

# **REGIONAL ADVOCACY TOOL**

Sexual and Reproductive Health and  
Rights Advocacy in South Asia

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DRAFT for discussion

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## Table of Contents

ACRONYMS .....	3
Tables .....	4
I. Executive Summary .....	5
Family planning and abortion.....	5
SRHR of young people.....	5
Reproductive rights.....	6
Challenges and action: A regional view .....	6
Introduction.....	7
II. THEME 1: Comprehensive Sexual and Reproductive Health Services .....	9
Regional Overview .....	9
Family planning .....	10
Contraceptive Choice .....	10
Abortion .....	12
Country case studies: Sri Lanka and Pakistan.....	12
Advances and Challenges .....	17
Family Planning.....	17
Donors and global priority .....	18
Abortion .....	19
Recommendations for Action.....	19
Family Planning.....	19
Abortion .....	20
III. THEME 2: Sexual and Reproductive Health Rights of Young People .....	21
Country Case Studies: India and Nepal.....	21
India.....	21
Nepal.....	23
Advances and Challenges .....	23
Implementation of youth services .....	24
Legal, social and cultural barriers to sexuality education .....	25
Recommendations for Action.....	25
Improve quality of services .....	26
Outreach and communication .....	26
Mobilisation .....	26
IV. THEME 3: Sexual and Reproduction Rights.....	28
Reproductive Rights in India.....	28
Policy approach.....	28
Program reality .....	28
Targets, Incentives and Coercion.....	29
Advances, Challenges and Actions .....	30
Privatisation .....	31
Historical context of privatisation in South Asia.....	31
Public Private Partnerships (PPPs) in SRH .....	31
Informal Providers .....	33
Quality standards and regulation.....	33
Recommendations for Action.....	34
V. Conclusion .....	35
REFERENCES .....	37

## ACRONYMS

ARSH	Adolescent reproductive and sexual health
D&C	Dilation and curettage
EmOC	Emergency obstetric care
FHB	Family Health Bureau
ICPD	International Conference on Population and Development
IUD	Intra-uterine device
JSY	Janani Suraksha Yojana
LHW	Lady Health Worker
MCH	Maternal and child health
MDG	Millennium Development Goal
MR	Menstrual regulation
NGO	Non-governmental organisation
PPP	Public-private partnership
RTI	Reproductive tract infection
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund

## Tables

Table 1 Select SRH indicators across South Asia .....	7
Table 2 Contraceptive Method Mix amongst Married Women.....	10
Table 3 Abortion laws in South Asia.....	12
Table 4 Sri Lanka, Contraceptive use by demographic characteristics .....	13
Table 5 Pakistan, Contraceptive use by demographic characteristics .....	16
Table 6 Youth SRH Indicators, South Asia .....	21
Table 7 Family planning in 4 Indian States .....	29
Table 8 Overview of ICPD Advances, Challenges and Actions Required in South Asia.....	35

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## **I. Executive Summary**

In the twenty years since the International Conference on Population and Development (ICPD), policy in South Asia has shifted away from solely population-driven targets to wider approaches grounded in a sexual and reproductive health and rights (SRHR) agenda. Programmatically, countries in the region have improved indicators related to life expectancy, infant and maternal mortality, total fertility rates and contraceptive prevalence. While countries have made strides in addressing contentious issues such as safe abortion and youth sexual health, maternal and child health have dominated health programmes across the region. Further, implementation barriers, weakened health systems and waning global and national priority for SRHR have impeded progress towards realising the commitments made in Cairo.

This review seeks to assess advances, barriers and challenges for the ICPD agenda in South Asia in an effort to identify areas for renewed action and advocacy, while highlighting progress at the national and regional level. It reviews the status of commitments to access to comprehensive and integrated sexual and reproductive health (SRH) services, SRH needs and rights of young people and reproductive and sexual rights through a selection of issues and country case studies: i) access to family planning and safe abortion services in Sri Lanka and Pakistan; ii) sexual and reproductive health and rights of young people in India and Nepal; iii-a) sterilisation in India and iii-b) privatisation across South Asia.

### **Family planning and abortion**

The provision of family planning services varies across the region, with a range of approaches to method mix and outreach. Sri Lanka, for example, has consistently reached women and men with a range of methods through integrated health service delivery. Notwithstanding barriers such as outreach in previously conflict-affected areas and variable service quality, the country's success in providing comprehensive and integrated family planning is a model for the region. Pakistan, though committed to improved family planning in policy, has struggled to improve access to services due to lack of human resources, commodity shortfalls and a severely weakened health system. In the case of abortion, despite diversity in legal status across the region, implementation barriers, lack of trained providers and poor quality services have impeded access to safe abortion. Thus in both Sri Lanka – where laws are amongst the most restrictive – and Pakistan, with more legal flexibility, high incidence of unsafe abortion is a pressing health concern that has not yet been accorded priority. While activists struggle to create national awareness, lack of global donor support for safe abortion remains an obstacle across the region.

### **SRHR of young people**

Global momentum, regional advocacy and national mobilisation have coalesced to ensure a place for youth SRHR on policy agendas in South Asia. In both India and Nepal, adolescent reproductive and sexual health programmes have been initiated to provide youth-friendly services to all young people, irrespective of marital status, disseminate information on SRH, improve capacity of providers, and establish peer-based education. Programme implementation has varied widely, however, with the majority of youth seeking services from informal providers. Sexuality education in

India was effectively banned in several states, whereas Nepal promotes information for all students in schools. Sociocultural barriers amongst educators, lack of innovative approaches and weak outreach at the community level have resulted in spotty access to reliable information. Despite a difference in policy, programme level barriers are quite similar in both countries – with calls for greater outreach and communication, mobilisation and multi-sectoral approaches as the way forward.

## **Reproductive rights**

In India, ICPD was projected as the end to a historical focus on sterilisation as the primary method of family planning. Yet recent analyses indicate that targets and incentives for sterilisation, with a focus almost entirely on women, are common. The persistence of female sterilisation as the predominant mode of family planning and new approaches to popularise insertion of intra-uterine devices (IUD) underscore the continued challenges to incorporation of a rights-based approach within local programme realities.

Given the common challenges of implementation of SRH services across South Asia, analysis of health systems provides insight into underlying barriers to realisation of ICPD. With the exception of Sri Lanka, all of South Asia has undergone health sector reforms that resulted in wide scale privatisation of services. The region has been marked by outsourced family planning and reproductive health services to non-state entities in public private partnerships and a mushrooming of informal and formal private providers. While partnership arrangements have increased access to family planning, for example, they have also contributed to greater fragmentation and inequity within sexual and reproductive health services on the whole. Informal providers have filled critical gaps in services for women and young people in particular – but lack adequate regulation of quality or cost. The wider health systems environment, particularly priority-setting and oversight / regulation, must be addressed with great urgency in order to address gaps in implementation of SRH services.

## **Challenges and action: A regional view**

According to civil society champions, a rights-based approach to comprehensive sexual and reproductive health has largely only been achieved in policy, theory and rhetoric across South Asia. Implementation of quality services and envisioned approaches is weak in almost every country, beset with political, social and practical obstacles. Recommendations for integrated service delivery, improved human resources and training, community and youth outreach and monitoring and regulation are all dependent on creating an environment conducive to SRHR programmes at the national and local level. The paths for advocacy and action moving forward are thus defined by three common challenges: weak health systems characterised by poor infrastructure and privatisation; MDG-induced international shifts toward maternal health and family planning; and the need to reposition SRHR within new global, regional and national agendas.

## Introduction

The 1994 International Conference on Population and Development (ICPD) enshrined a range of rights for individuals to comprehensive reproductive health services, breaking away from a focus on population control in many parts of the world. In South Asia, rapid, sustained population growth has been a predominant concern for policymakers and politicians. Thus the commitments made in Cairo hold particular significance for the region, as a catalyst towards a comprehensive, rights-based approach centred on promoting the sexual and reproductive health (SRH) and well-being of individuals.

Over the past twenty years, all of South Asia has improved indicators related to life expectancy, infant and maternal mortality, total fertility rates and contraceptive prevalence (Table 1). However, absolute levels of maternal mortality and unmet need, for example, remain high (Alkema, Kantorova et al. 2013). Advances have been made in bringing sexual rights to the agenda, such as in Nepal and India, and in working towards universal access to health services such as in Sri Lanka, despite low economic growth. Some countries in the region have also provided models of innovation in service delivery, such as longstanding house-to-house delivery of family planning in an integrated model and access to menstrual regulation in Bangladesh or progressive policies to improve youth access to information on sexuality and abortion services in Nepal. Yet implementation barriers are common to all: weakened health systems, lack of priority for SRH and shifting global agendas impede progress across the region.

**Table 1 Select SRH indicators across South Asia**

Country	Life Expectancy		IMR (per 1000)		MMR (per 100,000)		Contraceptive Prevalence		Unmet Need		Total Fertility Rate		Govt health exp/tot gov exp	
	1990	2009	1990	2010	1990	2010	1990	2010	1990	2010	1990	2010	2000	2010
Afghanistan	44	48	140	103	1300	460	5.5	22.2	28.1	29.5	8.0	6.3	-	1.6
Bangladesh	54	90	99	38	800	240	34.1	60.5	25.5	12.9	4.5	2.2	7.6	7.4
Bhutan	55	64	96	44	1000	180	14.1	64.6	29.4	12.5	5.8	2.4	12.2	12.1
India	58	65	81	48	600	200	41.5	57.3	20.2	14.2	3.9	2.6	3.6	3.7
Maldives	57	75	74	14	830	60	27.7	36.2	30.1	28.3	7.2	1.8	11.3	7.9
Nepal	55	67	97	41	770	170	18.6	48.8	33.6	26.3	5.2	2.7	6.5	7.7
Pakistan	59	63	96	70	490	260	12.2	32.4	30.2	25.9	6.0	3.4	2.3	3.3
Sri Lanka	68	71	26	14	85	35	65.9	71.5	10.6	7.3	2.5	2.3	6.8	5.9

Sources: World Health Organization. 2012. *World Health Statistics*. Geneva: World Health Organization. pp. 51,96,133,145 and Alkema, L et al. 2013. *National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis*. *The Lancet*, 381. Table 1, p.1645.

The purpose of this review is to assess the status of ICPD-related commitments in practice across South Asia around three themes:

- 1) access to comprehensive and integrated SRH services;
- 2) SRH needs and rights of young people; and
- 3) reproductive and sexual rights.

The review is not intended to be comprehensive of either all countries or all issues related to SRH in South Asia. It deliberately focuses on specific issues of key



importance to the region, with case studies from individual countries. The issues covered are:

- i) access to family planning and abortion services in Sri Lanka and Pakistan;
- ii) sexual and reproductive health and rights of young people in India and Nepal;
- iii) a) sterilisation in India and b) privatisation across South Asia.

The first part of each section provides regional background on the issue, drawn from published data and research. The second part details country case studies as illustrative examples, integrating the views of civil society actors. The third part synthesises advances and challenges for the countries reviewed, followed by recommendations for action, drawn from civil society perspectives and lessons from other countries in the region. The final section of the paper synthesises the issues and points to future directions for the region. Information sources include national and regional data, analyses and reports by intergovernmental bodies, published primary and secondary research; and writings of/interviews with civil society activists and stakeholders at the national and regional level.

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## II. THEME 1: Comprehensive Sexual and Reproductive Health Services

### Regional Overview

A cornerstone of the ICPD consensus was country commitments to ensure the provision of comprehensive and integrated reproductive health services by 2015. Of the range of services delineated in the Programme of Action (Box 1) and subsequent reviews, those related to maternal health have by far been the central focus of SRH funding and programmes in South Asia.

#### Box 1 Programme of Action, SRH services

##### Paragraph 7.6, ICPD Programme of Action

All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes.

Maternal mortality is a leading cause of death amongst reproductive age women in South Asia, with the exception of Sri Lanka. Indeed, the region accounts for close to one-third of global maternal deaths (UNFPA 2010). Since 1994, countries have implemented targeted measures to achieve ICPD and MDG 5 goals towards reduction of maternal mortality, such as an increasing access to attended and institutional delivery and improved facilities with comprehensive emergency obstetric care (EmOC).

These efforts have resulted in reductions in maternal mortality across South Asia since 1994. Some of the decline can be attributed to increased education, decreased fertility rates and improved access to maternal health care, particularly skilled birth

attendance (UNFPA 2010, Karlsen, Say et al. 2011) . For example, maternal deaths in India have declined by 66% between 1990 and 2010, although the current ratio of 200 deaths per 100,000 live births is still high(UNFPA 2010). Since 2005, India has amplified its efforts to promote institutional delivery in government facilities through a conditional cash transfer scheme, the Janani Suraksha Yojana (JSY). State level public-private partnerships, such as the Chiranjeevi scheme in Gujarat, have introduced free institutional delivery through contracts with private practitioners (Jehan, Sidney et al. 2012). Similarly, Nepal has experienced a 78% reduction in maternal deaths since 1996, a considerable decline by global standards (WHO 2012). In addition to the priority accorded to safe motherhood in health policy for two decades, Nepal’s decline can be attributed to decreased fertility, improved detection and institutional delivery for high-risk pregnancies, and improvement in social determinants such as education, anaemia and income (Hussein, Bell et al. 2011).

The translation of commitments – both to ICPD and MDG 5 – to reduce maternal mortality is testimony to country capacity to deliver on international pledges. However, efforts to improve maternal and infant health outcomes have largely not been accompanied by strengthened health infrastructure and outcomes related to comprehensive reproductive and sexual health. In fact, an overwhelming focus on specific maternal and child health outcomes, singled out from an integrated approach to SRH, may have been cause for widespread regressions and gaps in delivery of basic SRH services outlined in the ICPD Programme of Action. This section focuses on two such areas – family planning and abortion – that require action and advocacy.

## Family planning

All of South Asia has seen improvements in contraceptive prevalence rates and reduction in the total fertility rate over the past few decades. However, issues of access to quality services, decline in priority amongst governments, and health systems failures are of increasing concern (Khuda 2012). Unmet need for contraception remains high in most of South Asia, and has been the subject of recent regional initiatives.

## Contraceptive Choice

As Table 2 indicates, the contraceptive mix varies considerably across countries. Sterilisation predominates in India and Nepal, while women in Bangladesh and Pakistan access a wider range of methods, including the pill and injectables. Male methods are low in all countries, although condom use in Pakistan is a higher proportion of overall use than elsewhere.

**Table 2 Contraceptive Method Mix amongst Married Women**

Country	Any form of contraception	Female sterilisation	Pill	Male sterilisation	Injectable	Male condom	IUD	Any trad. Method
Bangladesh (2011)	61.2	5.0	27.2	1.2	11.2	5.5	0.7	9.2
India (2006)	66.0	37.3	3.1	1.0	0.1	5.2	1.7	7.8
Nepal (2011)	49.7	15.2	4.1	7.8	9.2	4.3	1.3	6.5

Pakistan (2007)	48.7	8.2	12.4	0.1	11.4	17.2	8.1	25.5
Sri Lanka* (2007)	68.0	16.9	7.9	0.7	15.0	5.5	6.3	15.2

\*Excludes Northern Province due to conflict

*Sources:*

*Bangladesh: NIPORT/ICF 2013. Bangladesh Demographic and Health Survey 2011. Dhaka, Bangladesh and Calverton, Maryland, USA.: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. India: IIPS/MACRO 2007. National Family Health Survey (NFHS-3); 2005-2006. Mumbai: IIPS. Nepal: MOHP/ICF 2007. Nepal Demographic and Health Survey 2007. Kathmandu, Nepal and Calverton, Maryland. : Ministry of Health and Population, New ERA, and ICF International. Pakistan: NIPS/ICF 2007. Pakistan Demographic and Health Survey, 2006-7. Islamabad, Pakistan, and Calverton, Maryland, USA: National Institute of Population Studies (NIPS)[Pakistan] and ICF International. Sri Lanka: DCS/MOH 2009. Demographic and Health Survey 2006-07. Colombo, Sri Lanka. Department of Census and Statistics and Ministry of Healthcare and Nutrition.*

In addition, the social determinants of family planning use are concerns throughout the region. Few programmes have created an environment that ensures women can access reproductive health services and exercise choice in family planning. Tackling early marriage and patriarchal values, for example, requires media and broad-based interventions. Efforts to improve girls’ education and participation of women in society are essential to reinvigorate fledgling family planning programmes such as in Pakistan and continue to expand programmes in Bangladesh and Nepal. Lastly, protracted conflicts in several countries have limited access to reproductive health services on the whole (See Box 2).

**Box 2 SRH in Conflict Zones**

Sri Lanka, Afghanistan and parts of Nepal, Pakistan and India have faced varying degrees of internal conflict and war in the past thirty years. In Sri Lanka, two decades of civil war have had a deep impact on security, development, and naturally, reproductive and sexual health and rights in Sri Lanka. An estimated 1 million refugees – the large percentage of whom remain internally displaced – have had limited access to health care (Nanayakkara and Guy 2003). Despite Sri Lanka’s effective health system, lack of outreach in refugee areas and limited human resources willing to work in conflict zones have resulted in high rates of home delivery and untreated reproductive and sexual health issues. The Demographic and Health Surveys were not conducted in conflict zones; thus exact health conditions are unknown. Further, high migration out of Jaffna, the main conflict zone, has forced women to search for employment in unfamiliar environments; resultant economic, social and physical insecurity has direct impacts on reproductive and sexual health. High rates of domestic violence, early marriage and less use of institutional services and benefits are three fall-outs for the victims of ongoing conflict (Kottegoda, Samuel et al. 2008). In Afghanistan, Soviet occupation followed by protracted war and Taliban rule destroyed most of the health infrastructure by the late 1990s. Although efforts to rebuild infrastructure and the health system have improved basic living conditions since 2001, reproductive and sexual health services in Afghanistan face severe challenges. (Aitken 2009). Even where services are available, women face social and cultural barriers in seeking care from men in public or private institutions. Donor aid has supported international and Afghan NGOs in providing care to supplement limited government facilities, with mixed results in terms of sustainability and effectiveness. Midwives are increasingly being recruited, although retention and provision of services in mountainous regions remain challenges. Several decades of conflict and unrest have given way to increasing stability and Afghan-led development, but reproductive and sexual health and services must be rebuilt from scratch, largely dependent on the priorities of international donor support.

## Abortion

Unsafe abortion poses a major risk to women's lives and well-being in all of South Asia. Abortion laws vary considerably in South Asia, ranging from unrestricted access in Nepal to exceptions only to save the mother's life in Afghanistan, Bangladesh and Sri Lanka (Table 3). Nepal, according to a regional abortion expert, serves as a model of enacting liberal laws and expansion of services. Since 2002, all women above 16 can legally obtain a first-trimester abortion without restriction due to reason, except for sex selection. Political will has been matched by programme efforts to provide abortion through government centres. Nepal has also encouraged access to abortion services through non-governmental organisations (NGO) such as Marie Stopes, with support from some donors.

Programmatic realities are largely similar across the region, with the exception of Nepal. Limited access due to lack of providers and health systems constraints, negative provider attitudes, social barriers and poor quality services have resulted in South Asia having the world's highest rate of unsafe abortion – approximately 6.8 million unsafe abortions are conducted annually. Resulting mortality is estimated at 200 deaths per 100,000 abortions performed (WHO 2012). Further, as a result of health systems issues and legal restrictions in some countries, abortion has always been extremely privatised across South Asia – leading to further financial barriers for women.

**Table 3 Abortion laws in South Asia**

Reason	Countries
To save the life of a woman	Afghanistan, Bangladesh, Sri Lanka
To preserve physical health and to save woman's life	Pakistan
In case of rape, incest or to save woman's life	Bhutan
Socio-economic grounds (and all above reasons)	India
Without restriction (except sex selection)	Nepal

Source: 'Facts on Abortion in Asia', Guttmacher Institute, January 2012.  
[http://www.guttmacher.org/pubs/IB\\_AWW-Asia.pdf](http://www.guttmacher.org/pubs/IB_AWW-Asia.pdf). Accessed 15 May 2013.

## Country case studies: Sri Lanka and Pakistan

### Sri Lanka

Sri Lanka's health system has been a model for developing countries. Despite relatively low per capita income, health indicators exceeded most ICPD goals before 1994. It is also the only country in South Asia with a sex ratio favourable to women throughout their lifetimes (UNFPA 2009). The Sri Lankan health system is premised on strong primary health care at the community level, with linkages to institutional health services. Outreach workers include community level health workers, midwives and nursing sisters who work with health-centre based staff. In addition to the health system, the social determinants of health are relatively strong in Sri Lanka: high literacy, established infrastructure and transportation and women and child welfare programmes have historically been a priority and success (Haththoutuwa 2012). Before 1994, Sri Lanka had a well-functioning maternal and child health (MCH) and family planning programme, controlled by a single Family Health Bureau (FHB). MCH services in particular have been a model for South Asia: 98.6% of births are attended by a skilled attendant, with 94% deliveries in a health facility (Abeykoon

2010). Although the four-decade long internal conflict in Sri Lanka has challenged the country's health system and resulted in regional variation in indicators, basic services remain strong.

### Post-ICPD Policy Advances

In Sri Lanka, the integration of family planning with other health services, along with strong community outreach, has provided safe, accessible family planning services at a large scale. Between 1985 and 1994, the FHB focussed on delivery of family planning services. After ICPD, Sri Lanka developed a Population and Reproductive Health Policy in 1998, followed by an action plan led by the Population Division of the Ministry of Health. The policy adopted a "life-cycle" approach to women's reproductive health. Diagnosis and treatment of sexually transmitted infections (STI) was integrated with MCH and family planning services. The FHB also established Well-Women's clinics at the sub-divisional level for breast and cervical cancer screening and detection of hypertension and diabetes among women above 35. Notably, STIs in non-pregnant or younger women were not addressed at this point. In 2008, the FHB developed a national maternal and child health policy to focus on increasing access to emergency obstetric care (Abeykoon 2010). Overall, Sri Lanka has demonstrated an impressive post-ICPD policy and results record: health indicators continue to improve while policy reflects the changing needs of the population. Quality of care, however, remains a challenge.

### Family planning services

From 1965 onwards, fertility has steadily declined, although there has been a more recent increase amongst adolescents aged 15-19. Contraceptive prevalence has remained steady or increased, with a slight increase in modern methods (DCS/MOH 2009). Sterilisation has decreased; there is a consistently diverse mix of methods utilised by women, albeit with regional disparities. Unmet need is highest in the Eastern provinces, with little variation by socioeconomic status (UNFPA 2009). There is some variation in contraceptive use, particularly of modern methods, by demographic characteristics, as presented in Table 4.

**Table 4 Sri Lanka, Contraceptive use by demographic characteristics**

Demographic characteristic	Any method	Any modern method
<b>Residence</b>		
Urban	59.2	43.5
Rural	69.6	53.7
Estate	64.2	61.0
<b>Education</b>		
None	72.7	68.0
Primary	70.8	61.9
Secondary	68.7	55.0
Passed General Exam	63.5	44.7
Higher	66.2	43.9
<b>Wealth quintile</b>		
Lowest	72.7	63.8
Second	69.6	54.9
Middle	70.0	54.5
Fourth	67.2	48.3
Highest	63.0	41.9



**Source: DCS/MOH 2009. Demographic and Health Survey 2006-07. Colombo, Sri Lanka. Department of Census and Statistics and Ministry of Healthcare and Nutrition.**

The family planning programme is delivered by a public health midwife, who provides house-to-house RH services in the community. Her role also includes linking women to Well Woman Clinics, providing advice to young couples and disseminating specific information to adolescents. At the policy and service delivery level, the family planning programme has historically been integrated with MCH services. However, women who do not use MCH clinics – both adolescents and older women – are largely left out of the existing family planning programme outside of community outreach services (UNFPA 2009). The government has initiated efforts to include family planning in Well Women clinics, although current utilisation is limited (Abeykoon 2010). Unmet need, as a result, is highest amongst adolescents and women 35-49 (MOHP/ICF 2007).

### Abortion

National statistics on abortion are not routinely collected in Sri Lanka. The only national survey estimated the rate of abortion to be 45/1000 women of reproductive age, or 600 to 700 abortions performed daily (Rajapaksha 2002). The rate was highest amongst married rural women. In 2008, septic abortion comprised 13% of maternal deaths, equal to that of post-partum haemorrhage. Further, 7-16% of all hospital admissions for women are attributed to abortion complications (WHO 2012).

### Legal and policy environment

Since 1883, Sri Lankan law continues to permit abortion only to save a woman's life (Kumar 2013). In December 2011, a proposal for abortion reform was introduced to consider legalisation in the case of rape, incest and foetal abnormality. It would also require two doctors in a government hospital to approve the procedure. The move towards reform faces strong opposition from the Catholic Church, although less than 10 percent of Sri Lanka is Catholic. Policymakers have restricted reform proposals to circumstances in which women are 'blameless', such as rape, incest and foetal abnormality. An attempt to register misoprostol and mifepristone as legal drugs failed in 2010, largely due to disagreement within the medical community (Kumar 2012). The National Strategic Plan on Maternal and Neonatal Health (2012-2016) states the objective of reducing abortion-related mortality deaths through provision of post-abortion care and family planning.

### Services

Research and data indicate that abortion also functions as a form of family planning (Women&MediaCollective 2010). Unmet need for family planning is high amongst women above 35; integration with MCH results in a contraceptive services gap for older women, filled by clandestine abortion providers. The highest rates of abortion are recorded in poorer rural provinces, where unmet need is likely higher as well. Most abortions are provided in the private sector, which remains unregulated due to the legal environment. Marie Stopes provided menstrual regulation services, but stopped its programmes in 2007 due to opposition by the political regime. Women have access to medical abortion through pharmacists and medical practitioners. Post-abortion care is available in government and private hospitals, but research indicates that quality requires great improvement. Further, women are likely to delay seeking post-abortion care due to fear of the police or legal repercussions (Abeykoon 2010).

Qualitative reports indicate many women are not treated well in post-abortion care settings, with experiences of verbal abuse, sexual advances and exploitation.

## Pakistan

Pakistan, with a population of 16 million, established a public health system premised on the primary health care approach. However political change, structural adjustment and inflation --as well as a low social sector budget – have impeded effective functioning of health services (Abrejo, Shaikh et al. 2008). Infant and under -5 mortality remains high, and the maternal mortality ratio remains intractable at 276/100,000 live births (Table 1). Institutional births are increasing, and the country has made significant improvements in ensuring skilled birth attendance and antenatal care(NIPS/ICF 2007). Twenty percent of care is provided in the public sector; the remainder is utilised in an unregulated private sector comprised of traditional healers, clinics, nursing homes and for-profit hospitals.

### Post-ICPD policy changes

In 1994, Prime Minister Benazir Bhutto's speech at the ICPD catalysed the introduction of Lady Health Workers (LHW), a cadre of community health workers to deliver family planning and primary health care services (Sathar and Zaidi 2010). While the National Health Policy of 1997 did not integrate reproductive health into primary health care, in 1999 the LHW package included STIs, family planning, MCH, cancer and RH services for men(Abrejo, Shaikh et al. 2008). The National Reproductive Health Policy of 2000 utilised the ICPD definition of reproductive health, with a commitment both to reproductive rights and women's empowerment. The policy was never formally approved, although it was followed by a National Population Policy that - while focused on population growth – included improved services for reproductive health (Sathar and Zaidi,2010).

The establishment of a National Population Commission and a Population Summit in 2005 marked a renewed commitment to family planning and to some extent, reproductive health(Sathar and Zaidi 2010). In 2010, the National Population Policy included a comprehensive reproductive health package for women through the life-cycle, as well as a focus on adolescents and male reproductive health. Further, the government has clearly articulated the Millennium Development Goals (MDG) as its focal goals; a reproductive health and rights agenda was elided in the process (Abrejo, Shaikh et al. 2008). Maternal and child health, as in most of the region, is the focus of both policy and services. In the post-ICPD era, the government has also initiated more collaboration with NGOs and the private sector in the areas of population and family planning. Recently, the decentralisation of health services through the 18<sup>th</sup> constitutional amendment empowers local bodies to set localised agendas, as well as raise awareness on the lack of progress in family planning and reproductive health.

### Family planning services

In South Asia, Pakistan has been the last country to experience a fertility decline. Inequality in access to services and a growing private sector result in limited options for low-income women, who continue to have the highest unmet need. Family planning services comprise mostly condoms and sterilisation, with equal use of withdrawal and rhythm methods (DHS 2007). Utilisation of modern methods is higher among urban, educated and wealthier women (Table 5).



Contraceptive prevalence has remained steady since 2001, with little improvement in coverage or diversity of methods. LHWs, overloaded with services for polio campaigns, are unable to manage community demand for family planning ([Sathar and Zaidi 2010](#)). At least 25% of women have an unmet need for family planning, of the 55% who demand services ([Sathar and Zaidi 2010](#)). Thus the health system cannot reach at least half of women who require services. In addition to lack of programme reach, religious objections, lack of women’s autonomy in decision-making – as well as low literacy and legal rights – remain obstacles to improvements ([Hardee and Leahy 2008](#)). Close to half of users depend on the government, while the remainder utilise private sources.

**Table 5 Pakistan, Contraceptive use by demographic characteristics**

Demographic characteristic	Any method	Any modern method
<b>Residence</b>		
Urban	44.8	32.0
Rural	30.7	23.1
<b>Education</b>		
None	30.2	23.4
Primary	40.8	28.8
Middle	40.7	29.5
Secondary	43.9	31.1
Higher	43.8	29.7
<b>Wealth quintile</b>		
Lowest	20.8	18.1
Second	29.7	22.9
Middle	38.2	26.9
Fourth	41.5	30.3
Highest	45.8	31.6

Source: NIPS/ICF 2007. Pakistan Demographic and Health Survey, 2006-7. Islamabad, Pakistan, and Calverton, Maryland, USA: National Institute of Population Studies (NIPS)[Pakistan] and ICF International.

## Abortion

The only study on induced abortion in Pakistan estimates the incidence to be 29/1,000 women: 14% of all pregnancies end in induced abortion and 11-15% of maternal deaths are caused by unsafe abortions (Population Council, 2004 in (Vlassoff 2009). Most women who undergo abortions are married and between ages 25-39; they seek the procedure for unwanted pregnancies after they have had the desired number of children (Casterline and Arif 2003). An estimated 6.4/1,000 women hospitalised in 2002 were for complications of unsafe abortion; this is likely an underestimate as many women do not seek care (Ahsan and Jafarey 2009) In one of the few hospital-based studies available, Shaikh et al found that 20% of women admitted for complications had undergone unsafe abortion, which led to morbidity and in a few cases, death (Shaikh, Abbassi et al. 2010).

## Legal and policy environment

The law in Pakistan allows for abortion to save a woman’s life. Medical abortion is not licensed for this purpose, but is freely available and utilised in Pakistan(Vlassoff

2009). In 1997, the government widened terms for abortion to include for necessary treatment within the first three months of foetal development. A Recommendation by the Commission on the Status of Women declared a woman's right to abortion in the first 120 days of pregnancy for any reason, yet this position was never implemented into policy. In effect, most abortions in Pakistan are clandestine due to cultural or social reasons or fear of legal repercussions. In 2009, the Karachi Declaration, a national strategy to scale up family planning, and maternal, newborn and child health best practices included a resolution to institutionalise post-abortion care in policies and health facility standards. However, the pledge has not resulted in programmatic changes or efforts to strengthen post-abortion care services (ShirkatGah 2013).

## Services

Patterns suggest that abortion is largely utilised as a method of family planning, particularly birth spacing, in Pakistan. Abortion rates are higher in the North West Frontier Province where contraceptive use is limited; conversely, levels are lower in Punjab and Sindh where more women report use of family planning. Both untrained and trained providers perform abortions, in often unsafe conditions. In a study of rural women, 42% used traditional midwives, while 7% went to doctors (Vlassoff 2009). Even when conducted by medical providers, safe abortion services and post-abortion care are both lacking due to inadequate training and skills (Shaikh, Abbassi et al. 2010, Farooq 2013)

Abortion services are typically a more invasive dilation and curettage (D&C) procedure rather than the safer, less expensive manual vacuum aspiration. The introduction of medical abortion could reduce complications, but the policy environment remains unfavourable (Ahsan and Jafarey 2009). In fact, 67% of providers have a negative view of abortion and favour stricter laws (Shirkat Gah 2012). Thus while civil society is working to improve access to safer abortion services, the law, service providers and government policy restrict progress (Shirkat Gah 2012).

## Advances and Challenges

### Family Planning

While Pakistan has initiated a degree of rhetoric and policy response utilising the language of ICPD, its progress has remained limited. Overall, MCH/SRH services have suffered low coverage, with weakened programmes at the national and local level (Hardee and Leahy 2008). The country's emphasis has been on institutional – rather than safe – delivery, despite the fact that traditional birth attendants continue to assist over one-half of deliveries (ShirkatGah 2013). Poverty, health sector weaknesses, social determinants and lack of coordinated implementation have impeded meaningful progress in family planning since 1994 (ShirkatGah 2012). In fact, experts conclude that a narrow mix of methods and health systems environment indicate that Pakistan has reached a plateau in family planning. The social aspects of family planning – women's role in the family, communication and acceptability – have not yet been addressed in Pakistan either. While decentralisation under the 18th amendment is progressive from a governance perspective, funds and priorities have also shifted. As a result, provinces must be convinced of the importance of family planning and a RH approach – in effect reversing gains made after ICPD (Sathar and Zaidi 2010).

A recent, albeit slow, expansion of services indicates the potential for greater access to reproductive health care for poorer women in particular. However, the potential of LHWs has not been exploited, both due to competing priorities and poor implementation. Despite longstanding demand, family planning is not yet integrated with other health services at the institutional level (Shaikh 2010). Where local health workers are central to the programme, competing priorities, such as polio and other vertical initiatives, result in lower priority for family planning service delivery. Further, according to activists and analysts, failures in health system delivery are the key barriers to expanding contraceptive choice in Pakistan. Shortfalls in contraceptive commodities and poor logistics systems across the region limit the availability of methods available as well as de-motivate users to switch methods (Khuda 2012). In addition, lack of government priority and limited human resources limit effective availability of a range of contraceptives.

In Sri Lanka, despite advances, continuing ethnic tensions post the cease-fire have raised a particular challenge to women's reproductive rights. Extremist Buddhist leaders have called for limitations on access to contraception and sterilisation for Sinhalese women, to ensure that their population is not displaced by other religious groups. Protesters recently succeeded in preventing women from accessing sterilisation services, despite their decision to utilise a health clinic for this express purpose. Although led by religious leaders, the protests and denial of services has tacit approval of local health authorities, according to those engaged in the issue. Activists such as the Women and Media Collective continue to protest these violations of women's choice and access to reproductive health services.

### **Donors and global priority**

Global funding is critical for strengthened, integrated family planning services through the region. With the exception of India and Sri Lanka, countries are largely donor-reliant for commodities, and unable to fund growing demand for contraceptives – even with support from the private sector and NGOs. In Pakistan, donor funding for family planning has declined in the 2000s, while SRH donor contributions peaked in 2004 (Hardee and Leahy 2008). In 2005, USAID provided 10 million USD for family planning, but this project has been criticised by leading activists at Shirkat Gah as localised and vertical – rather than a systemic and integrated – intervention that could address all women (Shirkat Gah 2012).

Activists and stakeholders raise two primary concerns with regards to donor priorities. One, MDG 5 and a singular focus on maternal mortality have eclipsed an integrated reproductive health agenda. A focus on maternal health has translated into promotion of institutional - not necessarily safe – delivery at the expense of women's other reproductive health needs. Two, the direction of the 2012 Family Planning Summit in London threatens to further erode the integrated approach set out in ICPD. Country governments' commitments to improve access to family planning methods have been strengthened by vertical funding from international donors, led by the Bill & Melinda Gates Foundation and bilateral donors. While family planning coverage may increase, the current vertical donor environment threatens an integrated approach steeped in ensuring women and men's right to contraceptive choice within a comprehensive package of SRH services. Overall, SRH activists in both countries, as well as across the region, concur that donor focus on specific family planning intervention – without provision of basic SRH services at the primary level – threatens the overall reproductive and sexual well-being of women, men and young people.

## **Abortion**

In Sri Lanka, where laws are amongst the most restrictive, attempts to provide post-abortion care have not reduced unsafe abortions and maternal mortality. Civil society representatives have reported to CEDAW on the country's inability to protect the health and lives of women due to restrictive abortion laws (Women&MediaCollective 2010). Fifteen years ago, activists had achieved consensus amongst physicians, religious leaders and the Ministry of Health to decriminalise abortion. However, once the proposal's main champion, a secretary of women's affairs, retired, the proposal was left dormant. An increase in sexual violence since the end of armed conflict has again created space to consider decriminalising abortion for girls below sixteen years of age. While not an acceptable limitation, activists view this as a potential opportunity for activism for a wider policy. Adding to what have typically been the sole efforts of civil society, the college of obstetricians and gynaecologists have emerged as public supporters of decriminalisation of abortion. Donors have not played a role in abortion advocacy, including the United Nations Population Fund (UNFPA) who otherwise has been influential in advancing women's health and SRH agendas.

In Pakistan, laws are less restrictive; abortion is permitted to save the mother's life and to preserve her health. However, there is no agreement on what the law actually permits and, according to a prominent women's organisation, the law itself is not a barrier. No one has ever been prosecuted under the Penal Law for abortion. Yet clandestine abortions and medical complications are common, due to inadequate availability and access to quality safe abortion services. In particular, bias of service providers, lack of information on abortion, and shortage of basic health services obstruct women's access to safe abortion. Access is further limited by a focus on married women in MCH services and emphasis by donors on family planning and reproductive health, implicitly excluding abortion. National policy has effectively left abortion off the health agenda, despite high mortality due to unsafe abortion. A focus on MDG targets, as well as social barriers, have prevented a comprehensive approach to family planning and reproductive health services, one which includes access to safe abortion and post-abortion services for all women.

Given legal barriers in both countries, Bangladesh offers an example in providing women critical services in a restrictive environment. Menstrual regulation (MR), a manual vacuum aspiration procedure between 6-10 weeks, has been offered by the Bangladesh government since 1972. Considered a family planning tool, it does not require approval by two doctors as abortion does, and can be delivered by paramedics. Available through both public and NGO services, menstrual regulation has undoubtedly improved women's access to safe abortion in the first trimester (Chowdhury and Moni 2004). However, complications of MR and unsafe abortion are common: 25-48% of MR procedures result in complications that require further treatment (PopulationCouncil 2013). In response, the Population Council is currently piloting and evaluating the use of medical menstrual regulation.

## **Recommendations for Action**

### **Family Planning**

A fully integrated approach to family planning and reproductive health, not only focused on women who access maternal health services, would ensure that Sri Lanka remains a model for the region. While aggregate results indicate the effectiveness of the programme, regional disparities, access in conflict-affected areas (See Box 2) and

outreach to women who do not utilise MCH services are three areas that require further focus. In Pakistan, coordination or integration between vertical programmes, improved communication and innovative partnerships are three potential areas for action to counter health services limitations.

Integration of family planning services, thus, is the pressing action for both Sri Lanka and Pakistan. In the region, Bangladesh offers an example of successful policy and practice in offering integrated family planning services. Since the 1980s, family planning was integrated with maternal and child health services, delivered with primary health services at the sub-district (*upazilla*) level and below (Randall 2012). Health workers, initially promoters of sterilisation, were later trained to deliver a range of services at women's doorsteps. By the mid-1990s, family planning was integrated in an inter-sectoral approach, not limited to health programmes alone. Despite challenges to quality of care, Bangladesh's achievements in consistently high coverage of contraceptive services (62%) are testament to how policy commitment, service integration and innovation in provision of door-to-door family planning services by female health workers can improve family planning services.

### **Abortion**

A dearth of trained providers is the primary limitation to women's access to safe abortion services in Sri Lanka and Pakistan, as well as the rest of the region. Mobilisation for introduction of training for midlevel providers has gained traction, in the face of medical lobbies and policy constraints. Medical abortion, easily available across the region's porous borders, has also transformed the contours of debate and presents an opportunity for action. Improvement to restrictive environments, whether due to systems or legal constraints, requires, as a start: legal review of restrictions; introduction and expansion of abortion services with means to monitor and hold providers accountable; training and service provision guidelines; and information to women on safe abortion as part of a comprehensive reproductive and sexual health agenda. In both countries, donor and national policy environments focussed on MCH and family planning, without addressing abortion, have contributed to diluting access, quality and the expansion of post-abortion care. Thus an integrated approach to SRH that includes abortion and post-abortion care requires sustained advocacy amongst both national and international stakeholders.

### III. THEME 2: Sexual and Reproductive Health Rights of Young People

Issues related to the sexual and reproductive health and rights of young people were addressed within ICPD, but focus strengthened over subsequent reviews (UNFPA 2010). Most recently, the Bali Global Youth Forum Declaration in 2012 articulated the inputs of thousands of youth stakeholders on the post-Cairo and post-MDG future. Staying healthy, a primary theme of the declaration, was defined to require government action to collect appropriate, age and gender-disaggregated data; enact laws and policies to promote reproductive and sexual health; ensure access to youth-friendly health services; and to establish an enabling environment for youth development through capacity building and multi-sectoral initiatives (ICPD 2012).

**Table 6 Youth SRH Indicators, South Asia**

Indicator	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
% of population aged 10-19	26.0	20.9	19.9	19.3	20.1	23.1	22.3	15.4
% married, female	19.8	44.7	15.2	30.0	5.2	28.8	15.7	9.0
Adolescent birth rate	90	128	59	38.5	16.1	81	16.1	24.3
HIV knowledge, females	1.9	11.4	21.9	18.6	21.5	25.0	2.0	-

Source: UNICEF Country Statistics, [http://www.unicef.org/statistics/index\\_countrystats.html](http://www.unicef.org/statistics/index_countrystats.html). Accessed 29 August 2014.

Countries of South Asia have the highest percentage of young people in the world, a significant proportion of whom are married and become parents as adolescents or youth (Table 6). While government policies have largely focused on skills and employment, information and services related to health, sexuality and rights pose a particular challenge for the region.

#### Country Case Studies: India and Nepal

##### India

Approximately one-third of India's population is between the ages of 10 and 24 (MoHFW/WHO 2009). In the context of unprecedented economic growth coupled with a decline in fertility rates, youth have been targets of education, training and work schemes in the hopes of harnessing a young labour force afforded by the country's demographic dividend. Yet, almost half of Indian women aged 20-24 are married by the age of 18, and a significant proportion have experienced forced sexual initiation (Jejeebhoy and Bott 2003, IIPS/MACRO 2007). Further, more than one in three married female youth have experienced physical, sexual or emotional spousal violence (IIPS/MACRO 2007). Since 1998, there has been a trend of increasing contraceptive use by young people, particularly married women (IIPS and ORC Macro, 1997, 2007). Consistently high rates of unwanted pregnancies, abortions and still births amongst girls 15-19, however, indicate the need for improved SRH services for young people.



## Policy advances: Adolescent Reproductive and Sexual Health

Unlike India's immediate post-ICPD commitment to a target-free family planning programme, policymakers have responded more slowly to youth sexual and reproductive health and rights. A National Youth Policy of 2003, and later version in 2010, recognised the multiple inputs required to support youth gender equality, promote health and empower youth with skills. The reproductive and child health programme (RCH), however, did not specifically address youth or adolescents in the 1990s.

In 2005, the Adolescent Reproductive and Sexual Health (ARSH) programme was introduced, with support from the second RCH policy, as an effort to reorganise youth-specific services and develop adolescent friendly health services. Specifically, the programme included: i) reorganisation of the public health system to meet the needs of adolescents through counselling services and routine check-ups at primary, secondary and tertiary levels of care at fixed times to adolescents, married and unmarried ii) training of health functionaries to understand the specific needs of adolescents iii) outreach programmes/health check-ups at the village level and community-based peer education and iv) convergence with other youth-related programmes to enhance outreach (NRHM 2013).

The policy also included a comprehensive set of standards for service provision and an enabling environment for outreach, including strict confidentiality measures. In rhetoric and intention, the ARSH policy, along with policy initiatives across sectors, advanced the government's commitment to ICPD and established a progressive direction for youth health and well-being (Santhya and Jejeebhoy 2012). Moreover, in 2014 a revised National Adolescent Health Programme (Rashtriya Kishor Swasthya Karyakram) further promotes SRHR. In addition to services for menstrual hygiene and birth preparedness, the policy calls for improved access to and use of contraceptives, STI/RTI treatment and safe abortion services for adolescents.

## Sexuality education

The ICPD consensus promoted information on sexuality as critical for women, young people and vulnerable groups to help them negotiate their rights to information and health. Sexuality education has raised particular controversy in India. In 2005, the government introduced a UNESCO-developed module on sex education into national school curricula for adolescents. However, thirteen state governments eventually banned sex education in schools, on grounds of morals and cultural propriety. In response to contentions that India's refusal to provide sexuality education contradicts its commitments to ICPD and the Convention on the Rights of the Child, the Supreme Court deemed that sexuality education, while important, is not a component of the fundamental right to education (Kumar and Kumar 2011).

Civil society concerns that the bans against comprehensive sexuality education violate the rights of adolescents and young people have not yet been heeded in either policy or programs (Sood 2008). The Central Government has neither addressed the state-level bans nor re-introduced modules officially, although sexuality education is increasingly part of some education curricula. The UNFPA has supported restructuring of sexuality education to adolescent education on life skills, working with schools and out of school youth (UNFPA 2008). More recently, a government-constituted commission on sexual violence recommended sexuality education in schools, expanding the current biology lessons currently taught from class 8 onwards (Verma Commission 2013). Although these efforts introduced some information,

analysts asserted that the lack of comprehensive sexuality education hampers health services and well-being for youth (Sood and Suman 2008). The 2014 Adolescent Health Program establishes the need for sexuality counselling for youth, but implementation will depend on political priority.

## **Nepal**

Like India, approximately one-third of Nepal's population is young (MOHP/ICF 2007). Almost half (47%) of young women are illiterate, compared to 17% of young men – despite free education for all till 7<sup>th</sup> grade (Pradhan and Strachan 2003). Internal migration is increasing due to prolonged conflict: 50% of internally displaced people are young. A systematic review of SRH amongst young people notes the limited research amongst adolescents and youth in Nepal (Regmi, Simkhada et al. 2008). According to the Demographic Health Survey in Nepal, early marriage, though on the decline, is common amongst 15-19 year old girls (35%), resulting in teenage pregnancy. Contraceptive use amongst married girls 15-19 is low at 14%, creating risks for unplanned pregnancies and STIs. Over one-third of adolescents report an unmet need for family planning (MOHP/ICF 2007). Unmarried adolescents are increasingly sexually active, but with low condom use and limited information about sexual and reproductive health. Further, the Nepal Adolescent and Young Adult Survey estimates that at least one-quarter of sexually active unmarried people are involved in risky behaviour (FHI 2000).

## **Policy advances**

Post ICPD, Nepal adopted a National Reproductive Health Strategy in 1998, a National Adolescent Health and Development Strategy in 2000 and a Young People Development Programme in 2002. The government articulated the specific goal of improving the health and socioeconomic status of adolescents through i) information and skills ii) counselling and health services and iii) a safe and supportive environment. Health-related program components include: integration of adolescent health services within the existing public health system; provision of youth-friendly services irrespective of marital status; linkages with existing youth clubs, the private sector and NGOs to improve service provision; peer counselling programmes; training to service providers on adolescent needs; and provision of micronutrient services and information to adolescents (Ministry of Health 2000). An implementation guide for youth-friendly services was also endorsed and adopted in 2008.

Each of these policies has focused on integrated SRH services for young people. Most notably, the Government of Nepal introduced population and reproductive health education in public schools from grades 6-10 and in university curricula in order to increase availability and accessibility of appropriate youth friendly SRH information. In the community, radio and television programs offer information for adolescents. In addition, NGOs are involved at the grassroots with advocacy, information awareness and services for adolescents (DRC 2013). The National RH Programme Steering Committee enacted a specific policy that adolescents, married or unmarried, shall not be denied family planning services. Although abortion is only legally available to women over the age of 16, age requirements are not typically enforced (Pradhan and Strachan 2003).

## **Advances and Challenges**

India and Nepal provide an interesting contrast in policy direction – and underscore the implementation barriers to achieving ICPD commitments. Social and cultural



constraints, particularly gender norms and low literacy, impact on the ability of interventions to be effective, at least in the short-term. In both India and Nepal, services even when available are not utilised by youth due to negative perceptions of public services, limited skills of providers and lack of privacy.

Directly for the health sector, two key implementation challenges emerge in providing youth-friendly services: 1) delivery of quality services that are attractive and accessible to youth 2) community-level outreach, information dissemination and counselling for married, unmarried and out-of-school youth. Regarding sexuality education, both systemic and socio-cultural barriers must be addressed.

### **Implementation of youth services**

Particularly in India, the most common critique by activists of ARSH policy has been the medicalisation of adolescent issues. By setting primarily health-related targets, ARSH policy becomes limited to ensuring there is a painted wall in a medical clinic, regardless of availability of trained, sensitive providers. Further, the provision of ARSH services by insufficiently trained providers in health care settings alone contributes to access barriers resulting from issues of stigma, convenience, cost and perceived quality of care.

National evaluations of the services provided under the ARSH policy indicated several gaps in design and implementation (TRIOS 2012). ARSH services in select districts were established, but without referral or follow-up systems. The dedicated clinics were located at the district or sub-district level, rather than the recommended, more accessible village level sub-centres (TRIOS, 2012b). As stand-alone services, youth-friendly services were not mainstreamed into the existing public health system. While separate clinics allowed for privacy, maintaining confidentiality proved challenging (TRIOS 2012).

Utilisation of specific ARSH services by adolescents and youth is generally low, due to social norms, poor accessibility and lack of outreach. Social and cultural norms obstruct both service delivery and outreach: for example, a majority of providers feel uncomfortable or do not believe in providing SRH information or contraception services to youth (Collumbien, Mishra et al. 2011). As a result, outreach activities are also limited to married adolescent girls, and only those issues deemed appropriate, such as nutrition or anaemia, are addressed rather than comprehensive sexual and reproductive health. Not surprisingly, myths and misconceptions about SRH amongst youth are common. Given that government information and education activities are weak both in content and delivery, girls tend to utilise TV and radio for their information, while boys seek information from peers as well as pornography downloads (TRIOS 2012). While adolescent girls identified a need for information on contraception, RTI/STIs, pregnancy and abortion, counselling for youth, although identified as critical, is not available in either clinical or outreach services.

As a result, young people tend to seek informal or private providers due to greater accessibility and comfort. Unmarried youth in particular seek informal providers for all services, particularly contraception and abortion. In a large survey in two Indian states, 30% of informal providers reported provision of abortion services to unmarried young women (Collumbien, Mishra et al. 2011). Although young married women are accessing contraception in greater numbers, young men are almost completely left out of both service outreach and formal facilities.

In Nepal, despite strategic direction, implementation of programs and services for adolescent SRH is far from comprehensive (YUWA 2012). Publicly available health

services are not widely utilised by youth due to timings, accessibility and lack of same-sex providers. Hilly terrain and an increasingly weakened health system, due to conflict and privatisation, are longstanding access issues. Specific to youth-friendly services, staff capacity building has been limited, leading to lack of confidentiality and sensitivity in providing young people with services (Pradhan and Strachan 2003, YUWA 2012). Coupled with barriers related to social stigma and poor perception of public services, utilisation of youth-friendly services is limited, despite availability.

An evaluation of school-based sexuality education in Western Nepal found that, despite the directive from the Adolescent Health and Development Strategy, adolescents did not receive mandated information (Pokharel, Kulczycki et al. 2006). Researchers found that teachers were uncomfortable addressing sensitive topics such as sexual behaviour, and feared censure from colleagues if they did so. Educators also lacked skills on how to provide information on sexuality beyond biological facts. Some students reported being uncomfortable in such sessions, and were fearful of asking a teacher further questions. Evaluators concluded that the policy, though important, has in practice contributed little to improving SRH knowledge amongst youth. Further, out of school youth and young married women required specific outreach. Recommendations for better implementation included guest lecturers, single sex classes and improved audiovisual materials.

### **Legal, social and cultural barriers to sexuality education**

Ensuring provision of sexuality education as a core component of youth SRH rights has been particularly challenging across South Asia. Whereas many Indian states banned sexuality education, Nepalese policy at the other end of the spectrum promotes it through schools and adolescent programmes. Yet both countries face similar barriers in implementation: transforming cultural and moral attitudes towards youth sexuality. Societal mores, as the Nepalese example demonstrates, cannot be transformed by policy alone.

According to youth activists in India, current policy lacks a comprehensive, rights based approach to youth SRH and embodies a dissonance with law and programs. Recent legal developments in reaction to sexual violence in India, for example, have led to the definition of sexual activity amongst youth under the age of 18 as statutory rape (Lok Sabha 2013). Yet ARSH policy, focussed on sexual and reproductive health, implies the reality of sexual activity of both married and unmarried youth. Programs, however, tend to focus on married youth regardless of age. Further, different agencies within the government address sexual health in diverse ways; sexuality education is fragmented or framed differently by HIV prevention, life skills and reproductive health programmes. A rights-based approach to sexuality education will require a great deal of sensitising, particularly to counter what has largely become a protectionist agenda for youth in India. Recent outrage over sexual violence, though critical, may further limit acceptance of sexuality education as a right for youth. Formalising community participation of adolescents and youth in development of policies related to sexuality education and ARSH is articulated as a key direction for reducing cultural barriers, improving policies, and introducing monitoring of services provided. Most critically, political will is required both for coherence in content and assurance that adolescents can access SRH information.

### **Recommendations for Action**

Overall, a multisectoral approach to SRH for youth – such as linkages with education, skills and economic programs – rather than the vertical approaches adopted in both countries – is required to improve outreach and quality.

### **Improve quality of services**

A more holistic approach, one that is based in needs articulated by youth and focuses on reaching them outside of a medical clinic, is a means towards improving quality of youth services for SRH. Specific recommendations for actions by experts and civil society include: capacity building on youth-friendly services for providers; availability of same-sex providers, health workers and/or other medical staff; removal of stigmatising advertising on facilities, i.e. ensure that youth feel comfortable, but not singled out, for using a service; and hours conducive to youth schedules.

Privacy concerns could be addressed through sensitivity training for providers and medical staff and measures to keep files confidential. Development, dissemination and utilisation of training modules would be a key start. Further, engaging with and training informal providers who are the main source of care, including for abortion services for unmarried youth, will help improve quality and outreach, as well as expand abortion referral services.

### **Outreach and communication**

Outside of services, more emphasis is required on outreach and communication efforts. Experience in both countries demonstrates that youth require information provided in a sensitive, confidential and non-stigmatising manner. Capitalising on electronic media, particularly TV, and radio broadcasts requires a multi-sectoral approach, rather than isolated health messaging separated from existing popular channels, shows and media. The availability of trained outreach workers, either by strengthening the skills of community health workers such as ASHAs in India or recruiting peer educators, is critical to provide information and link youth to services. Similarly, peer groups at the community level can be formed, in collaboration with schools where feasible.

Multisectoral approaches, mass media interventions and use of research evidence are all required to normalise the concept of sexuality education for youth. Donors may play a critical role, by supporting innovative programmes targeted at society, parliamentarians and media to de-mystify why sexuality education is critical to youth well-being and reproductive health. Where sexuality education is already a policy directive, in some Indian states and in Nepal, alternative message sources may be helpful to support teachers not yet comfortable with the material. Audiovisual content, trained health workers and local leaders may provide safer, more comfortable means of communication for students and out-of-school youth.

### **Mobilisation**

In recent years there has been unprecedented mobilising around issues related to employment, skills and rights of young people. However, at the national level in particular, youth political and social activism has largely not addressed issues related to sexuality and SRHR. Although positive gains have been made at the global level through the Bali Youth Forum, the link to domestic policies and youth activism must be further strengthened. Mobilisation around sexuality education in India, for example, illustrated the critical role of local, grounded NGOs placed to engage with official processes.

The future for mobilisation around youth SRH issues requires linking movements as well as grounding global issues in local realities. For example, a link between legal protection against sexual violence and sexuality education in India, or the right to abortion and youth sexuality education in Nepal, requires activism that traverses health, youth rights and community participation. Given the particular cultural

barriers faced in South Asia, the challenge is to strike a balance between protection and freedom – to ensure that youth are rightfully equipped with both the information and services to promote their sexual and reproductive health.

DRAFT for discussion

## **IV. THEME 3: Sexual and Reproduction Rights**

Across South Asia, political concerns and the sociocultural environment have dictated the extent to which sexual and reproductive rights have been upheld by the government. The last several years have seen advances in some countries in the movement for sexual equality, the right to be free from discrimination based on sexual orientation and policy recognition of women's right to be free from sexual violence, albeit not necessarily within marriage. However, many challenges remain to ensuring women and men's sexual and reproductive rights, particularly regarding freedom of individual choices and the right to health care that promotes sexual and reproductive health.

This section details the coercion in family planning policy and programs in India, a critical issue concerning reproductive rights in the country. It also surveys the region's progress in ensuring the right to accessible, affordable and quality SRH services in light of increasing privatisation. The latter does not focus on a specific service, but rather on the systemic and political directives taken by countries in the area of health care.

### **Reproductive Rights in India**

India's history with family planning has been chequered at best: coercive male sterilisation during the Emergency in the late 1970s engendered a deep mistrust of family planning services amongst the poor, particularly men. In the post-emergency 1980s, voluntary tubal ligation replaced vasectomy as the primary method offered to the poor in family planning 'camps.' In effect, the family planning program shifted focus to women as acceptors and agents of population control methods.

### **Policy approach**

Post ICPD, India adopted a target-free, voluntary approach to family planning in 1996. The National Population Policy of 2000 specifically articulates an ICPD-based approach to reproductive health policy in India. At the 2012 Family Planning Summit, India reiterated its commitment to a target-free approach to reproductive health and contraceptive choice. However, evaluations of programmatic reality post-ICPD indicate a different picture. When India crossed the 1-billion population mark in 2000, alarmism was evident in the government. Indeed, a government official was quoted in defence of coercive practices: "Yes it's coercion, but we can't wait. Family size is not a personal matter" (Bhatia 2007).

### **Program reality**

Sterilisation remains the predominant method of contraception for women. Male sterilisation comprises 4.4% of all sterilisation operations (MoH 2011). Male methods are seldom promoted, and there are no male workers for family planning services (Nat Coal). Prevalence of sterilisation has risen in several states, while other methods lag. Further, research indicates that sterilisation at a young age is not medically ideal. In addition to potential regret later in life, sterilisation is also linked to greater incidence of gynaecological morbidity and hysterectomy (Singh, Ogollah et al. 2012). The predominance of sterilisation suggests that contraceptive choice is not guaranteed by Indian health services. The young age at sterilisation also indicates that birth spacing

and other, reversible methods safer for younger women are not being adopted – at the expense of informed choice.

**Table 7 Family planning in 4 Indian States**

Percentage change in state level achievements 2006-7 to 2010-11				
State	Sterilisation	IUD	Oral Pill	Condom
Bihar	245.1	138.4	58.8	25
Madhya Pradesh	85.5	-34	-31.8	-55.3
Rajasthan	17.5	34.2	-14.7	-28.2
Uttar Pradesh	-11.6	-15.3	-51.9	-53.6

Source: National Coalition. 2012. *Family Planning in India: A need to review our current approaches* [http://www.2cnpop.net/uploads/1/0/2/1/10215849/briefing\\_paper\\_-\\_ii\\_\\_24-12-12\\_e-copy.pdf](http://www.2cnpop.net/uploads/1/0/2/1/10215849/briefing_paper_-_ii__24-12-12_e-copy.pdf). Accessed 4 April 2013.

Sterilisation is typically conducted through government ‘camps’ where at least twenty women undergo the procedure. Despite government recognition that static services provide better quality, the camp approach is utilised due to a human resources shortage in the public health sector. The quality of care within these camps has been cause for both alarm and research, with particularly egregious incidents in 2013 (Bengal news cite). The Ministry of Health and Family Welfare adopted quality of care parameters, but research has indicated breach of basic protocols (Das, Rai et al. 2004). After a 2005 case filed in the Supreme Court demanded improved quality in camps, the government established a quality assurance mechanism; subsequent studies, however, indicate that quality continues to be inadequate (HRW 2012) (Das et al., 2004) (Das 2012). For example, the number of surgeries recommended per camp is twenty, yet this figure is routinely exceeded. Although women are entitled to be informed of their options outside of sterilisation, research finds that they are only presented with sterilisation as an option. Further, while there is no routine data collected on adverse outcomes of sterilisation, camp-based reports indicate that failure rate and complications are indeed a concern (NatCoalition 2012).

### **Targets, Incentives and Coercion**

Health is a state subject in India, with national policy directives but state-level implementation that varies based on need and environment. Thus despite a national target-free policy, research indicates that several Indian states openly set targets in practice. “Expected levels of achievement” for community health workers, for example, are set at the state level for specific methods of family planning, with sterilisation accorded the highest priority (NatCoalition 2012). The project implementation plans, which are state-level budget proposals submitted to the central government, illustrate significantly higher budgets for sterilisation and intra-uterine devices (IUD) than other forms of family planning. They report on ‘planned sterilisation vs. achievements,’ reflecting the use of targets in practice. Further, budgets for incentives for sterilisation acceptors are sanctioned and distributed.

In a 2012 study in Gujarat, community health workers reported being assigned annual targets, with a focus on female sterilisation. They also reported being threatened with punishment or reduced compensation if they failed to meet targets (HRW 2012). In Madhya Pradesh, the government set an annual target of 750,000 sterilisations for 2011 (Das 2012). It also provided incentives – for surgeons, motivators and women – that included washing machines and cars, while the Rajasthan government distributed



gifts through a lottery for sterilised women (Majumdar 2012). In Bihar, the state utilised NGO contractors to provide sterilisation services, which increased figures three-fold over a five-year period.

Notably, sterilisation has been promoted through a multi-sectoral approach. Several public policy schemes have adopted sterilisation as a requirement for benefits. In 2003, the Supreme Court approved as constitutional a two-child limit for government officials elected at the local level. In practice, this system disproportionately affects poorer and lower-caste families: those disqualified are largely from economic and socially disadvantaged groups (Buch 2006). In several states, a government conditional cash transfer for institutional child birth limited the benefit to two children, though the condition was subsequently removed from policy in 2013 (NRHM 2013). Schemes to improve the sex ratio and promote female education, however, require a sterilisation certificate from the parents to claim benefits (HRW, 2012).

### **Advances, Challenges and Actions**

Recently, a historical focus on sterilisation is being widened with financial support for routine intra-uterine device insertion, post-partum or through camps. Linked to national incentives for institutional delivery, donors such as USAID, Norway India Partnership and the Bill & Melinda Gates Foundation are supporting the Indian Government in scaling post-partum IUD services in 19 states (USAID 2011). Guidelines indicate that IUD insertion should be part of a broader antenatal and postnatal care package, wherein women are clearly informed of the benefits and risks of IUD. The government views donor support as key to maximising an opportunity, as conditional cash incentives for institutional delivery have increased the number of women who utilise a facility for childbirth. Post-partum IUD insertion is questioned by activists and researchers who doubt the nature of informed consent amongst women who have just delivered a child. Earlier research in Tamil Nadu indicates that IUD targets may simply replace those of sterilisation, with similar lack of informed consent or safety precautions (Van Hollen 1998). Further, longstanding concern with the poor quality of public institutions raises further doubt about the safety of widespread introduction of IUD insertion.

The dissonance between national statements and state-level practice regarding sterilisation targets is not simply one of federal structure. Stronger commitment to contraceptive choice is required, according to activists and health experts in India. The comparison of India with other countries in South Asia is most stark in the proportion of sterilisation. Steps to improve women and men's right to informed decision-making regarding family planning require policy and programmatic changes as well as legislative action. All schemes that promote or require sterilisation at the state level must be evaluated for violation of informed choice and India's commitments to ICPD. In assessing multi-sectoral promotion of sterilisation, social security benefits must be reviewed; the lack of old age security may be linked to the desire for more children. Further, the national government must develop indicators for access to and use of contraceptives beyond numerical targets, including those that assess quality of care. The programmatic focus should also widen to include birth spacing and promotion of other methods. Within program implementation, independent grievance redress mechanisms must be set up and monitored as part of quality control. Involvement of men as family planning agents and male workers for information and counselling is a first step away from the focus solely on women.

The role of the private sector, an increasingly popular service delivery agent in family planning services, requires careful evaluation. Mechanisms for oversight and accountability, as required in the public system, must be extended to private providers.

### **Privatisation**

Since 1994, most South Asian countries have undergone a range of health sector reforms. Resultant health policies have included sexual and reproductive health services to some extent, albeit with difficulty in translating policy commitments into services for all, particularly the marginalised. Lack of public funding and support for the health sector has resulted in widescale privatisation through the region – which in turn has limited governments' ability to achieve ICPD goals. Privatisation of health services has included the outsourcing of family planning and reproductive health needs to non-state entities in public private partnerships (PPPs), as well as a mushrooming of informal and formal private providers.

### **Historical context of privatisation in South Asia**

The 1990s were witness to an accelerated marketisation of health care across South Asia, largely in response to adopting of structural adjustment programme (SAP) measures linked to loans (Baru 2003). The role of industry and private players such as pharmaceutical companies and insurance firms was nascent, yet growing rapidly, by the time of ICPD. According to one of the few analyses across countries in South Asia, while there is regional variation in the health sector and health sector reform, privatisation has become a hallmark of each country's provision of services, with the exception of Sri Lanka (Baru 2008). Longstanding investment in public health and a welfare system in Sri Lanka has allowed for available, accessible and effective public health services across most of the country. Government physicians are allowed to practice privately, which has contributed to the growth of private health care at the primary care and ambulatory level.

In the rest of South Asia, privatisation has exacerbated inequity in the health sector. The middle class increasingly relies on private care and slowly, on health insurance, to access private care, while the poor depend on underfunded, typically poor quality public care. For example, Bangladesh, while investing in public hospitals since Independence in 1971, also offered incentives for private hospitals and nursing homes to establish themselves. Decline in health care investment through the 90s resulted in a largely inadequate health care system – resulting in increased importance of NGOs and the private sector in provisioning services. Similarly, in Pakistan, public sector investment in health services has been minimal. Urban residents have significantly better access to health care, whereas close to half of the remaining population has virtually no access to basic health facilities. The situation in India is no different: as policy commitments of the post-Independence era faded, public services stagnated through the 1990s. The private sector did not remain limited to primary care; tertiary care is significantly privatised as well.

### **Public Private Partnerships (PPPs) in SRH**

The path to privatisation of health systems was established before or during the early years of the Cairo consensus. Specifically, PPPs have become the increasing mode of delivery of services for SRH across the region. PPPs aim to improve utilisation of services through strengthened capacity, provision in underserved areas and expanded access to drugs. However, such arrangements have not widely translated into ensuring



and fulfilling peoples' right to basic SRH care, with three primary concerns in South Asia.

One, the overwhelming focus of public and donor priority has been on maternal health care, and to a lesser extent, family planning – at the expense of comprehensive sexual and reproductive health. The concentration of PPP services in these areas has resulted in the provision of fragmented services, such as contraceptive commodities without gynaecological care, or delivery without counselling and information on post-partum care. Thus the limited range of services available provides poor returns to women and men in terms of their actual SRH needs. To illustrate, bilateral donors such as USAID and DFID and private foundations have invested in expanding contraceptive and SRH service program networks such as Janani clinics in India and other contraceptive services initiatives managed by international NGOs such as Population Services International in Pakistan. Evaluations indicate that such PPPs have increased access to contraceptive services, in greater volume and at a subsidised cost to users compared to private services. Community outreach services also reflect an advance, particularly in the use of male health workers. However, in both countries, the actual range of services provided is quite narrow. Post-abortion care, treatment for reproductive tract infections (RTIs), STIs, EmOC and antenatal care were not included with improved access to contraceptives.

Two, contracting cannot address underlying malaise of public health systems, such as staff shortages, coordination between different vertical programmes, and lack of equipment. For example, Pakistan's privatisation was marked by an increase in contracts to NGOs for family planning services (Ravindran 2010). User fees were introduced in public hospitals, and social franchises were established to promote government-funded service delivery by private health providers. At present, much of the country (69 of 105 districts) is covered by a PPP model of basic health units that provide primary health care and reproductive health services. The latter is mandated to include maternal and child health care, gynaecological care and family planning services. In practice, these clinics have increased utilisation of basic health services, largely due to availability of drugs in areas where public services have long faltered. Evaluations have found that RH services were limited to institutional deliveries and some antenatal care, without contraceptives or non-maternity care for women or services for men. Quality of delivery services was also found lacking, due to lack of staff, equipment and 24-hour availability of care.

Three, SRH services provided by informal, not-for-profit and profit making private services are not accountable to either local citizens or effective regulatory mechanisms. PPPs may be accountable to a donor or international NGO for performance according to set targets, but ownership of such initiatives is generally not locally rooted. Hence grievance redress, quality control and responsiveness to community needs are dependent on individual organisations rather than systemic standards. Experience indicates that regulatory bodies are largely non-functional, effectively allowing both formal and informal private providers of SRH services to flourish and remain unaccountable for quality of care. Further, PPPs are dependent on existing government structures, yet with little control over government staff. Thus in addition to ensuring their own ability to manage PPPs, government must continue to invest in basic infrastructure and systems to ensure effective delivery.

### **Informal Providers**

The vacuum in availability of SRH services has also been filled by a wide variety of providers, including unregulated, informal practitioners, medicine sellers, government providers with private practices, small private maternity hospitals and large corporate health care networks. Women and men who utilise these private services tend to spend more out-of-pocket, leading to financial concerns and indebtedness as well as barriers to care.

In Bangladesh, the formal public health system is ill-equipped to provide services for common SRH issues such as reproductive tract infections, menstrual difficulties, infections and sexual disorders. Shortages in health work force, lack of providers willing to work in rural areas, and a weak knowledge base limit the scope of public care (Rashid, Akram et al. 2011). Even where primary care is available, government staff is not trained in providing care for SRH needs. As a result, across South Asia, informal providers play a major role in treatment due to greater accessibility and willingness to address these issues, regardless of skill and competence. In Bangladesh, 85% of the population is treated by informal health care workers.

In a study of women's reproductive health needs and treatment-seeking in Bangladesh, women reported high morbidity due to RTIs, but few were aware of any treatment available in formal services (Rashid, Akram et al. 2011). The most popular providers for SRH issues are informal, including medicine sellers, healers and local doctors with a wide range of experience or qualifications, if any. Patients utilise government facilities for required maternity and family planning services, but access a range of informal and formal private providers for issues such as white discharge, infertility and prolapsed uterus. Since SRH issues comprise a considerable proportion of spending by women and men, mechanisms for financing utilisation in the private sector are critical for achieving ICPD goals.

### **Quality standards and regulation**

The pace – and far reach – of private sector growth in India is likely the fastest in the region, with accompanying concerns of quality standards. Many PPPs have emerged in urban areas where hospitals have established themselves, leading to further inequities in access to care. In well-performing states like Tamil Nadu and Gujarat, PPPs have led to increases in institutional delivery, use of contraception and some care for RTI/STIs (Balasubramanian and Ravindran 2009). By and large, however, the full range of SRH services remains unavailable in the public sector or through PPPs (Khanna, Pradhan et al. 2012). As in Bangladesh and Pakistan, Indians must turn to the private sector for abortion, gynaecological care and sexual problems – with variable standards of care and little regulation.

Indeed, in an exploratory study of small private hospitals that focus on maternity care in the state of Maharashtra, researchers found the rapid expansion of private hospitals was not accompanied by improved quality of care (Deosthai-Bhate, Khatri et al. 2011). Lack of proper equipment, specialist staff and infrastructure plagued small hospitals as well, which comprise close to 90% of all hospitals in the state. Data on health outcomes and quality are unavailable for such facilities, many of which are also unregistered in state records. Increasingly, PPPs have included such small hospitals in the provision of maternity care, with no methods of evaluating quality prior to engagement. Although regulatory bodies exist, they have been largely ineffective. The private sector is governed by separate bodies than public hospitals, without minimum standards to monitor either PPPs or private providers.

## **Recommendations for Action**

Access to SRH services requires sustained investments of both public and private resources to achieve equity in both outreach and utilisation in both urban and rural areas. A range of actions –experimenting with basic, publicly provided package of SRH services; financial protection for outpatient and inpatient services; strengthened public health systems; and monitoring and regulation – are required to rein in an entrenched private system for SRH services across most of South Asia. Where efforts toward universal health coverage are gaining ground to improve health systems, advocacy and mobilisation must focus on ensuring policy and programme priority to reproductive and sexual health beyond maternal health services.

DRAFT for discussion

## V. Conclusion

Twenty years later, statistics and analysis by civil society present a mixed picture of progress and the protection of the spirit of ICPD in South Asia. While general improvements have been achieved in specific programs such as maternal mortality and family planning, a rights-based approach to comprehensive sexual and reproductive health has largely remained limited to policy, theory and rhetoric. In fact, almost all civil society champions of ICPD expressed that the Cairo document was all but forgotten in national policy discussions: replacement by target-oriented MDGs and regression to vertical programs have eroded commitment to the promises made in Cairo.

**Table 8 Overview of ICPD Advances, Challenges and Actions Required in South Asia**

Key Advances	Primary Challenges	Actions Required
<i>Family Planning</i>		
<b>Increase in family planning coverage</b>	Ensuring contraceptive choice	Integrated approach to family planning
<b>Promotion of community-based distribution of contraceptives</b>	Poor quality of services	Donor support for integrated family planning and range of methods
<i>Abortion</i>		
<b>Introduction of post-abortion care as priority where abortion illegal</b>	Poor service quality and access	Training mid-level providers with quality guidelines for all providers
<b>Provision of medical abortion/MR</b>	Legal/policy restrictions	Advocacy for monitoring/accountability
<i>Youth SRHR</i>		
<b>Youth centred SRH policy and agenda</b>	Implementation of policies	Youth participation in policy/programs
<b>Youth-friendly SRH services/education</b>	Socio-cultural barriers	Mobilisation across sectors and actors
<i>Right to SRH services</i>		
<b>Policy commitments to SRH services</b>	Fragmented, vertical services	Accountability and regulation of private providers and PPPs
<b>PPPS/mechanisms for provision of SRH services through govt financing</b>	Poor quality of services	Govt guaranteed essential SRH services

In addition to those outlined in Table 8, several cross-cutting challenges will define the path for advocacy and action moving forward. First, weak health systems with limited capacity to provide public health services pose the largest barrier to

implementation of policy intentions. As illustrated in almost every country in the region, lack of investment and basic infrastructure impede delivery and expansion of SRH services. Concomitant privatisation has resulted in a market that provides SRH services, though often fragmented and at considerable cost to users, particularly for the vulnerable.

Second, MDG-induced international shifts toward maternal health and family planning – at the expense of a comprehensive SRH approach – have produced targets that are more palatable to policymakers. Although achievements have been made in coverage of some services, qualitative, social and cultural processes intrinsic to ensuring SRH and rights have been buried in older policy documents. Services such as abortion and sexuality education have suffered the most from vertical approaches, while others are implemented in a fragmented manner. Activists have called for critique of the role of donors in these processes, in which global agendas eclipse local needs.

Lastly, actors in the SRH movement have become fragmented by competing issues and newer concerns. Given the multitude of challenges facing South Asia, more work towards building bridges across issues is required to preserve the spirit of Cairo and develop a progressive agenda to reposition SRHR in the future.

DRAFT for discussion

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