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Economic and Social Commission for Asia and the Pacific
Midterm Review of the Asian and Pacific Ministerial Declaration on Population and Development

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Item 3 (b) of the provisional agenda*
Thematic discussion on emerging issues and gaps in the implementation of the Programme of Action of the International Conference on Population and Development, the key actions for its further implementation and the recommendations of the Asian and Pacific Ministerial Declaration on Population and Development

Advancing gender equality and universal access to sexual and reproductive health and reproductive rights

Note by the secretariat

Summary

Gender equality and sexual and reproductive health and rights are central to the Programme of Action of the International Conference on Population and Development and the Asian and Pacific Ministerial Declaration on Population and Development. They also feature prominently on the 2030 Agenda for Sustainable Development, in particular in regard to the Sustainable Development Goals related to ensuring healthy lives (Goal 3) and achieving gender equality (Goal 5). However, gender equality and sexual reproductive health and rights are cross-cutting issues that are vital to achieving sustainable development in general. This document contains an overview of levels and trends in sexual and reproductive health and rights, gender-based violence and harmful practices and highlights the interlinkages with the goal of achieving gender equality.

I. Introduction

1. At the International Conference on Population and Development in 1994, Member States affirmed that achieving gender equality and equal access for women and girls to participation, opportunities, information and services depended on and was a prerequisite for the full realization by women and girls of their sexual and reproductive health and rights. Together, the Programme of Action of the International Conference on Population and Development and the 2030 Agenda for Sustainable Development provide a holistic framework, encompassing the commitments that must be met to achieve gender equality and sexual and reproductive health and rights. The Asian and Pacific Ministerial Declaration on

* ESCAP/APPC/2018/L.1.

Population and Development, developed as part of the 20-year review of the Programme of Action and adopted in 2013 at the Sixth Asian and Pacific Population Conference, sets out comprehensive commitments, in line with the Programme of Action.

2. The past two decades have seen profound and measurable benefits of investment in sexual and reproductive health globally and in the region. However, this progress has been undermined by persistent gender inequality, inadequate investment in quality and responsive sexual and reproductive health services, and reluctance to address issues related to sexuality and reproductive health comprehensively.

3. While there has been unprecedented progress in reducing maternal deaths in the Asia-Pacific region, in 2015, 85,000 women in the region died while giving birth. Despite important gains in improving access to contraception, in 2017, an estimated 132 million women in the region had an unmet need for contraception. Profound inequalities remain in access to skilled birth attendance and antenatal care. Limited access to health services and breakdown in protection systems during humanitarian emergencies heighten existing vulnerabilities to pregnancy-related illness and deaths and gender-based violence.

4. Progress towards eliminating gender-based violence has included the introduction of laws and efforts to strengthen law enforcement capacity and access to services. However, barriers remain including lack of quality services, inhospitable judicial systems and harmful sociocultural norms that underpin acceptance and underreporting of gender-based violence.[1] Harmful practices such as child marriage and gender-biased sex selection persist and are rooted in gender inequality and the lower value given to girls. Across the region, laws, policies and practices continue to discriminate against women and girls and undermine their rights.

5. This document contains a review of progress in Asia and the Pacific towards achieving the commitments reflected in the Programme of Action, the Asian and Pacific Ministerial Declaration and the 2030 Agenda. The interlinkages between gender inequalities and other forms of inequality and vulnerability are highlighted, which challenge the enjoyment and fulfilment of the right to sexual and reproductive health for women and young people throughout the Asia-Pacific region.

II. Interlinkages between gender equality and sexual and reproductive health and rights

6. Investing in sexual and reproductive health and rights saves lives, advances gender equality, improves health and well-being, helps women to access quality education and find decent work, increases productivity and household income and improves children's health and well-being, thereby contributing to broader development goals. Gender equality is a prerequisite for achieving sexual and reproductive health and rights, including the right of individuals and couples to decide freely and responsibly on the number and spacing of their children.

7. Inequalities in the enjoyment of sexual and reproductive health and rights intersect with and are reinforced by gender inequality. Often, women experience gender-based discrimination which compounds other inequalities,

1 See E/ESCAP/GEWE/1.

whether along economic or geographic lines or among specific population groups. Stigma, discrimination and social exclusion creates severe obstacles to the enjoyment and fulfilment of sexual and reproductive health and rights. These barriers are exacerbated by widening disparities in wealth, education and rural residence.

8. Gender inequality is manifested in violence against women and girls and harmful practices, and undermines their right to decide whether, when or whom to marry, and whether, when or how often to become pregnant. Women and young people's lack of sexual and reproductive agency is reflected in high levels of maternal mortality, unintended pregnancy and unmet need for contraception, as well as challenges in accessing sexual and reproductive health services including safe abortion where legal and post-abortion care. Poor sexual and reproductive health outcomes constrain access by women and girls to education, employment and income-earning opportunities, and undermine their ability to participate on an equal basis with men and boys in all spheres of life.

9. Throughout the Asia-Pacific region, women and girls continue to experience significant inequalities in voice and participation and access to education and employment, and are more likely to experience poverty and vulnerability. Women's chance of completing secondary education is lower, and women are less likely to be in full-time employment than men across the region.[2] In 2017, the gender gap in economic participation, educational attainment, health and well-being, and political participation stood at 29.4 per cent for Eastern Europe and Central Asia, 32 per cent for East Asia and the Pacific, and 34 per cent for South Asia.[3]

10. Addressing discriminatory laws, policies and practices and transforming unequal gender power relations is necessary to ensure women's freedom from violence and their bodily autonomy and agency to make and act on their own decisions about their sexual and reproductive health and rights.

III. Sexual and reproductive health, services and rights

A. Maternal health

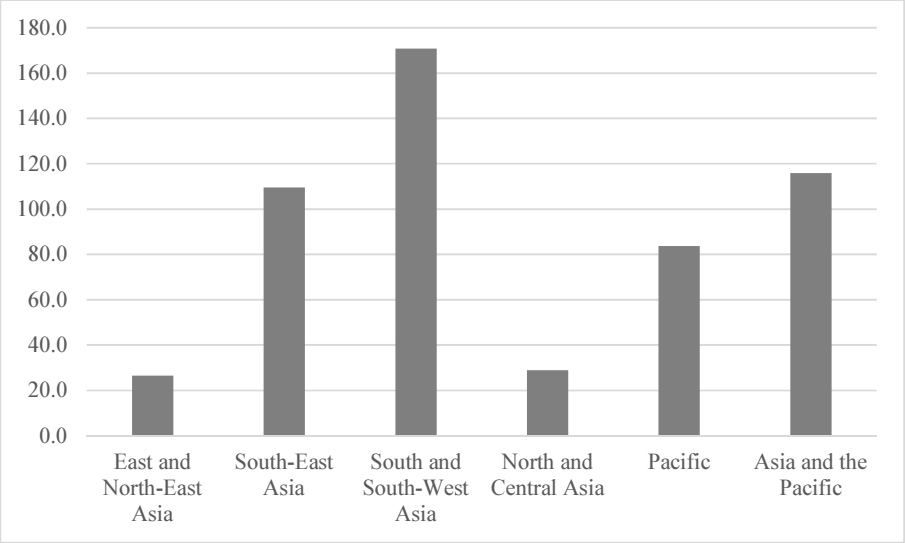
11. Poverty and gender inequality have a significant impact on maternal health. Poverty exacerbates lack of access to maternal health services and creates the conditions for inadequate, inaccessible and costly services in poor and underserved areas. Gender norms privilege men's and boys' well-being and access to health services over that of women and girls, reinforcing women's lack of economic choice and autonomy. Unintended pregnancy is more prevalent among rural, poor and less educated women and girls who have reduced access to quality maternal health services. Girls from poorer households are more likely to give birth as adolescents and have less access to skilled birth attendants and antenatal care. Pregnancy-related health risks impair women's ability to care for their families and participate in social and economic life, and undermine the capacity of households to weather economic and environmental shocks.

[2] *Inequality in Asia and the Pacific in the Era of the 2030 Agenda for Sustainable Development* (United Nations publication, Sales No. E.18.II.F.13).

[3] World Economic Forum, *The Gender Gap Report 2017*, (Geneva, 2017).

12. There was unprecedented progress during the era of the Millennium Development Goals, with maternal mortality declining by 61 per cent in the region between 2000 and 2015.[4] Despite this progress, in 2015, 85,000 women in Asia and the Pacific still died while giving birth, 75 per cent of whom are from the five leading preventable causes of maternal mortality.[5] As figure I shows, rates of maternal mortality were highest in South and South-West Asia and South-East Asia.

Figure I
Maternal mortality in the Asia-Pacific region by subregion, 2015
(Per 100,000 births)



Source: ESCAP Statistical Online Database (based on data from Statistics Division of the Department of Economic and Social Affairs, Global Sustainable Development Goal Indicators Database). Available at http://data.unescap.org/escap_stat/ (accessed 18 June 2018).

13. On average, progress will need to be two to three times faster than current trends to reach Sustainable Development Goal target 3.1 of reducing maternal deaths to 70 per 100,000 live births by 2030.[6]

14. Conflict and disasters have hindered progress in reducing maternal mortality. In Asia and the Pacific, approximately 4 per cent of women in any displaced or disaster-affected population will be pregnant, of which 15 per cent will experience pregnancy-related complications.[7] The breakdown of health systems and reduced access to services can cause a dramatic rise in deaths due to complications that would be easily treatable under more stable conditions.

[4] Economic and Social Commission for Asia and the Pacific (ESCAP), Asian Development Bank and United Nations Development Programme, *Making It Happen: Technology, Finance and Statistics for Sustainable Development in Asia and the Pacific – Asia-Pacific Regional MDGs Report 2014/15* (Bangkok, 2015).

[5] World Health Organization (WHO), *Trends in Maternal Mortality: 1990 to 2015 – Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (Geneva, 2015).

[6] Susan Nicolai and others, "Projecting progress: reaching the SDGs by 2030" (London, Overseas Development Institute, 2015).

[7] United Nations Population Fund (UNFPA), "Emergency preparedness and response in the Asia-Pacific region", February 2017.

Many women also lose access to contraception, exposing them to unwanted pregnancies and HIV and sexually transmitted infections.

15. A continuum of quality health care is needed to reduce preventable maternal mortality and improve maternal health, including antenatal care with a skilled provider and delivery by a skilled attendant in a health facility. While access to skilled birth attendance and antenatal care increased between 1990 and 2014, coverage still falls short of universal access (figure II).

Figure II
Skilled birth attendance in the Asia and the Pacific by subregion, 1990–2014
(Percentage)

Source: ESCAP Statistical Online Database (based on data from Statistics Division, Global Sustainable Development Goal Indicators Database).

Note: Empty cells have been interpolated.

16. There are significant disparities within countries, particularly when urban and rural differences and wealth disparities are taken into account: in Southern Asia, for example, there is a 33-per-cent gap in coverage between rural (42 per cent) and urban (75 per cent) areas.[8]

17. The coverage of antenatal care for at least four visits is uneven across the region. Between 1990 and 2014, South-East Asia saw an increase in coverage from 45 per cent to 84 per cent, while South Asia lagged behind with an increase from 23 per cent to only 36 per cent.[9] Coverage varies considerably

[8] United Nations, *The Millennium Development Goals Report 2015* (New York, 2015).

[9] Ibid.

from very low levels in Afghanistan (23 per cent), Bangladesh (31 per cent) and Pakistan (37 per cent) to near universal coverage in Thailand (91 per cent) and Fiji (94 per cent). Coverage in North and Central Asian countries is more than 90 per cent, apart from Azerbaijan (66 per cent) and Tajikistan (52 per cent).[10] Significant disparities persist between urban and rural areas and wealth quintiles.

18. Renewed efforts are required to ensure the availability of quality, accessible basic and comprehensive emergency obstetric and neonatal care. Obstetric fistula continues to be a significant cause of morbidity, suffering and social isolation for girls and women, particularly in South Asian countries, where a large gap persists in the availability of health and social services in rural areas.

19. Cost is a significant barrier to the utilization of maternal health-care services, including user fees and costs of travel. Opportunity costs of seeking health care, including taking time off from productive work and unpaid care responsibilities, also impede access to maternal care services for poor women. High health-care costs and out-of-pocket health-related expenses in the Asia-Pacific region exacerbate these barriers.

20. Unsafe abortion is a major and preventable cause of maternal mortality and disability. Of the estimated 53.8 million unintended pregnancies that occur each year in Asia, 35.5 million (65 per cent) end in abortion. [11] In Oceania, there are 4,000 unintended pregnancies each year, of which 1,520 (38 per cent) end in abortion. The annual rate of abortion, averaged over the period from 2010 to 2014, is estimated to be 36 per 1,000 women of reproductive age in Asia and 19 per 1,000 in Oceania.

21. Induced abortion is considered safe when (a) WHO-recommended methods are used, and (b) these methods are used by trained persons; it is considered less safe when only (a) or (b) is met, and least safe when neither is met. In Asia, estimates indicate that 62 per cent of abortions are considered safe, 30 per cent less safe and 8 per cent least safe.

22. Abortion is more likely to be unsafe in settings where it is highly restricted legally. Even where abortion is legal, many women continue to face barriers to obtaining safe, legal procedures that are affordable and accessible. Obstacles include difficulty in finding providers to perform abortions, substandard conditions in health facilities, lack of awareness of the legal status of abortion and fear of stigmatization for terminating a pregnancy, which can lead to isolation, shame and guilt, compromising women's health and well-being.

23. About 4.6 million women in the region are treated for abortion complications each year. In 2014, at least 6 per cent of all maternal deaths (5,400 deaths) in Asia were from unsafe abortion. Poor and rural women are the most likely to experience an unsafe abortion and severe complications. Improved and expanded provision and quality of comprehensive post-abortion care is required to reduce illness and death from unsafe abortion.

24. There is a clear correlation between unmet contraceptive need and abortion. Most women who have an abortion do so because they become pregnant when they do not intend to. Young women in particular are at high risk

[10] ESCAP Statistical Online Database (based on data from Statistics Division, Global Sustainable Development Goal Indicators Database) (see figure I).

[11] Guttmacher Institute, "Abortion in Asia: fact sheet", March 2018.

of unintended pregnancy, leading to high rates of unsafe abortion. Addressing the unmet need for contraception is critical to reducing unintended pregnancies, and the abortions or unplanned births that often follow.

B. Family planning services

25. Realization of the right to decide whether, when and how often one becomes pregnant is fundamental to achieving gender equality and women's empowerment. Unintended pregnancy constrains women's and girls' opportunities for education, civic participation and economic advancement. Lower fertility can contribute to increasing women's life expectancy and allows women to pursue economic opportunities. Smaller family size is associated with higher educational attainment, and greater investment in girls.

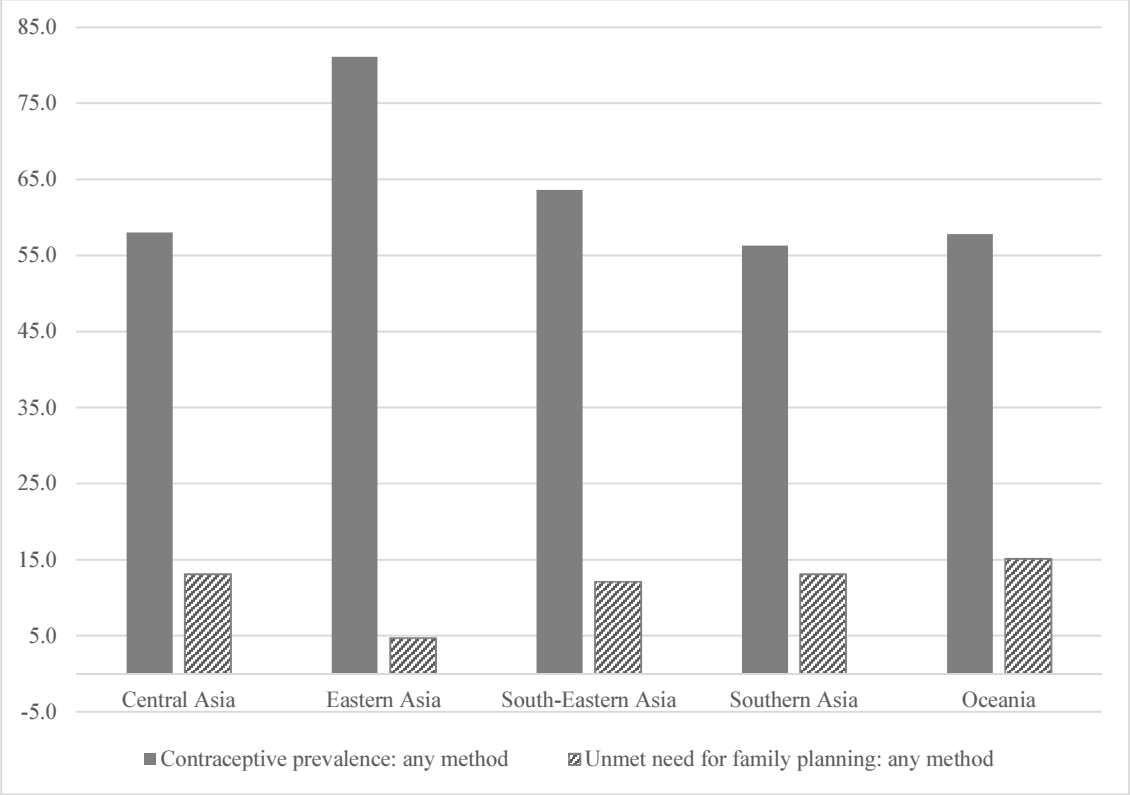
26. Globally, almost half of women aged 15–49 cannot decide for themselves regarding health care, contraceptive use and sexual relations, while in Asia, 31.5 per cent of women cannot make these decisions for themselves.[12] Women who are in violent relationships are more likely to report that they are unable to negotiate contraception use. Covert use of contraception, due to lack of agency and decision-making power, can also increase women's risk of experiencing violence.

27. While modern contraceptive use has increased since 1980, with more than half of married and in-union women using a modern contraceptive method, in 2017 an estimated 132 million women in Asia and Pacific had an unmet need for contraception. The proportion of women with an unmet need for family planning ranges from 4.7 per cent in Eastern Asia to 15.1 per cent in the Pacific (figure III). Southern Asia is home to the largest absolute number of women in the world who have an unmet need for modern contraception (70 million).[13] Unmet need is significantly underestimated, as available data reflect unmet need among women who are married or in union only.

[12] *The Sustainable Development Goals Report 2017* (United Nations publication, Sales No. E.17.I.7).

[13] Guttmacher Institute, "Adding it up: investing in contraception and maternal and newborn health, 2017 – fact sheet", December 2017.

Figure III
Estimates of contraceptive prevalence and unmet need for family planning in Asia and the Pacific among married or in-union women aged 15–49, median estimates, 2018
(Percentage)



Source: United Nations, Department of Economic and Social Affairs, Population Division, "Estimates and projections of family planning indicators 2018".

Note: The subregions shown do not correspond to the ESCAP subregions.

28. Moreover, although a woman's contraceptive need is considered "met" if she is using a method of contraception at a given point in time, this does not necessarily reflect her ability to make informed choices. In developing countries, female sterilization and intrauterine devices make up more than 60 per cent of the method mix.[14] Increased investment is required to ensure informed choice of contraceptive method across the region. Availability of the full range of contraceptive methods and quality service provision would enable women and girls to newly adopt or switch to appropriate methods based on their fertility preferences, sexual behaviour and health status.

29. Satisfying unmet need for contraception in Asia would result in a 75-per-cent reduction in unintended pregnancies (from 52 million to 13 million), a 77-per-cent decline in unplanned births (from 13 million to 3 million) and a 75-per-cent decline in abortions (from 33 million to 8 million). Full provision of modern contraception, combined with care for all pregnant women and newborns, would reduce maternal deaths by 72 per cent (from 90,000 to 25,000 a year) and newborn deaths by 77 per cent (from 1.5 million to 328,000). In addition to realizing women's right to access information and services and

[14] UNFPA, *Universal Access to Reproductive Health: Progress and Challenges* (New York, 2016).

exercise choice and agency in determining their reproductive lives, this would also improve women's educational attainment, labour force participation and earnings, and would increase household savings and assets.

C. HIV and other sexually transmitted infections

30. Asia and the Pacific is home to the second highest number of people living with HIV in the world, at an estimated 5.1 million in 2016. China, India and Indonesia account for about 75 per cent of the total number of people living with HIV and 70 per cent of all new infections. Treatment coverage more than doubled between 2010 and 2017 – decreasing HIV/AIDS-related deaths by 30 per cent – but is still below the global average of 53 per cent.[15] In 2017, the proportion of pregnant women accessing treatment to prevent mother-to-child transmission was 46 per cent, well below the global average of 76 per cent.[16]

31. In 2016, there were estimated to be 280,000 new HIV infections in Asia and the Pacific. Progress in reducing new HIV infections has slowed in recent years, and there are rising epidemics in some countries. While from 2010 to 2016 new HIV infections declined by 13 per cent, the pace of decline is far too slow to reach agreed targets and end the epidemic by 2030.[17]

32. The majority of new HIV infections occur among key populations at higher risk of HIV exposure, including people who inject drugs, sex workers, transgender people, prisoners, and men who have sex with men. Key populations are often highly stigmatized, and, in some countries, criminalized, creating barriers to effective HIV responses. More than 23 countries have undertaken national reviews or consultations on laws and policies to address legal and policy barriers that impede effective HIV responses.

33. Globally, HIV is a leading cause of death among women of reproductive age. Harmful social norms, gender inequality, poverty and violence increase women's risk of exposure to unsafe sex. Unequal power relations between women and men prevent women from accessing condoms and insisting on their use. In Asia and the Pacific, women account for 35 per cent of all adults living with HIV.[18] In maturing epidemics such as those in Cambodia, Myanmar and Thailand, female partners of men at higher risk of HIV exposure are becoming a large cohort of people living with HIV.[19]

34. Women living with HIV and female key populations often experience discrimination and disproportionately high rates of unintended pregnancy. Access to HIV services provides an important opportunity to address women's HIV and broader sexual and reproductive health needs. There are also significant intersections between gender-based violence and HIV. Gender-based violence is both a cause and consequence of HIV. Gender-based violence

[15] Joint United Nations Programme on HIV/AIDS (UNAIDS), *UNAIDS Data 2017* (Geneva, 2017).

[16] UNAIDS, *Snapshots: HIV Epidemic in Asia and the Pacific* (Bangkok, 2017).

[17] UNAIDS, *UNAIDS Data 2017*.

[18] UNAIDS, *Snapshots: HIV Epidemic in Asia and the Pacific* (Bangkok, 2016).

[19] United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), "Policy and programme guidance: HIV and gender-based violence – preventing and responding to linked epidemics in Asia and the Pacific Region (Bangkok, 2016).

increases HIV risk and is a consequence of stigma and discrimination against people living with HIV.

35. In 2015, there were 207 million new cases of curable sexually transmitted infections in the Western Pacific and South-East Asia combined, which comprise almost 60 per cent of new sexually transmitted infections globally.[20] Limited data on sexually transmitted infections and inconsistent reporting compromise effective responses. Left untreated, sexually transmitted infections increase the risk of HIV transmission and lead to complications, such as infertility, ectopic pregnancy, miscarriage, foetal death and congenital infections. Human papillomavirus infection is a proven precondition for the development of cervical cancer. Despite progress, there is still a substantial burden of adverse outcomes of pregnancy due to maternal syphilis, even among women attending antenatal care. The prevention and treatment of sexually transmitted infections has largely been driven by the HIV response. With significant rates of sexually transmitted infections in the region, particularly within the Pacific, dedicated attention to sexually transmitted infections for the general population is critical.

36. The integration of HIV-prevention services, including voluntary counselling and testing, with sexual and reproductive health-care services can increase voluntary screening for HIV and improve understanding of the risks of contracting HIV and other sexually transmitted infections.

D. Young people's sexual and reproductive health and rights

37. The region is home to about 690 million adolescents and young people, aged between 15 and 24 years. Access to media and high levels of urbanization and globalization among young people are contributing to changing their sexual values, norms and behaviours, often in conflict with traditional sociocultural attitudes towards premarital sex. A significant proportion of young people in the region are sexually active, an increasing number before marriage. Yet powerful cultural taboos and harmful gender norms surrounding premarital sex persist. Female chastity and virginity until marriage are still highly prized, contributing to significant shame and stigma attached to premarital sexual activity, and inhibiting unmarried young women's access to information and services. Traditional views regarding adolescent sexual behaviour create reluctance among health-care workers to provide information or services to young people.

38. Many young people in the region lack the knowledge and life skills to negotiate safe and consensual relationships and face barriers in accessing the services and commodities needed to avoid unsafe sex and its consequences. As a result, they are at risk of early and unintended pregnancy, unsafe abortion, sexually transmitted infections and HIV. Where young people are from poor households and are marginalized because of ethnicity, disability, migration status, sexuality and gender identity, among other factors, these risks are amplified.

39. A significant proportion of adolescent girls and young women report having experienced physical and sexual violence, including coerced sex, which exacerbates the risk of poor outcomes such as early and unintended pregnancy, unsafe abortion, sexually transmitted infections and HIV.[21] Adolescent girls

[20] WHO, *Report on Global Sexually Transmitted Infection Surveillance 2015* (Geneva, 2016).

[21] UNFPA, United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO, *Sexual and Reproductive Health of Young People in Asia and the Pacific: A Review of Issues, Policies and Programmes* (Bangkok, UNFPA, 2015).

who experience forced or coerced sex are less likely to use condoms or other contraception in future sexual encounters.

1. Adolescent pregnancy

40. Despite a 40-per-cent decrease in adolescent pregnancy in South Asia, reflecting reductions in child marriage, the overall rate of adolescent pregnancy in the region has decreased only slightly over the past 20 years. Indeed, several countries in South-East Asia and the Pacific are showing increasing rates of adolescent pregnancy, in contrast to global trends.[22]

41. In 2015 across the Asia-Pacific region, 5.2 million children were born to adolescent girls, most of whom were married. The adolescent birth rate in the region is 30.6 live births per 1,000 adolescents. The highest rates of early childbearing now occur in South-East Asia, where adolescent births are 47 per 1,000 girls aged 15–19.[23] Of all adolescent pregnancies in the region, 43 per cent are unintended,[24] contributing to a significant, often underreported, burden of unsafe abortion.

42. By the age of 18, one in seven girls in the region has given birth and more than one third of girls are married. While the majority of adolescent births continue to occur among married adolescent girls, up to 25 per cent of first births before the age of 20 in Asia were conceived before marriage, suggesting that premarital pregnancy is contributing to early marriages and unions for many adolescent girls.

43. Early childbearing not only has significant health consequences, but also compounds gender inequality, frequently leading to girls leaving school, reducing their future earnings potential and trapping them in a cycle of poverty. Addressing stigma and discriminatory social norms related to adolescent sexuality, especially for girls, together with a legal and policy environment that enables sexually active adolescents to access information and services to protect their sexual and reproductive health and rights, can help to reduce adolescent pregnancy rates and ensure that young women are able to access education and employment.

2. Access to contraception

44. It is estimated that 6.3 million adolescent girls aged 15–19 in Asia and the Pacific have an unmet need for contraception. The contraceptive prevalence rate among married girls is 22 per cent, of which only 16 per cent are modern methods, with an unmet need of 24 per cent. While the use of any contraceptive method is higher among sexually active unmarried adolescent girls (41 per cent), only 21 per cent are using modern methods and only 6 per cent are using more effective methods. South Asia and Pacific island countries have particularly low contraceptive prevalence rates, especially among girls aged 15–19, and high unmet need compared with East and South-East Asia. In Asia and the Pacific, it is estimated that 50 per cent of unmarried sexually active girls (aged 15–19) lack access to contraception.[25]

[22] UNFPA, *Universal Access to Reproductive Health*.

[23] Population Reference Bureau, "2017 world population data sheet with a special focus on youth" (Washington, D.C., 2017).

[24] Jacqueline E. Darroch and others, "Adding it up: costs and benefits of meeting the contraceptive needs of adolescents – report", Guttmacher Institute, May 2017.

[25] UNFPA, *Universal Access to Reproductive Health*.

45. The factors affecting young people's access to contraception vary across subregions, and according to marital status. For example, the low contraceptive prevalence rate in South Asia among young married women is consistent with the prevalence of child marriage, societal pressure to bear children soon after marriage and lack of information, power and means for young married girls to make informed decisions about reproduction.

3. Access to sexual and reproductive health services and information

46. Most countries in the region have addressed young people's sexual and reproductive health in national laws and policies, including through the provision of rights-based national sexual and reproductive health programmes. Some countries have also adopted laws that explicitly recognize the evolving capacity of young people to make independent decisions regarding their own health. However, there are also examples of laws and policies that prevent access – for example, by unmarried people – or that require parental consent for those under the age of 18 to access services.

47. The age at which young people can legally consent to sex, marriage and medical treatment varies considerably between countries, and between young men and women. While laws regarding age of consent to sex are important to protect young people from sexual abuse and exploitation, such laws should be drafted in such a way as not to deter those engaging in peer-to-peer consensual sex from accessing services. For example, some countries do not criminalize sexual conduct between adolescents who are of similar age, as recommended by the Committee on the Rights of the Child in its general comment No. 20 (2016) on the implementation of the rights of the child during adolescence.

48. Nearly all countries refer in national policies to youth-friendly health services, which provide quality care that is accessible, appropriate and acceptable to young people, and most have or are developing national standards to guide the delivery of youth-friendly health services. To date, however, the scale of these services is limited, and coverage is low owing to a variety of factors including inadequate budget, poor facility infrastructure and lack of privacy, inadequate health-worker training and supportive supervision and limited awareness of services among young people. Young people lack access to cash for user fees, and have limited freedom to access services independently of their parents.

49. Comprehensive sexuality education – an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information – is proven to improve knowledge and self-esteem, change attitudes and behaviours, and promote more gender-equitable relationships. Programmes that address gender or power relations are five times more effective than programmes that do not. Young people who receive quality comprehensive sexuality education are more likely to delay sexual debut, use condoms and contraception and have lower rates of sexually transmitted infections, HIV and unintended pregnancy, and are less likely to be in violent relationships.

50. Because young people who face discrimination and abuse are at greatest risk of poor sexual and reproductive health outcomes, particular attention is needed to ensure that comprehensive sexuality education tackles discriminatory social and gender norms, and addresses the realities and rights of all young people.

51. A significant gap remains between policy and implementation with regard to comprehensive sexuality education. A review of 11 Asian countries found that outreach strategies to many out-of-school adolescents and youth remained a serious challenge.[26] Increasing investment in the implementation of age-appropriate comprehensive sexuality education that is gender-transformative and based on life skills, both in and out of school, is essential to realize young people's sexual and reproductive health and rights and promote gender equality and non-violent, respectful relationships.

E. Gender-based violence and harmful practices

1. Gender-based violence

52. Violence against women and girls is deeply rooted in gender inequality and is a serious violation of their human rights. Women are much more likely to have experienced intimate partner violence than to have experienced violence by someone other than a partner.[27] In 2014, the prevalence of intimate partner violence was 43 per cent in South Asia and 30 per cent in East Asia and the Pacific.[28] By country, the proportion of ever-partnered women aged 15–49 who have reported experience of physical or sexual violence by an intimate partner in their lifetime ranges from 15 to 68 per cent. Particularly high rates of intimate partner violence have been reported in the Pacific.

53. While the vast majority of gender-based violence is perpetuated against women and girls, men and boys are also affected, particularly during childhood. Men's experience of violence in childhood is also associated with the perpetration of violence against women later in life. People who do not conform to social norms regarding sexual orientation or gender identity are often subjected to violence and many are criminalized. In emergencies, conflicts and natural disasters, the risk of violence, exploitation and abuse is heightened, particularly for women and girls.

54. Violence has significant consequences for women's and adolescent girls' sexual and reproductive health and rights. Women experiencing violence are less likely to seek health-care services, including maternal health care, and are less likely to be able to negotiate sexual relations, including protection from HIV and sexually transmitted infections and use of contraception. Violence in relationships often starts early and also occurs during pregnancy with significant impact on the health and well-being of both mother and child. Further, the cycle of violence starts in childhood – and even in pregnancy – with repercussions throughout life. Promoting gender equality and addressing gender-based violence and harmful practices are critical to realizing women's sexual and reproductive health and rights.

55. A majority of countries in the region have laws in place criminalizing violence against women, including sexual violence. While most countries in the region prohibit domestic violence, many do not protect unmarried intimate partners or include all forms of violence such as sexual harassment and marital rape. Five countries in South Asia have domestic violence laws that cover physical, sexual and emotional violence. Four of these five countries also

[26] Asian-Pacific Resource and Research Centre for Women, *Comprehensive Sexuality Education (CSE) in Asia: A Regional Brief* (Kuala Lumpur, 2018).

[27] UNFPA, "Violence against women: regional snapshot (2017) – kNOwVAWdata violence against women prevalence map in Asia-Pacific" (Bangkok, 2017).

[28] Jeni Klugman, "Gender based violence and the law: World Development Report background paper" (Washington, D.C., World Bank, 2017).

include economic violence. In 17 countries in East Asia and the Pacific, 74 per cent of women are not protected from sexual violence and 76 per cent are not protected from economic violence. Reforms are needed to ensure that laws prohibit all forms of violence and provide protection for unmarried intimate partners.

56. Effective implementation of legislation is undermined by limited awareness and knowledge of existing laws; barriers to reporting violence; bias, unresponsiveness or weak capacity among law enforcement officials; and legal systems and courts that are insensitive to the needs of victims/survivors.[29] Greater attention is required to improve awareness of laws against gender-based violence and to address barriers to access to justice.

57. A comprehensive, multisectoral response is needed to provide effective support to survivors of violence, including legal, psychosocial, health and social services. The health sector has a unique role to play in an effective multisectoral response. Women who have experienced violence identify health-care providers as those that they most trust to tell about the abuse.[30] Most countries in the region have initiated health-sector responses to gender-based violence, though there is significant variation in the scale, scope, quantity and quality of the response, and the level of integration that has been achieved in each country's national health system remains uneven. There is a need to strengthen the capacities of health systems and health providers to respond effectively to gender-based violence, including by implementing routine screening and effective referrals. Comprehensive post-rape care services need to be made available and accessible on a much larger scale than is currently the case.

58. The prevalence of violence varies within and between communities, countries and regions, highlighting that violence is not inevitable and can be prevented. Tackling the underlying drivers of violence, including harmful social and gender norms and practices that enable men to assert power and control over women and that condone, justify and excuse violence and gender inequality, is critical to preventing violence.

59. Scale-up of prevention efforts to end gender-based violence has been slow, despite increasing evidence for effective programming. Recent reviews of evidence on what works in the prevention of gender-based violence indicate that multicomponent interventions are the most effective, including working with multiple groups of people in a setting, engaging couples, parents and children, and combining approaches such as programming to change harmful gender norms, group education with community outreach to engage men and boys, and economic empowerment.

60. There are significant links between violence against women and violence against children, including shared risk factors, commonly held social norms, co-occurrence of violence in the same family and the intergenerational cycle of abuse. Adolescence offers a crucial window of opportunity to address this violence. It is essential to prioritize prevention efforts among adolescents that challenge gender norms and build girls' agency, help young people to create healthy relationships and enable adolescent girls to postpone unwanted

[29] Klugman, "Gender based violence and the law"; and Eileen Skinnider, Ruth Montgomery and Stephanie Garrett, *The Trial of Rape: Understanding the Criminal Justice System Response to Sexual Violence in Thailand and Viet Nam* (Bangkok, UN-Women, UNDP and United Nations Office on Drugs and Crime, 2017).

[30] UN-Women and others, "Module 2: health" in *Essential Services Package for Women and Girls Subject to Violence* (New York, 2015).

sexual debut, marriage, cohabitation and childbearing until adulthood.[31] This includes investing in comprehensive sexuality education that addresses gender and power relations, as evidence shows that this can help to reduce the likelihood of young people being in violent relationships.

2. Harmful practices

61. Arranged and forced child marriage reflects and reinforces gender inequality. It is a serious violation of girls' human rights with significant consequences for their health and well-being, including increased risk of early pregnancy, maternal morbidity and mortality, gender-based violence, and reduction in girls' educational attainment and access to employment and income-generation opportunities.

62. The largest number globally of women aged 20–24 who were married before the age of 18 live in South Asia. Of women aged 20–24 in South Asia, 30 per cent were married before the age of 18, and 8 per cent before the age of 15.[32] The prevalence of child marriage has been declining, but owing to population growth, the total number of child brides continues to increase. Over the last decade, a girl's risk of marrying in childhood reduced by more than a third in South Asia, although the rates are still more than double those of other subregions.[33] In South Asia, 19 per cent of girls aged 15–19 are married or in union, compared with 6 per cent in East Asia and the Pacific. Projections show that current trends need to increase fourfold to eliminate child marriage by 2030.[34]

63. Many countries have adopted the age of 18 as the legal age for marriage for girls, but many also allow younger girls to marry with the consent of their parents or the court.[35] A recent analysis of child marriage laws found that almost 60 million girls aged 10–17 were not legally protected against child marriage in the region in 2017.[36] Even where laws exist, they are not sufficient to end the practice, as many girls marry illegally. For example, in 2017, 77 per cent of all child marriages in South Asia were illegal.

64. Different patterns of early and child marriage are evident across the region. Arranged and forced child marriage is prevalent in South Asia, while consensual relationships between adolescents – so-called 'love marriages' – and informal unions are more common in South-East Asia and the Pacific. Up to 25 per cent of child marriages in Asia are preceded by pregnancy. Interventions to ensure safe and consensual sex, prevent adolescent pregnancy and empower adolescent girls to make their own sexual and reproductive health choices are essential to reduce both early and child marriage and adolescent pregnancy.

65. Education is a strong protective factor against child marriage, and policies that promote girls' completion of secondary schooling can help to reduce child marriage. Empowerment approaches that give girls information,

[31] Emma Fulu, Sarah McCook and Kathryn Falb, "What Works evidence review: intersections of violence against women and violence against children", What Works to Prevent Violence, September 2017.

[32] UNICEF, UNICEF Data. Available at https://data.unicef.org (accessed in May 2018).

[33] UNFPA, UNESCO and WHO, *Sexual and Reproductive Health of Young People in Asia and the Pacific*.

[34] Nicolai and others, "Projecting progress".

[35] Quentin Wodon and others, "Ending child marriage: child marriage laws and their limitations" (London, Save the Children; Washington, D.C., World Bank, 2017).

[36] Ibid.

skills and support structures to advocate improvement of their own status and well-being have been shown to be more successful than economic approaches, such as providing families with economic incentives or opportunities to offset the costs of raising girls and to discourage them from marrying girls off. Comprehensive sexuality education and access to sexual and reproductive services are among the key interventions to prevent adolescent pregnancy as a driver of child marriage.

66. Female genital mutilation is a violation of human rights and an extreme form of discrimination against women. It is associated with a range of complications, including severe bleeding, infections, and complications in childbirth. While female genital mutilation is not widespread in the region, evidence suggests that it may be becoming more common, owing to a confluence of medicalization of female genital mutilation together with rising conservatism and extremism. There is a high prevalence of female genital mutilation in Indonesia and Malaysia. It is also evident in India and Sri Lanka among specific population groups. In Indonesia, nearly 50 per cent of girls under the age of 12 have undergone some form of female genital mutilation, and around three in four girls underwent the procedure when they were less than six months old.[37] A study in a rural area of north Malaysia found a 93-per-cent prevalence rate of female genital mutilation among the study population of Muslim Malay women.[38]

67. The practice of gender-biased sex selection is evident in a growing number of countries in the region where the sex ratio at birth is above the natural ratio of 1.07 boys to girls, and is a manifestation of gender inequality and son preference.

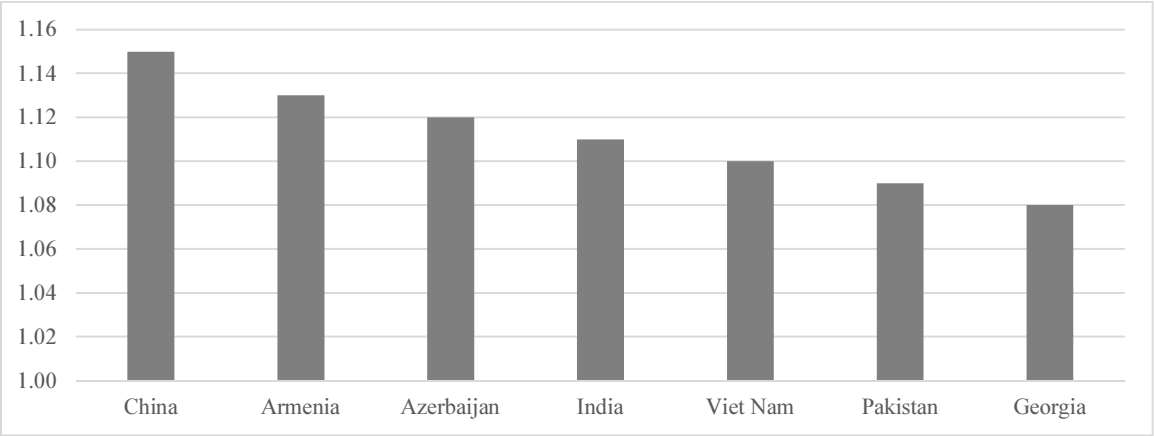
68. Recent data shows a sex ratio at birth in favour of boys at 1.15 in China, 1.13 in Armenia, 1.12 in Azerbaijan, 1.11 in India and 1.10 in Viet Nam (figure IV). Where gender-based sex selection is practised, it tends to be geographically concentrated. Very high sex ratio imbalances are evident in some regions and provinces. Although the prevalence of gender-based sex selection has declined at the national level in countries such as China, India and Viet Nam, the practice appears to be spreading to areas within these countries where it was not previously evident.[39]

[37] UNICEF, "Statistical profile on female genital mutilation/cutting: Indonesia", February 2016.

[38] Abdul Khan Rashid, Sapna P. Patil and Anita S. Valimalar, "The practice of female genital mutilation among the rural Malays in north Malaysia", *Internet Journal of Third World Medicine*, vol. 9, No. 1 (2009).

[39] Christophe Z. Guilmoto, "The masculinization of births: overview and current knowledge", *Population*, vol. 70, No. 2 (2015).

Figure IV
Asia-Pacific countries with a sex ratio at birth of more than 1.07, 2015–2020



Source: United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects: 2017 Revision. Available at https://population.un.org/wpp/.

69. The resulting gender imbalance is profoundly impacting societies. An estimated 117 million women are missing in 13 countries with a high sex ratio at birth, and 90 per cent of these missing women are in India and China. Sex imbalance drives violence, trafficking and outmigration for marriage.

70. Several countries in the region have passed laws to restrict the use of technologies for sex selection and for sex-selective terminations. However, these laws have had limited effect in isolation from broader measures to address underlying social and gender inequalities. Key strategies include understanding the underlying causes of son preference, focusing on measures designed to increase gender equality including by promoting women's autonomy, economic empowerment, control and decision-making over assets and property and inheritance rights, and conducting campaigns to increase the value of girls.

IV. Conclusion

71. Addressing gender inequality yields benefits for all of society. The Sustainable Development Goals provide a critical framework to accelerate efforts to achieve gender equality, eliminate harmful practices and realize sexual and reproductive health and rights. A rights-based approach to sexual reproductive health implies proactive engagement of Governments to ensure that reproductive rights are respected.

72. The provision of sexual and reproductive health services will be critical if countries are to achieve the Sustainable Development Goal target 3.7 on universal access to them. Increased investments in integrated interventions are required, guided by data on coverage and quality of care to effectively address inequalities and disparities, and supported by financing strategies to increase access to universal health coverage that includes the full range of comprehensive, accessible and non-discriminatory sexual and reproductive health services. The cost of delivering sexual and reproductive health is estimated to be on average $9 per capita annually in developing countries, a

modest and affordable investment for most low- and middle-income countries that will yield enormous returns.[40]

73. The acceleration of efforts to reduce maternal deaths and morbidity, improve the coverage and quality of skilled birth attendance and antenatal care, and ensure access to quality, accessible basic and comprehensive emergency obstetric care will continue to be a critical priority area for action. Alongside this, there should be efforts to prevent unsafe abortion and ensure access to safe abortion, where legal, and comprehensive post-abortion care.

74. In addition to the above, the key driver of unplanned pregnancies needs to be addressed by reducing the unmet need for contraception and improving the quality and coverage of services. This is particularly important for adolescents and young women, ensuring the availability of the full range of contraceptive methods and the quality of service provision to enable women and young people to make informed choices about contraceptive use. The acceleration of efforts to prevent HIV infections among key populations remains a critical challenge, along with a need to emphasize the reform of laws and policies that discriminate against key populations and hinder effective HIV responses.

75. Attention to laws, policies, practices and social norms that undermine the right of young people to information, commodities and services related to sexual and reproductive health and rights is vital. There is a need to address young people's access to information and services, and invest in and scale up youth-friendly services and age-appropriate comprehensive sexuality education that is gender-transformative and based on life skills, both in and out of school.

76. Addressing discriminatory laws, policies and practices, and challenging harmful social and gender norms is essential to transform gender inequality and unequal power relations and to ensure women's and young people's agency to make and act on decisions about their lives. Accelerated efforts are also required to implement evidence-based prevention and a comprehensive multisectoral response to gender-based violence and harmful practices.

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[40] Ann M. Starrs and others, "Accelerate progress: sexual and reproductive health and rights for all – report of the Guttmacher-*Lancet* Commission", *The Lancet*, vol. 391, No. 10,140 (30 June 2018).