains in education, for example, but that has not translated into gains in other areas. For example, women hold only 9% of seats in national parliaments in Malaysia and Thailand and 15% in the Philippines. In Thailand and Vietnam, studies show that women are paid less than men for the same work. In China and Thailand, the age of compulsory retirement is lower for women than for men. Women are discriminated against with respect to their ability to transfer citizenship to their children. In Malaysia, for example, if a child is born outside of the country, the child is considered a

citizen only if his/her father was a citizen of Malaysia at the time of the child's birth. Furthermore, inequalities in marriage persist for women. For instance, in Malaysia, 20% of all Muslim marriages are polygamous. In Thailand, a husband may divorce his wife if she commits adultery, but a wife can divorce an adulterous husband only if she can prove that in addition to committing adultery, her husband has financially supported or "honored" another woman as his wife. In Vietnam, a woman cannot file for divorce if she is pregnant or nursing a child under one year of age. Such circumstances may compel women to silently accept inequality and even abuse within marriage. Women who lack equal rights and the ability to make independent decisions within marriage are often unable to control the number and timing of their pregnancies, and they risk exposure to unplanned pregnancy, unsafe abortion, maternal mortality, or HIV/AIDS.

In addition, with the exception of the Philippines, each of the countries surveyed for this report has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) with reservations to provisions that ensure equality in marriage and political participation, and an end to gender stereotypes. Indeed, the Malaysian Constitution was amended only in 2001 to recognize gender as a prohibited ground for discrimination, but this provision does not apply to personal laws. Furthermore, gender discrimination against non-citizens such as migrant workers and refugees has been quite intense throughout the region, leaving these populations particularly vulnerable to exploitation and abuse. Malaysia's two million foreign workers are charged higher fees than Malaysian citizens for their use of public health facilities, and the renewal of a foreigner's work permit may be refused on the ground of pregnancy. In addition, legislation such as the domestic violence act, which is meant to protect women's rights, does not extend to foreign workers. The very failure to enact laws that safeguard the right to reproductive health-care services unique to women—such as contraception, maternal health care, and safe abortion care—itself constitutes gender discrimination. Further, the absence of laws that ensure patient

confidentiality, privacy, and informed consent to medical procedures such as abortion and sterilization can make women vulnerable to coercion or discrimination in health-care settings and deter them from seeking health services. The promotion of gender equality, and in some instances of human rights, has been included as a strategy in most reproductive health policies, but this is not enough to ensure that women's rights to health, equality, non-discrimination, and self-determination are in fact guaranteed and protected. Despite the ratification of international treaties that call for the formal adoption of a rights-based approach to health care, not one of the governments studied here has introduced a comprehensive reproductive health-care bill. In the Philippines, a proposed reproductive health law has been languishing for years due to conservative opposition to abortion. In Thailand, advocacy groups are working in partnership with the government to draft a bill, but nothing has been passed.

2. Insufficient data on women's health

An important first step in monitoring and addressing human rights violations is gathering reliable data, since a firm grasp of grassroots realities is the very backbone of sound and effective laws and policies. Governments bear the primary responsibility for collecting data to measure the level of human development of their citizens because it is a resource-intensive process. Without reliable data, policymakers can neither understand nor address the incidence, causes, and consequences of health and social problems.

International treaty-monitoring bodies have repeatedly emphasized the importance of data collection for monitoring the implementation of laws, policies, and basic human rights. However, in East and Southeast Asia, there is a consistent lack of official data on key reproductive health and rights issues for women and girls, especially sexual violence, unsafe abortion, and adolescent access to reproductive health services. Although awareness of domestic violence is widespread throughout the region, only Malaysia has conducted a national survey on the problem. Official data on the incidence of deaths due to unsafe abortion is virtually nonexistent. In some instances, especially with regard to maternal deaths, con-

Reports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture.

*General Recommendation 24,
CEDAW Committee, para. 9.*

Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.

*General Recommendation 24,
CEDAW Committee, para. 11.*

cerns about the multiplicity of data have led to confusion about the true nature and scope of the problem. Without an accurate baseline, it is difficult to measure progress, determine disparities, and hold governments accountable for their failure to provide critical services.

3. Religious fundamentalism

Religious fundamentalism promotes stereotypes about women based on inequality between the two sexes, thereby undermining women's ability to make independent decisions about their bodies and their health. Religion is used frequently in the political arena to deny women full recognition of their rights.

In the Philippines, where 83% of the population is Roman Catholic, religious fundamentalism backed by political power has become a formidable barrier to women's access to family planning. Catholic forces have gained considerable influence over the policy-making process and have used their influence to push forward a conservative agenda that focuses upon only natural methods of family planning.

The influence of religious forces is not limited to women's access to health care, but extends to intimate relationships within the private sphere. In Malaysia, which is an Islamic state, a proposal to recognize marital rape as a punishable offense was dropped from a national domestic violence act because of opposition from religious conservatives in Parliament. In general, religious conservatives impose their moral and theological views to undercut a human rights approach to issues such as sexual violence, HIV/AIDS prevention, and reproductive and sexual health education for adolescents.

4. Limited access to legal services

Access to the judicial system through legal counsel and the guarantee of a fair trial are essential for securing the enforcement of rights guaranteed by the state. Without access, citizens cannot hold governments accountable for violations of human rights, and this may foster impunity. Free legal assistance and counseling are important for women who may lack the information and support necessary to file a complaint and navigate the judicial system when their rights have been violated. In East and Southeast Asia, government legal aid services are not widely available to women. The Women Lawyers Association of Thailand offers legal aid to low-income women, children, and youth. In the Philippines, women have a formal right to legal counsel under the Anti-Violence Against Women

The duty to fulfil rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. The Committee is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies.

*General Recommendation 24,
CEDAW Committee, para. 17.*

and Their Children Act of 2004; however, considering the broad and persistent nature of human rights violations, such limited services are not enough. It is the government's duty to ensure that legal counsel and representation are available to people who cannot secure access to such services on their own. Furthermore a responsive judiciary is an important pre-condition for securing the proper interpretation and application of laws. There are clear indications that, particularly in cases involving sexual violence and harassment, courts tend to favor the perpetrators of violence by placing the burden of proof on victims, who must satisfy

demanding evidentiary requirements rather than elaborate upon the injuries they have sustained.

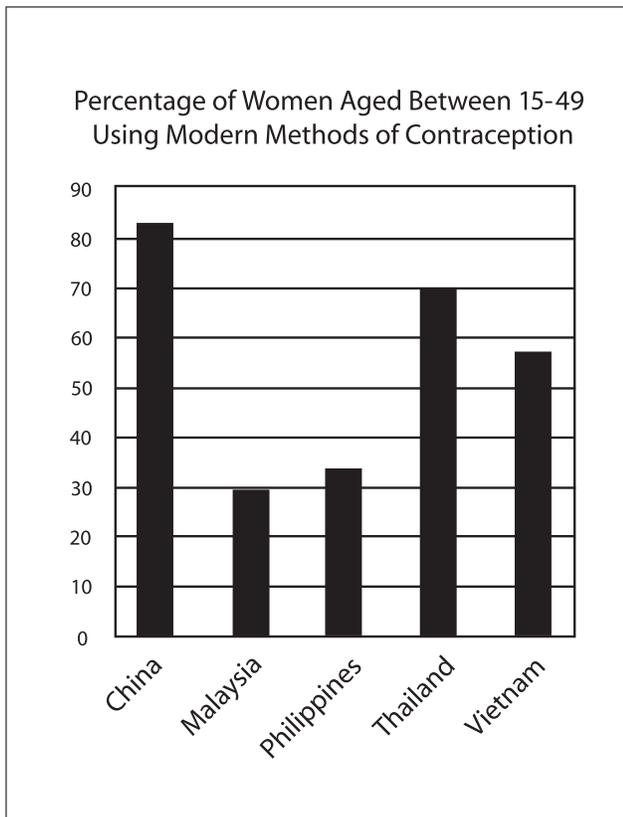
5. Harmful impact of international policies

Across the region, international institutions including the World Bank and the International Monetary Fund have been active in helping governments reform their economies. Countries in the region have experienced remarkable economic growth in the last few decades, but conditions attached to loans and health-sector reforms proposed by international institutions have forced governments to cut public spending on health and education and introduce fees for basic health services. Health sector reforms, which were expected to increase the efficiency, affordability, coverage, and quality of health-care services,¹ have in fact reduced women's access to basic care. In Malaysia, efforts to reduce public expenditure on health care have led to the establishment of private hospitals that are known to charge more for services. And in Vietnam, doctor's salaries in the public health system are subsidized by user fees, leading to discrimination against those who are insured or, due to poverty, unable to pay such fees. The dependence of governments on foreign sources for contraceptives has had an adverse impact on their availability and affordability. In the Philippines, for example, experts have noted a crisis in contraceptive supplies, which has been compounded by the decision of the U.S. Agency for International Development (USAID) to phase out its supply of contraceptives to the country. Furthermore, the conservative views of the current U.S. administration on reproductive rights, particularly abortion, have emboldened local fundamentalists and hampered progress in the region through restrictive policies such as the global

gag rule, threats of funding withdrawal, and censorship at regional, UN-sponsored meetings.

LEADING CONCERNS

This section presents key issues that require urgent attention from policymakers, legislators, and advocates: fertility control, inadequate maternal health care, criminalization of abortion, sexual violence, rising prevalence of HIV/AIDS among women, and lack of reproductive health care for adolescents.



Source: UNFPA, State of World Population 2005.

1. Fertility control

The ability of women to control the number, spacing, and timing of their children is a fundamental aspect of their reproductive rights. Universal access to modern methods of contraception is both an important pre-condition and an indicator of the fulfillment of this basic right. International legal bodies have repeatedly emphasized the obligation of states to create universal access to family planning, but also to protect women from coercion and discrimination when seeking contraceptive information and services. Although many governments in the region have taken noble strides toward this goal, important concerns include uneven access to family planning services, incentives to influence reproductive choice, restrictions on childbearing, and insufficient access to infertility treatment.

Uneven access to family planning services

Access to family planning in the region is highly restricted for some women and modern methods of contraception remain beyond the reach of many. The use of all forms of contraception appears to have increased in the region, particularly among married women, with rates now ranging from to 49% in the Philippines to 84% in China. However, the use of modern methods of contraception is still notably low. In Malaysia and the Philippines, approximately only 30% of married women aged 15–49 use modern methods. The unavailability of reliable data suggests that certain groups of women, including unmarried women, adolescent girls, and widows, have either extremely limited access or none at all to information and services relating to family planning. In the Philippines, the rate of contraceptive use among women aged 15–19 is an alarmingly low 4%. In Malaysia the government prohibits the distribution of contraceptives to unmarried adolescents. Disparities in access also exist based on residence and ethnicity. In Thailand, the northern region has reported a contraceptive prevalence rate of 83.8%, whereas the Muslim-populated south has reported a lower rate of 73%. Rural Muslim women in Malaysia report a lower rate of modern contraceptive use, which is prohibited by Islam. Access also varies according to the type of contraception. Emergency contraception, for instance, is prohibited in the Philippines but widely available in Thailand and prescribed by doctors in public health facilities in Malaysia to victims of rape and incest.

Religious conservatives and other ideologues have constructed barriers to women's access to contraception. In the Philippines, under pressure from the Catholic church, the Arroyo government has adopted strict laws regulating the sale, dispensation, and distribution of contraceptive drugs and devices. Encouraged by this policy shift, some local government officials have begun to use the enhanced executive authority they were given through the decentralization of health care in the Philippines to further restrict the promotion of condoms, making access more limited in some places than others. In Manila City, a local administrative order that permits only natural family planning and actively prohibits the delivery of modern methods is still in place.

Attempts to curtail women's access to family planning have also been introduced in Malaysia, where public awareness programs on contraception have been discontinued in some public health facilities because of the government's pro-natalist stance.

Incentives for the use of contraception

Providing incentives for couples to practice family planning has been a controversial issue because doing so may impair a

woman's ability to freely and responsibly decide the number, spacing, and timing of her pregnancies and may result in de facto coercion, particularly among low-income women. Nonetheless, incentives are the norm in many parts of the region. In China, women are offered incentives to undergo sterilization. In Vietnam, the government provides incentives for the use of specific methods of family planning such as sterilization and IUD insertion. In some instances, the Vietnamese government has made access to loans contingent upon women's participation in family planning programs.

Restrictions on childbearing

With the exception of Malaysia, which has adopted a pro-natalist stance, governments in East and Southeast Asia are using family planning programs as a tool to reduce population size. This is particularly evident in Vietnam and China. In Vietnam, the government formally stresses the benefits of small family sizes through the Law on Protection of Health, which promotes a family norm of one to two children. In Vietnam, incentives are mandated by law to ensure small families, although coercion is prohibited. China has a longstanding one-child policy that was codified in 2001. Although there are clear exceptions to the Chinese policy, there are indications that it has been rigorously—and sometimes coercively—enforced by both national and local government officials. Official incentives to have only one child include health insurance, welfare benefits, loans focused upon poverty alleviation, and paid leaves of absence for couples who comply with the policy. Furthermore, the one-child norm penalizes those who violate it with social compensation fees that can be hefty. China also restricts couples who may transmit congenital defects to their children from marrying unless they agree to use birth control or undergo sterilization. Childbearing in general is strictly monitored in China and couples are required to obtain “birth permits” before having children. Given the option of having only one child, Chinese couples tend to opt for male children and resort to sex-selective abortion as a means to this end despite the fact that sex determination during pregnancy and sex-selective abortion are prohibited. Those who are unable to terminate their pregnancies frequently abandon their female children shortly after birth. This has had devastating consequences for women in China and is evidenced by prevailing gender imbalance.

Insufficient access to infertility treatment

The problem of infertility for women needs greater attention from governments in the region. Assisted reproductive technologies (ARTs) are not widely available in the public health sector despite the growing demand. ART is in high demand in China, since 10% of Chinese couples of childbearing age suffer from infertility. However, in vitro fertilization

is allowed only if it does not contravene the government's “family planning, ethical principles, or relevant law.” Other prohibitions in China prevent single women from using ART and forbid the use of surrogates.

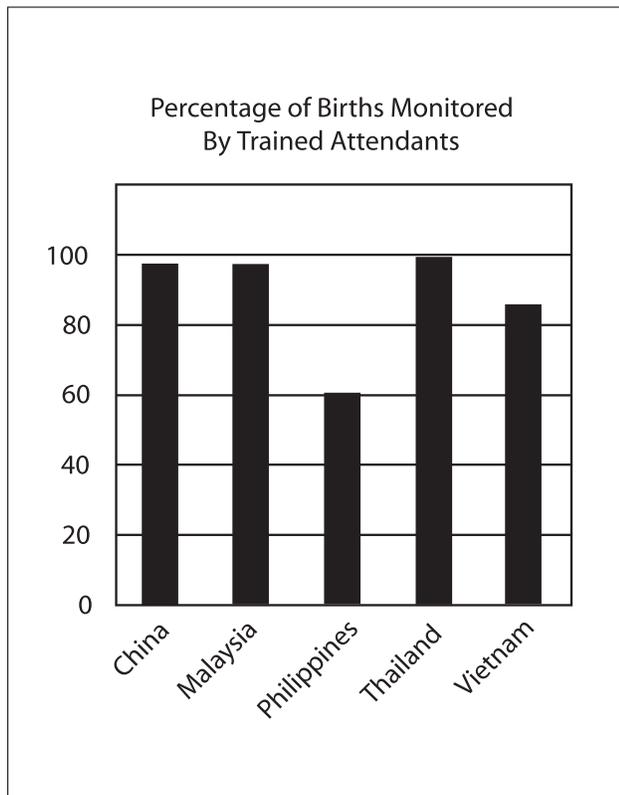
There is currently no law that regulates assisted reproductive technologies in the Philippines, although the prevention and treatment of infertility is one of the government's top ten reproductive health priorities. Thailand has no specific law on ART, but in 1997, the executive committee of the Medical Council approved regulations that permit infertility research and treatment. However, infertility services are not covered by social security or other health plans although sterilization may be covered; this situation persists despite the fact that infertility has been designated as a priority in the reproductive health program. Vietnam's first in vitro fertilization birth took place in 1998, and by March 2003, 1,090 such births had occurred. Since then, the government has pledged to work toward the prevention and treatment of infertility, in part by introducing laws regulating the donation and reception of ova, sperm, and embryos, and other issues concerning in vitro fertilization. Multiple forms of ART are available in Malaysia, including artificial insemination and in vitro fertilization.

STRATEGIES FOR ACTION

- Expand family planning programs to ensure universal access to a full range of family planning services, including emergency contraception without coercion or discrimination.
- Promote the use of condoms to reduce the risk of infection to women of HIV/AIDS and other sexually transmissible infections (STIs).
- Introduce infertility treatment in public health facilities.
- Involve women in the formulation of family planning laws and policies and make improvements based on their experiences and needs.
- Abolish restrictive one—and two—child norms and encourage individuals to limit births by choice.
- Remove penalties for failure to comply with restrictions on childbearing and take steps to address coercion in the delivery of family planning services.

2. Inadequate maternal health care

The right to survive pregnancy and childbirth is a basic human right. UN committees that monitor governmental compliance with international treaties have interpreted the



Source: UNFPA, State of World Population 2005.

failure of governments to protect women from maternal death as a failure to protect their right to life. Maternal deaths are largely preventable and can be avoided through routine prenatal care and appropriate care during childbirth, including emergency obstetric care. Yet the persistence of high rates of maternal death in the region highlights the failure of governments to fully comply with international standards that obligate them to protect women's rights to life, equality and nondiscrimination, and health care. The persistence of maternal deaths in the region, especially due to unsafe abortion, and disparities in access to maternal health care is problematic.

Persistence of maternal mortality

Although maternal mortality rates have decreased throughout the region and the proportion of births attended by trained personnel is high, the fact that a relatively prosperous and literate region continues to face a significant number of maternal deaths is cause for concern. Of the countries surveyed for this report, Malay-

sia has the lowest maternal mortality rate of 41 deaths per 100,000 live births, and the Philippines reports the highest rate at 200 deaths per 100,000 live births. Although Malaysia, China, and Thailand appear to have met the ICPD target of fewer than 125 deaths per 100,000 live births, there is a need to investigate the causes behind the continuation of maternal deaths despite the high number of hospital deliveries and the high rate of home births monitored by trained attendants. In Vietnam, the overall maternal death rate is 130 deaths per 100,000 live births and studies show that the percentage of women receiving prenatal care decreased from around 73% in 1990 to 68% in 2003, and 70% of births in 2002 were attended by health professionals, down from 90% in 1990. Maternal deaths can be prevented and the existing death rates indicate a breach of duty by governments to protect the lives of women. Malaysia's confidential inquiry system for determining the causes of maternal deaths and making recommendations for improving maternal health services is an exemplary measure worthy of emulation by governments in the region. Unsafe abortions account for a significant proportion of maternal deaths in the region. Restrictive laws that criminalize abortion along with limited access to family planning and safe abortion services fuel this trend. According to some estimates, the proportion of maternal deaths due to unsafe abortion in China, Malaysia, and the Philippines exceeds the global average of 13%.²

Uneven access to maternal health care

Maternal mortality rates in the region vary greatly by income level and proximity to care. Disparities in access may be symptomatic of discrimination and therefore warrant close attention. As a general rule, wealthy women or those in urban areas have greater access to services than low-income women, rural women, or those who live in areas marred by conflict. The disparity is particularly stark in China, where the 2000 maternal mortality rate was 96 deaths per 100,000 births in Shanghai, but was significantly higher at 161 deaths in rural Xinjiang and 466 deaths in Tibet.

States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women. Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women punish women who undergo those procedures.

*General Recommendation 24,
CEDAW Committee, para. 14.*

Furthermore, averages can be dangerously misleading, as is the case in Malaysia, where the overall rate of maternal deaths is the lowest in the region but current data actually points to an increase in the maternal mortality rate. This is attributed to deaths among migrant populations who work

STRATEGIES FOR ACTION

- Strengthen the primary health-care system by making emergency obstetric care widely available and by improving the overall standard of maternal health services.
- Expand access to maternal health services without discrimination on the basis of age, marital status, or nationality.
- Compile national data on the incidence of maternal deaths and identify the barriers that lead to disparities in maternal mortality rates within countries.
- Develop strategies to address unsafe abortion as a cause of maternal death.

in the informal sector without health benefits or adequate access to public health services.

3. Criminalization of abortion

The right to safe and legal abortion is a basic human right and an important pre-condition for women's reproductive autonomy. Legal prohibitions on abortion have been recognized as violations of women's right to life. International legal bodies have specifically taken issue with the criminalization of abortion when a pregnant woman's life and health are endangered and when a pregnancy results from rape or incest. There is international consensus for reviewing laws that contain punitive provisions against women who undergo illegal abortion. In most parts of East and Southeast Asia, the criminalization of abortion persists, and there is limited access to a full range of safe abortion services where the procedure is permitted. Another leading concern is the failure to address unsafe abortion.

Denial of abortion rights

The legal status of abortion in the countries surveyed for this report varies from highly restrictive to liberal. The constitution of the Philippines recognizes life from the moment

of conception and criminalizes abortion except to save the life of the mother, while both Vietnam and China allow abortion for any reason. In Malaysia, the Philippines, and Thailand, abortion is not legally permitted on grounds of rape or incest although in Malaysia and Thailand, a victim of rape or incest may obtain an abortion if the procedure is authorized by doctors. In countries where the procedure is legal, governments have failed to ensure that accessible and safe abortion care is available to women. Medical abortion is available only in China.

There are additional restrictions on minors seeking abortion, such as parental consent requirements that undermine the ability of young people to make independent decisions about their own health, and making them vulnerable to abuse. In China, for example, young women may be required to obtain parental consent before obtaining an abortion.

Restrictive abortion laws have stigmatized the procedure and created an unfavorable environment for women seeking even legal abortions and post-abortion care. This problem is compounded by the absence of protocols for requesting and providing services. Often times, service providers endanger women's lives by refusing to provide abortions to women in need because of their religious convictions and willful ignorance of the law. It has been widely reported that Filipino health-care professionals providing post-abortion services are often biased and abusive toward their patients, which may constitute inhumane and degrading treatment.

Failure to address unsafe abortion

The lack of comprehensive official data anywhere in the region about the prevalence of unsafe abortion has the dangerous consequence of rendering one of the most serious threats to women's lives invisible. Sample studies and anecdotal evidence suggest that the number of deaths due to unsafe abortion and the rate of complications is high. In Thailand, where abortion is not covered by health insurance, 28.8% of women who sought abortions in 1999 developed severe complications. In the Philippines, approximately

	To Save the Woman's Life	To Preserve Physical Health	To Preserve Mental Health	Rape	Incest	Fetal Impairment
China*	●	●	●	●	●	●
Malaysia	●	●	●			
Philippines	●					
Thailand	●	●		●		
Vietnam	●	●	●	●	●	●

This table indicates the grounds on which abortion is explicitly permitted. Refer to the country chapters to understand how they are interpreted.

*sex-selective abortion is prohibited

STRATEGIES FOR ACTION

- Abolish criminal abortion laws.
- Create access to safe and affordable abortion services, including nonsurgical abortion, and post-abortion care by expanding access to such services at the level of primary health care.
- Ensure the humane treatment of women who have undergone abortion, whether legal or illegal.
- Undertake public education campaigns to eliminate the stigma against abortion.
- Compile national data on the incidence of deaths due to unsafe abortion as a basis for developing strategies to prevent these deaths.

400,000 unsafe abortions occur each year. In Malaysia, police reported a mere nine abortion-related deaths in the year 2002, but experts believe that the actual number is much higher. In China, instances of forced abortion have come to light. The procedure is often ordered by government officials without concern for the pregnant woman's health or preference. This is a cause for concern in a country where, in 1999, an estimated four million abortions took place. The lack of reliable information on the incidence and circumstances in which women have abortions indicates the failure of governments to prioritize and allocate sufficient resources to a major human rights concern, and has made it difficult to assess the real impact of laws that criminalize abortion and the real scope of deaths due to unsafe abortion. Hard data is essential for countering moral and religious challenges to the legalization of the procedure in addition to ensuring that abortions are undertaken by choice and under safe conditions.

4. Sexual violence

The right of women to be free from gender-based violence, including rape and other forms of sexual violence, has been recognized by the international community as a basic human right. International law formally recognizes gender-based violence as an impediment to women's equality. In recent years, countries in the region have introduced a variety of laws and policies to deal with the crisis of sexual violence against women and girls, including a national domestic violence law in Malaysia and the Anti-Abuse of Women in Intimate Relationships Act in the Philippines. However, problems in the region include an overly narrow definition of rape, the absence of sexual harassment laws, and the trafficking of women and girls into commercial sex work.

Overly narrow definitions of rape

With the exception of the Philippines, laws in the coun-

tries surveyed define rape narrowly and recognize it only in limited circumstances. In Malaysia, for example, only vaginal penetration constitutes rape. Additionally, evidentiary rules requiring independent corroboration and proof of the use of force, such as those prescribed in the Malaysian Penal Code, make it difficult to convict rapists. Furthermore, women's groups throughout the region have advocated for penal code reform to broaden the definition of and penalties for rape. A successful example is the Philippines, where an anti-rape law now classifies marital rape as a criminal offense, and rape has been reclassified as a crime against the person rather than just a socially unacceptable crime against chastity (efforts of women's groups in Malaysia to criminalize marital rape have been unsuccessful despite their success in pushing for domestic violence legislation).

Absence of sexual harassment laws

Of the five surveyed countries, Malaysia, Thailand, and Vietnam have no specific legislation addressing sexual harassment. In Malaysia, women seeking to bring claims of sexual harassment must rely upon penal code provisions that categorize these offenses as being against the "modesty" of a woman. In addition, victims carry the double burden of proving the alleged perpetrator's offense and his intention to sexually harass beyond a reasonable doubt. In response to the government's indifference to sexual harassment crimes, the Joint Action Group against Violence against Women, a coalition of women's organizations in Malaysia, proposed a sexual harassment bill to the Ministry of Human Resources in 2001, but the bill never became law. Even where laws have been adopted, government apathy exists. For example, the Philippines adopted the Anti-Sexual Harassment Act of 1995, which prohibits sexual harassment in employment, education, and training environments, and even extends liability to an employer or head of an institution who fails to take action in response to a claim of sexual harassment. However, the act has rarely been invoked: No Supreme Court cases have resulted from it, and cases filed in lower courts have failed to rule in favor of the woman. In China, a sexual harassment law was only introduced in 2005 and will not go into effect until January 2006.

Trafficking

Another major form of violence against women in most of the countries surveyed is the trafficking of women and girls into commercial sex work. The number of women trafficked from China, the Philippines, and Vietnam to more affluent countries such as Malaysia and Japan is on the rise. Governments are aware of the growing industry, and most have passed legislation criminalizing the practice. However, the construction and enforcement of these laws

STRATEGIES FOR ACTION

- Introduce an official zero-tolerance policy against sexual violence through appropriate legislation.
- Institute penal code reform to broaden the definition of and penalties for rape, and recognize marital rape as an offense.
- Undertake national studies to determine the true nature, scope, and causes of sexual violence against women and create a national database for developing effective strategies.
- Integrate domestic violence services with reproductive health services in the public sector and introduce emergency contraception as a routine part of emergency care.
- Ensure effective enforcement of anti-trafficking laws and integrate emergency medical care for victims of trafficking with enforcement strategies.

remains problematic. Law enforcement officials frequently threaten victims of trafficking as illegal aliens and prosecute women rather than the traffickers and clients. In Malaysia, for instance, police generally arrest or deport individual women, rather than prosecuting the traffickers. Victims of trafficking tend to be foreign women and are denied the legal protections normally available to citizens. They may be fined, whipped, or imprisoned for allegedly trying to enter the country illegally. A significant proportion of women in jails in Malaysia are believed to be victims of trafficking. Furthermore, poor enforcement of existing laws remains a problem. In Thailand between 1996 and 1999, 355 people were arrested for violating the Prostitution Prevention and Suppression Act, but only 14 were convicted and sentenced.

5. Rising prevalence of HIV/AIDS and other reproductive infections

The vulnerability of women to HIV/AIDS has been internationally recognized, and governments have been urged to pay special attention to the critical links between women's reproductive roles, their low sociolegal status and their vulnerability to HIV/AIDS. Almost half a million women are living with HIV/AIDS in East and Southeast Asia; with the exception of Thailand, prevalence rates have increased in each country since 2001. Experts maintain that despite growing rates of HIV/AIDS, governments have been slow to respond comprehensively to the pandemic. Some of the pressing concerns include the absence of laws that protect the rights of people living with HIV/AIDS, dwindling access

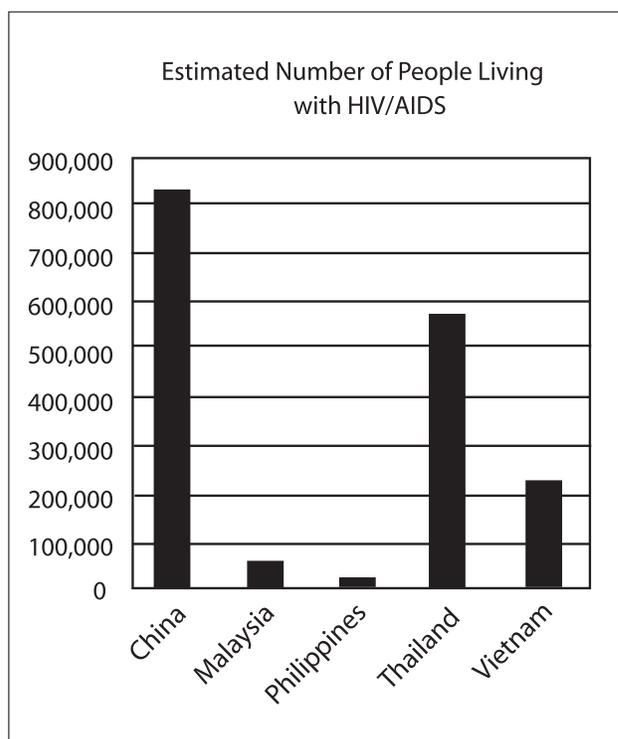
to condoms, the absence of prevention of mother-to-child transmission programs, and the neglect of other sexually transmissible and reproductive infections and diseases.

Absence of laws guaranteeing the rights of persons living with HIV/AIDS

China, Malaysia, Thailand and Vietnam have national policies for HIV/AIDS prevention and control, but they have failed to pass laws that formally recognize the human rights of persons living with HIV/AIDS. Such legislation would include recognition of the right to nondiscrimination in all aspects of life, including health care, and the right to treatment. This is of special concern because a number of formal measures to prevent the transmission of HIV/AIDS constitute inherent threats to individuals' rights to privacy and to non-discrimination. Examples include compulsory HIV/AIDS testing by several Malaysian states, Chinese laws that restrict the movement of HIV-positive individuals into and out of the country, and the Thai government's requirement that individuals disclose their HIV status in order to receive financial assistance for education or occupational training and support. In contrast, the Philippines has passed a groundbreaking non-discrimination law for persons living with HIV/AIDS.

Dwindling access to condoms

The changing nature of the HIV/AIDS epidemic has raised concerns about women's ability to protect themselves against transmission. In most countries, the epidemic has spread



Source: UNFPA, State of World Population 2005.

STRATEGIES FOR ACTION

- Enact legislation that guarantees people living with HIV/AIDS their basic human rights to life, nondiscrimination, health, privacy, confidentiality, and humane treatment.
- Prohibit mandatory HIV testing, and ensure that tests are performed with the informed consent of individuals and are accompanied by pre- and post-test counseling.
- Protect pregnant women living with HIV/AIDS against coerced sterilization and abortion, while making both options available for women who choose to undergo these procedures. Introduce PMTCT programs to address the specific needs of pregnant women living with HIV/AIDS with due respect for their privacy, confidentiality, and personal decisions.
- Undertake public education campaigns to eliminate stigma, discrimination, and violence against people living with HIV/AIDS.
- Expand efforts to gather data on, prevent, and treat STIs and reproductive diseases.

beyond high-risk groups, leading to rising rates of infection among heterosexuals. The most common method of transmission in Thailand is through sexual relations. Although intravenous drug use remains the predominant method of transmission in China and Malaysia, the incidence of sexual transmission is steadily increasing in both countries. In Malaysia, the largest proportion of infected women is composed of housewives. Condoms are the only available and affordable means of preventing sexual transmission of the virus in these countries, but without gender equality, women are not able to insist on condom usage. In addition, restrictions on contraceptive advertising, as in Malaysia, and the growing shortage of condom supplies are likely to further restrict access to condoms for women. Unavailability of national data on condom usage also affects the direction and focus of public health programs. Furthermore, the Catholic church in the Philippines has blocked the use of national funds for condoms and other contraceptives. And there are deep concerns among reproductive health advocates that global funding for HIV/AIDS focuses on treatment and care rather than prevention, which may compel governments to shift their focus from prevention programs to treatment and care exclusively.

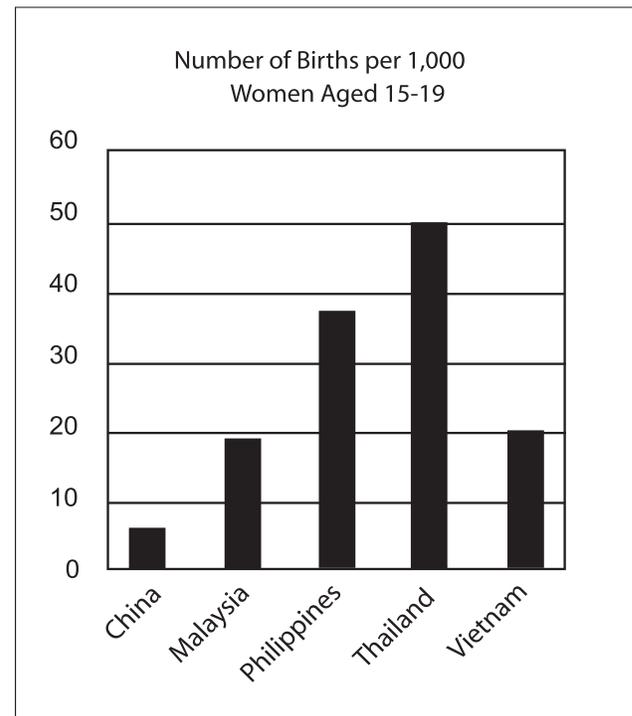
Absence of prevention of mother-to-child transmission programs

Prevention of mother-to-child transmission (PMTCT)

programs have become an important aspect of HIV/AIDS care globally as policymakers recognize the impact of gender discrimination on rising HIV/AIDS rates among women. Women become vulnerable to HIV and pregnancy when they have limited power to refuse sex or to demand the use of condoms despite knowing that their partner is HIV-positive. In the countries surveyed, China, Malaysia, Thailand, and Vietnam operate PMTCT programs; these initiatives are limited in scope, and information about their methodologies is not available. Nonetheless, the growing rate of HIV/AIDS in the region underscores the immediate need for PMTCT programs as an integral part of reproductive health care. Since these programs are primarily conceived as prevention programs for infants, policymakers must be careful not to compromise a mother's right to informed consent with respect to testing, treatment, and confidentiality in care. The lack of PMTCT programs in the Philippines is potentially devastating. In the Philippines, for example, abortion is illegal, so an HIV-positive mother who does not want to risk transmission of the disease to her fetus has no option but to carry her pregnancy to term. In these situations, the risks of forced pregnancy and unsafe abortion are high. Both are detrimental to women's health and involve violations of their basic human rights.

Sexually transmissible infections (STIs) and other neglected reproductive infections and diseases

HIV/AIDS has been able to draw the attention of governments, but other sexually transmissible infections and non-



Source: UNFPA, State of World Population 2005.

transmissible infections such as reproductive tract infections (RTIs) and reproductive cancers have been largely neglected. Data on the incidence of these diseases is virtually nonexistent in each of the countries surveyed, and legal and policy information is sparse. The failure to address infections other than HIV/AIDS leaves women vulnerable to other chronic diseases, ectopic pregnancy, cancer, stigma, and even domestic violence. Malaysia is the only country in the region that has pledged to address reproductive cancer by establishing the National Technical Committee for Cervical Cancer Screening. However, services needed to effectively detect and treat STIs, RTIs, and reproductive cancers have generally not been integrated with other health services and have not been prioritized in the ongoing health-sector reforms.

6. Lack of reproductive health care for adolescents

The human rights of children and adolescents have been unequivocally articulated and affirmed through a range of international human right treaties and policy documents. The Children's Rights Convention in particular establishes children's right to the highest standard of health and recognizes that in all matters relating to children, the best interests of the child should take precedence over all other considerations. International legal bodies have persistently emphasized the need to provide adolescents full access to reproductive health information and services, including sex education. However, adolescents in the region are repeatedly denied access to reproductive health-care services and information. Governments have failed to ensure full access to reproductive and sexual health services as part of general health care for adolescents, and they have also failed to guarantee comprehensive sexual and reproductive health education in schools.

Denial of information and services in health-care settings

Although children and adolescents comprise more than 50% of the total population of at least Malaysia, the Philippines, and Vietnam, their needs are neglected. In some instances, adolescents are outrightly denied sexual and reproductive health services in public facilities. The government of Malaysia does not provide

certain services, including family planning services, to unmarried adolescents. The denial of sexual and reproductive health services is especially problematic for a region in which the average age of marriage is 22. To presume that adolescents do not engage in any sexual activity or find themselves vulnerable

to unwanted sexual encounters prior to marriage is unrealistic. In Vietnam, it is estimated that around one-fifth of all women become mothers by the age of 19. According to the country's ministry of health, around 60% of HIV carriers were adolescents in 2001. Furthermore, the situation may not necessarily improve after marriage. For example, in Thailand,

less than half of all married adolescent girls use contraception. Denial of services and information critical to the well-being of children and adolescents is contradictory to their best interest and amounts to a denial of their basic rights, including their rights to life, nondiscrimination, and health. Health risks for adolescent girls are further compounded in countries where abortion is criminalized. In Thailand in 1991, girls under the age of 21 accounted for around 30% of women hospitalized for abortion-related complications. China seems to be an exception as it officially allows unmarried individuals, including adolescents, full access to family planning services, although minors may be required to obtain parental consent for abortion.³ The nonexistence of laws and policies recognizing the reproductive rights of adolescents may make them vulnerable to discrimination in educational institutions. Legal provisions allowing educational institutions to expel students for getting married or pregnant were only recently amended in China.

Reproductive and sexual health education

Governments in the region have recognized the need for sex education as part of their reproductive health, population and HIV/AIDS prevention strategies; however, one weakness of these programs as noted by experts in the region is that the sexual and reproductive health

and rights education that adolescents receive is intended to change adolescent sexual behavior rather than recognize the rights of adolescents to reproductive health care

Adolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.

General Comment 4,

Committee on the Rights of Children, para. 6.

States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

General comment No. 14,

Committee on Economic,

Social and Cultural Rights, para. 23.

and show respect for their bodily integrity.⁴ Furthermore, abstinence is often the only socially sanctioned message in health education programs for adolescents. In Malaysia and the Philippines, sex education is often incorporated into other topics, including physical education, biology, and moral and religious studies. This diminishes the importance of sex education as a topic worthy of separate treatment. It also overlooks children and adolescents who are not in school, leaving them even more vulnerable to a host of reproductive health problems, including unplanned pregnancy and HIV/AIDS. In China, approximately one million students belonging to ethnic minority groups, 70% of whom are girls, drop out of school each year to provide financial support to their families.

THE VITAL ROLE OF NON-GOVERNMENTAL ORGANIZATIONS (NGOS)

NGOs that advocate for women's human rights play an important role in the region by conducting research for law and policy reform, advocating on behalf of women, monitoring law and policy implementation, and holding governments accountable for violations of women's reproductive rights.

In countries with less open political climates, state-sponsored mass women's organizations have played an important role. For instance, the All-China Women's Federation (ACWF) and the Vietnam Women's Union (VWU) review laws that discriminate against women and participate in the drafting of laws. At the same time, these state-sponsored organizations have limited freedom to detract from the state's official position on key issues, including birth control.

NGOs such as those in Thailand, Vietnam, China, and the Philippines have been playing an active role in providing women access to health services by offering family planning information, counseling, and services. They have worked to increase access to antiretroviral treatment in Malaysia and to prevent and manage abortion complications in the Philippines. In Thailand, they focus on eliminating gender violence and the trafficking of women and children. In China, the ACWF and other women's NGOs have established shelters, hotlines, and counseling centers for battered women, and they have trained law enforcement officials to curb domestic violence.

STRATEGIES FOR ACTION

- Formally prohibit age-based discrimination in the provision of health-care services and ensure that the best interests of children and adolescents supercede all other considerations.
- Ensure that adolescents have access to information and services without discrimination and with due respect to their level of maturity and dignity.
- Ensure that the same rights to informed consent, privacy, and confidentiality that are granted to adults are granted to adolescents.
- Institute age-appropriate reproductive and sex education programs based on a human rights framework in schools and colleges.
- Involve adolescents in the development of laws and policies pertaining to their health and rights.

PROMOTING A RIGHTS-BASED APPROACH TO WOMEN'S REPRODUCTIVE HEALTH

In relation to health, a rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of health-related policies and programs. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles.

– World Health Organization⁵

The role of international law

International law is fundamental to safeguarding women's reproductive rights in East and Southeast Asia. With the notable exception of Malaysia, the countries surveyed for this report have largely committed to six core international human rights treaties (see "Human Rights Treaty Ratification in East and Southeast Asia"). Of these treaties, CEDAW and the CRC are the most widely ratified treaties in the region.

Treaty ratification

Governments that have signed and ratified, or acceded to, international treaties bear certain legal obligations. They are obligated to recognize women's reproductive rights by ensuring that national laws and policies are in compliance with international legal standards; to report to treaty monitoring bodies that monitor compliance; to implement and publicize concluding observations and recommendations issued by treaty monitoring bodies; and, to work in partnership with NGOs to ensure the protection and advancement of human rights.

HUMAN RIGHTS TREATY RATIFICATION IN EAST AND SOUTHEAST ASIA

The chart below provides the current status of the following six core international human rights treaties in each of the countries surveyed for this report:

- International Covenant on Civil and Political Rights (ICCPR)
- International Covenant on Economic, Social, and Cultural Rights (ICESCR)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Children's Rights Convention (CRC)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- Convention against Torture and Other Cruel, Inhuman, and Degrading Treatment (CAT)

	CHINA	MALAYSIA	PHILIPPINES	THAILAND	VIETNAM
ICCPR	Signature	-	Ratification	Accession	Accession
CCPR-OP1	-	-	Accession	-	-
ICESCR	Ratification	-	Ratification	Accession	Accession
CEDAW	Ratification with reservations	Accession with reservations	Ratification	Accession with reservations	Ratification with reservations
CEDAW-OP	-	-	Ratification	Ratification with reservations	-
CRC	Ratification	Accession	Ratification	Accession	Ratification
CERD	Accession	-	Ratification	Accession	Accession
CAT	Ratification	-	Accession	-	-

Source: Office of the United Nations High Commissioner for Human Rights, *UN Treaty Database*, <http://www.unhcr.ch/tbs/doc.nsf>.

Reservations to treaties

Malaysia has ratified (acceded to) the fewest treaties; the Philippines is the only country to have ratified all six without reservation. Although some governments in the region have expressed reservations to key treaty provisions, it is a widely accepted norm of international law that once a government has signed a treaty, it is obligated not to act contrary to the treaty's spirit and principles.

Thailand⁶ and Malaysia's⁷ reservations to CEDAW are particularly noteworthy because they disregard provisions that would guarantee women's equality. Specifically, Thailand has refused to recognize Article 16, which eliminates discrimination against women in marriage and family matters and prohibits child marriage. Malaysia has refused to recognize particular provisions in Article 16 that secure women's equal rights upon entering marriage, in being a party to a marriage, in dissolving a marriage, and as guardians of children. Further reservations reflect Malaysia's unwillingness to dismantle gender stereotypes, to permit women to participate in politics, and to grant women equal rights with men regarding their

children's nationality. In Malaysia, international treaty provisions are ratified on the understanding that international standards will be modified to accommodate national laws.

The Philippines has also ratified ICCPR's first optional protocol⁸ and, along with Thailand, CEDAW's optional protocol.⁹ Optional protocols accompany existing treaties and create procedures for individuals seeking to redress the violation of their human rights when attempts to secure a domestic remedy have failed. Their ratification is important because it can open doors for women who have exhausted domestic channels and have nowhere else to turn. The remedies that treaty-monitoring bodies may provide for those who use optional protocols may include recommendations to governments for punishing the perpetrator of a crime, compensation for victims, and suggestions for specific reforms in the country's health-care system or legal system. While the decisions of international bodies are not legally enforceable in the strictest sense, they are binding and can be used by advocates to create political pressure on errant governments to fulfill their treaty obligations.

THE ROLE OF TREATY-MONITORING BODIES

International treaty-monitoring bodies (TMBs) occasionally issue general recommendations that elaborate upon existing treaty provisions. The CEDAW Committee drafted General Recommendation 24 on Women and Health, which explains the nature of States obligations created by the right to health that's guaranteed by CEDAW¹³. It establishes the importance of women's health as "a central concern in promoting the health and well-being of women," and requires States to "eliminate discrimination against women in their access to health-care services throughout the life cycle"¹⁴. It further recognizes that the obligation to respect women's right to health requires States parties to "refrain from obstructing action taken by women in pursuit of their health goals"¹⁵. The Committee has expressed particular concern about the health needs and rights of women belonging to vulnerable and disadvantaged groups.¹⁶ Furthermore, the Committee on the Rights of the Child has expressed concern about the failure of states to pay attention to the specific needs of adolescents as rights holders and to promote their health and development. This concern motivated the Committee on the Rights of the Child to draft General Comment 4 on "Adolescent health and development in the context of the Convention on the Rights of the Child" which requires States parties to "take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention."¹⁷ It requires States parties to "ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development"¹⁸.

TMBs regularly issue concluding observations or comments during the periodic state reporting process that may contain expressions of concern about certain specific issues and recommendations for action. The following are key examples of the committees' potential for advancing women's reproductive rights in the region (emphasis is added by the Center):

"The Committee urges the Government to maintain free *access to basic health care* and to continue to improve its family planning and reproductive health policy, inter alia, through making modern contraceptive methods widely available, affordable, and accessible."

Vietnam, Committee on the Elimination of Discrimination Against Women, July 31, 2001, U.N. Doc. A/56/38¹⁹

"The Committee is deeply concerned about reports of *forced abortions* and *forced sterilizations* imposed on women, including those belonging to ethnic minority groups, by local officials in the context of the one-child policy, and about the high *maternal mortality* rate as a result of unsafe abortions."

China, Committee on Economic, Social, and Cultural Rights, May 13, 2005, U.N. Doc. CESCR/E/C.12/Add.107²⁰

"The Committee urges the Government to examine the ways in which its *population policy* is implemented at the local level and initiate an open public debate thereon. It urges the Government to promote information, education, and counseling, in order to underscore the principle of reproductive choice, and to increase male responsibility in this regard."

China, Committee on the Elimination of Discrimination Against Women, February 3, 1999, U.N. Doc. A/54/38²¹

"The Committee expresses concern about the prevalence of *violence against women* and, in particular, domestic violence. It also expresses concern at the lack of legal and other measures to address violence against women, as well as at the failure of the State party specifically to penalize marital rape."

Vietnam, Committee on the Elimination of Discrimination Against Women, July 31, 2001, U.N. Doc. A/56/38²²

"The Committee is particularly concerned over the absence of data on *adolescent health*, including on teenage pregnancy, abortion, suicide, accidents, violence, substance abuse, and HIV/AIDS. In this regard, the Committee recommends that the State party increase its efforts to promote adolescent health policies and strengthen reproductive health education and counseling services."

Thailand, Committee on the Rights of the Child, October 26, 1998, U.N. Doc. CRC/C/155/Add.97²³

"The Committee recommends the State Party to ensure access to reproductive health counseling and provide all adolescents with accurate and objective information and services in order to prevent teenage pregnancies and related abortions; and strengthen formal and informal education on sexuality, HIV/AIDS, STIs, and family planning."

Philippines, Committee on the Rights of the Child, June 3, 2005, U.N. Doc. CRC/C/15/Add.259²⁴

Reporting status

Most of the countries have reported at least once on their compliance with the international human rights treaties they have ratified. With the exception of Malaysia, all of the countries have reported to the CEDAW Committee.¹⁰ Malaysia's first combined initial and second periodic report is due for consideration by the Committee in 2006.¹¹ Similarly, with the exception of Malaysia, the countries surveyed have reported to the CRC, although they have been three to six years late in submitting their reports.¹² The failure to meet reporting deadlines may indicate a country's failure to prioritize human rights.

STRATEGIC RECOMMENDATIONS

Women's health policies must be developed within a broad framework linking human rights principles with population and development, poverty eradication, social justice, gender equality and equity, and women's empowerment, and comprise a comprehensive set of strategies that are designed to protect and promote their rights.

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

The fulfillment of women's reproductive rights requires multidisciplinary strategies based on a human-rights framework. At the very least, governments should introduce comprehensive reproductive health legislation that guarantees the rights of individuals to determine the number, spacing, and timing of their children and the right to make choices about reproduction free from discrimination, coercion, and violence. Comprehensive reproductive health legislation that includes penal code reform regarding issues such as abortion and sexual violence can provide a formal means for addressing reproductive rights violations. This will help improve the delivery of reproductive health care—a goal shared by governments in the region.

What follows are general recommendations for promoting a rights-based approach to reproductive health care and holding governments accountable for violations.

To governments:

- Introduce gender concerns in the daily work of key departments such as ministries of health, law, women's affairs, and finance, and ensure that these offices obtain sufficient technical and financial resources to support law and policy implementation, the monitoring of reforms, and research.
- Promote the participation of women in all levels of government including parliament, ministries, and judicial bodies.
- Make the legal system more accessible by undertaking public campaigns that raise awareness of legal rights, and create legal aid services for those who require free

legal counsel and assistance.

- Increase the capacity of government officials to incorporate human rights principles into every aspect of their work through training and sensitization. As a first step, help law and health ministries and the judiciary to promote a human rights approach to health.
- Submit reports to treaty-monitoring bodies with adequate information and data on key reproductive health issues, and publicize and implement concluding comments issued by such bodies at the national level.
- Withdraw reservations to CEDAW and ratify the optional protocol to CEDAW to ensure full implementation of the treaty.

To advocates for women's health and rights:

- Build collaborative strategies with health-service providers, lawyers, and community-based organizations to monitor and document violations of human rights, and develop strategies to establish accountability for violations by government and non-state actors through various strategies, including litigation.
- Monitor governments to ensure that they respond to complaints about discrimination, coercion, and violence that undermine women's health in the private and public spheres.
- Develop collaborative strategies among diverse nongovernmental organizations by strengthening sexual and reproductive health and rights partnerships at the international, national, state, and local levels.
- Monitor and publicize governmental compliance with human rights principles in reproductive health and women's empowerment policies and programs and in relationships with international financial institutions and donors.
- Expose and advocate against the political collusion of religious conservative bodies with the state in the formulation of reproductive health policy, legislation, and judicial decision-making.
- Counter the influence of international funding institutions that propose budget cuts for health programs by pushing governments to defend their international treaty obligations to citizens.
- Seek remedies for violations of human rights in national courts and if national remedies fail, consider filing complaints with international legal bodies.
- Lobby governments for the withdrawal of reservations to CEDAW and for the ratification of the optional protocols to CEDAW and the ICCPR.

ENDNOTES

1. Asian Pacific Resource and Research Centre for Women (ARROW), *ICPD: Ten Years On: Monitoring on Sexual and Reproductive Health and Rights in Asia* (2005), at 32.
2. World Health Organization (WHO), *Reproductive Health Strategy § 17 (May 2004)*, available at <http://www.who.int/reproductive-health/publications/strategy.pdf>.
3. ARROW, *supra* note 1, at 9.
4. ARROW, *supra* note 1, at 9.
5. World Health Organization (WHO), *Human Rights-Based Approach to Health*, <http://www.who.int/trade/glossary/story054/en/>.
6. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (entered into force Sept. 3, 1981, ratified with reservations by Thailand Sept. 8, 1985).
7. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (entered into force Sept. 3, 1981) available at <http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm>
8. Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, adopted May 25, 2000, G.A. Res. 54/263, U.N. GAOR, 54th Sess., U.N. Doc. A/RES/54/263 (2000) (ratified by the Philippines, entered into force Jan. 18, 2002).
9. Optional Protocol to the Convention on the Elimination of Discrimination against Women, Oct. 6, 1999, G.A. Res. 54/4, U.N. GAOR, 54th Sess., U.N. Doc. A/Res/54/4 (1999) (ratified by the Philippines and Thailand, entered into force Dec. 22, 2000).
10. Consideration of reports submitted by States parties under article 18 of Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Combined initial and second periodic reports of States parties, Malaysia, CEDAW Committee, U.N. Doc. CEDAW/C/MYS/1-2 (2005).
11. *Id.*
12. *Submission of Reports By State Parties of the Committee on the Rights of the Child*, 39th Sess., U.N. Doc. CRC/C/148 (2005).
13. *General Recommendation 24 of the Committee on the Elimination of Discrimination Against Women*, 12th Sess., para. 2, (1999).
14. *Id.*
15. *Id.* para. 14.
16. *Id.* para. 6.
17. *General Comment 4 of the Committee on the Rights of the Child*, 33rd Sess, para. 39 U.N. Doc. CRC/GC/2003/4 (2003).
18. *Id.* para. 39 (d).
19. *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Vietnam*, 25th Sess., para. 232-276, U.N. Doc. A/56/38 (2001).
20. *Concluding Observations of the Committee on Economic, Social, and Cultural Rights: China*, 34th Sess., para. 36, U.N. Doc. CESCR/E/C.12/Add.107 (2005).
21. *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: China*, 20th Sess., para. 251-336, U.N. Doc. A/54/38 (1999).
22. *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Vietnam*, 25th Sess., para. 232-276, U.N. Doc. A/56/38 (2001).
23. *Concluding Observations of the Committee on the Rights of the Child: Thailand*, 19th Sess., para. 25, U.N. Doc. CRC/C/155/Add.97 (1998).
24. *Concluding Observations of the Committee on the Rights of the Child: Philippines*, 39th Sess., U.N. Doc. CRC/C/15/Add.259 (2005).