

SRHR in the Asia Pacific: Advances and Challenges

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Good morning!

Let me start by thanking the Philippines NGO Council and the organisers of this conference for inviting me to speak at this opening plenary session. It is a great honour and pleasure to be back here in the Philippines.

The last time I was here was before the RH Bill had been passed, and I am hopeful that the Supreme Court will do what we all think is the right thing. But no matter what happens, we honour the courage and commitment of the President and Congress, of the many organizations that are working to bring the most basic reproductive health to all people in this country, and the thousands and thousands of ordinary Filipinas and Filipinos who have taken to the streets, and have worked so hard to make change happen.

This session is on Advances and Challenges and I will not therefore repeat those broader issues that Nafis Sadik has spoken about so eloquently. So, what advances have we made and where do we go from here?

Let me first acknowledge here a group of researchers too numerous to name with whom I have been working on just this question in the last few months, and whose work supports this talk. The evidence we have been putting together suggests a glass both half full and half empty. So first, how is the glass half full?

Advances

The ICPD POA has been called many times a major paradigm change, and paradigmatic changes take time to be completed. When we look at the progress made after ICPD, we must recognize the extent to which that vision has infused and entered into parallel and intersecting efforts such as the MDGs. For instance, India as a very large country has not particularly aligned its policies to the MDGs. Yet, there is no doubt in my mind that recent attention to maternal mortality in India is partly a result of the MDGs that came in turn from the ICPD POA. Not everything has been done right – policy change is often a messy and complex process. But there is certainly greater recognition, including funding of the problem of maternal mortality and morbidity, and of the extent to which the health of new-borns

depends on the nutritional and health status of women. Four important general advances have been made.

First, a number of advances have been made towards **SRH service provision**, despite many ongoing challenges. While we await UNFPA's global report on progress, I want to draw attention to two examples from South Asia. In our region, South Asia has been a laggard in human development with poorer SRH indicators as is well known, and that is why my examples are drawn from there. The first is Bangladesh (drawing from the work of Rounaq Jahan and Kausar Afsana) where the focus on vertical family planning before the ICPD broadened considerably in part due to major inputs from women activists. Among many changes, contraception, menstrual regulation, and emergency obstetric care (EmOC) received attention; nutrition and HIV/AIDS were added; the govt partnered with NGOs to get services to the urban poor; and recently the government announced the setting up on one-stop crisis centres in public hospitals for women survivors of violence. The result is a significant drop in the TFR to near replacement level and very low unmet need for contraception, as well as a general reduction in maternal mortality, high availability of EmOC, and a very low share of abortion deaths in total maternal deaths.

Another example is that of Tamilnadu state in India. (This draws on the work of Girija Vaidyanathan). While investments in reproductive health services especially contraception began much earlier, the period after the ICPD saw more funds and staff for RCH services, innovative responses to HIV, and more attention to STIs and RTIs as well as school-based adolescent health education. Important public health innovations in staffing and supply chains has meant that not only has the TFR fallen significantly below replacement but the state will meet the MDG goal on maternal mortality, and antenatal HIV prevalence has dropped sharply. Importantly, the state abjured user fees leading to an increase in the use of public health services by the poorest.

Second, (drawing from the work of Eszter Kismodi and colleagues) the general direction of movement on **sexual and reproductive rights** has been positive despite setbacks. This forward movement is due to mobilizing by women, young people and HIV/AIDS activists. In the region, we have the examples of the decriminalization of abortion in Nepal, the passing of the RH Bill in the Philippines, and the collective endorsement of sexual and reproductive rights by the govts of the region at the 6th Asia Pacific Population Conference in Bangkok last September. This affirmation was due in no small measure to the commitment of Pacific countries whose parliamentarians had approved the pathbreaking Moana Declaration earlier.

In India growing recognition of the huge problem of sexual violence has led to the passage of laws against violence and sexual harassment, and is evidenced by the increasing courage of girls and women in bringing violators to book. Even the recent retrogression by the Supreme Court on the colonial and infamous Article 377 of the Indian Penal code so-called "unnatural" sexual acts is under review and will hopefully be corrected. I might remark here that those who argue against rights on the basis of sexual orientation and gender identity as antithetical to traditional culture (whether in Africa or Asia) should know their own history better. Any imperialist assault on sexuality traditions in our countries has happened only twice - once during the colonial era when Article 377 and laws of that ilk were promulgated

against our traditionally more tolerant and open sexual cultures; and currently through the huge inflow of right wing funding for evangelical shock-troops whose primary focus is against gender equality, women's rights and sexual and reproductive rights. Nonetheless, we *will* prevail: our people are sensible, our courts are aware even when they are under pressure; and time and history are on our side.

Third, (drawing on the work of Shireen Jejeebhoy, KG Santhya, Fadekemi Akinfaderin and Jennifer Redner and others), in many of the countries of the region populations are young and there has been much talk of a demographic bonus or dividend. In the region at large, **young people including adolescents** (aged 10-19) are demanding sexual and reproductive rights including particularly comprehensive sexuality education and SRH services suited to their needs and life situations. Young people's lives have changed and changing dramatically – despite many barriers, they marry later, stay in school longer, and have access to the IT revolution more than their elders. I won't speak to the demands of young people; they have spoken yesterday clearly and eloquently as they did in Bali, at the CPD in 2012 and in many other places.

Fourth, the **health reforms** of the last two decades have left much to be desired when it comes to equity, access or quality of services, and this is the larger institutional and policy environment for SRH services. Nonetheless in many countries (as shown by the work of Viroj Tangcharoensathien and colleagues for Thailand, and Fang Jing for China), many advances have been made in integrating SRH services as part of larger health reforms. These experiences provide valuable lessons for approaches to universal health care/coverage (UHC) that can advance SRHR.

Despite these four major sets of advances, many challenges remain. I now turn to those.

Challenges:

In multiple venues during the past year I have been arguing that there are three major gaps require priority attention: *inequalities in access* to SRH services and information that have marginalized the poorest 40% of women and adolescents, and those living in rural and remote areas; *poor quality* of SRH services and of health services generally; and weak *accountability* mechanisms. These gaps in Equality, Quality and Accountability (EQA) mean that governments and their development partners are not paying sufficient attention to the human rights foundation of the ICPD POA. Improved laws and policies, as well as strengthened design, implementation and monitoring of health programmes and services are required.

Ensuring quality and comprehensive SRH services to all, especially all women and adolescents including those aged 10-14, and with particular attention to the bottom two quintiles in both urban and rural areas requires us to pay consistent attention to a number of issues of which I will focus on three today.

We need to progressively move from the programme silos that Nafis mentioned to *providing integrated services*. This requires training SRH providers in a larger range of

services and to refer effectively; to remove legal, administrative and other barriers to integration; to develop specific indicators for integration; and to experiment with providing multiple services in order to learn how best to do so.

Secondly, we need to focus on *improving quality on a priority basis*. If we think of contraception services as an illustration, this requires expanding the range of methods made available so that they meet the needs of those who are married or unmarried, young or old and in different life circumstances. It also means that service providers must be made accountable for meeting needs and expanding choices rather than being incentivized to 'motivate' people. They must inform girls and women about the pros and cons of different methods, the risks and benefits and side effects, and enable them to make choices effectively. Before ICPD and till today, large numbers of users stop using methods in less than a year because of side effects, but they receive little support for this or for starting a different method. In the era of long acting contraceptives such as implants and post partum IUCDs, users should be able to have them removed on request. If such basic requirements are not met, service quality will continue to remain poor and dissatisfaction high. Health care providers must be trained to meet medical standards, ethical standards and human rights especially of younger adolescent users who all too often get short shrift.

Thirdly, programme managers need to move to better monitoring indicators that directly focus on equality and accountability. For instance, CPR has long been known to be not very effective as a measure. But substituting it by CYP could favour longer acting contraceptive methods and sterilization thus incentivizing against choice. Indicators for the CSE need to be better than they currently are by tracking who doesn't have access, as well as the quality of content and delivery.

Friends, I've tried in this talk to focus on some specifics of the key challenges we face in advancing SRHR in programmes and services. But we mustn't forget the larger picture and the bigger challenges to policies at the global level that we face in 2014. If we are to secure and advance the gains we have made in this region, including those at the APPC last September in Bangkok, we must prepare ourselves to negotiate effectively for SRHR during the upcoming CPD in April this year. We all know this is crucial not only for the post ICPD advances we can make but also for our ability to influence the post 2015 development agenda. To that challenge let us collectively set our efforts from here on.

Thank you.