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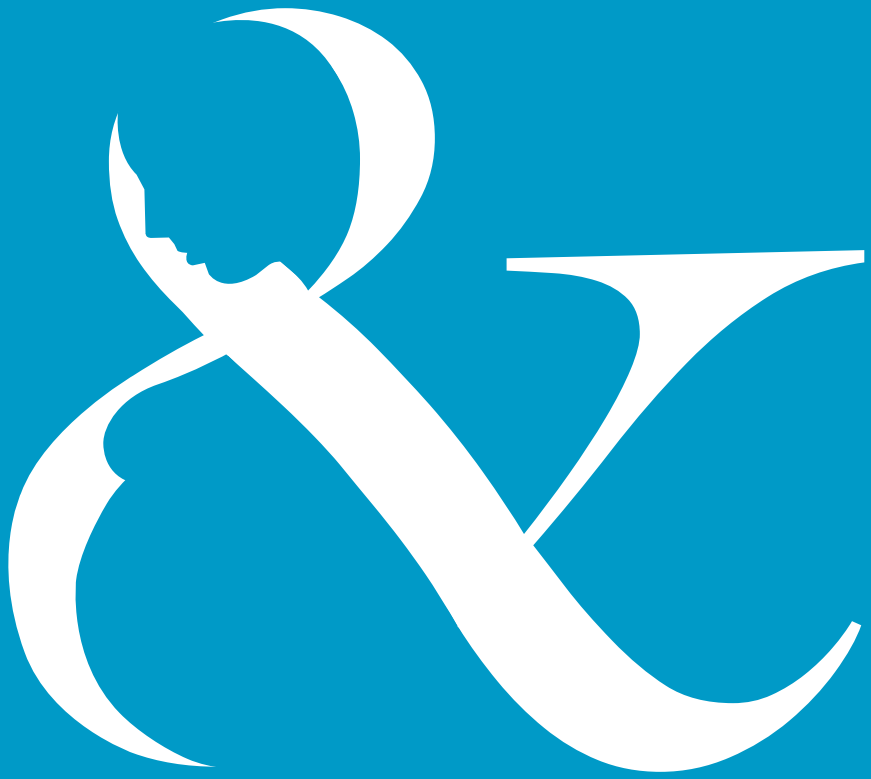

REDEFINING RIGHTS

Thematic Studies Series 3:
Reproductive Autonomy and Rights in Asia

Asian-Pacific Resource and Research Centre for Women arrow

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RECLAIMING

REDEFINING RIGHTS

Thematic Studies Series 3:
Reproductive Autonomy and Rights in Asia

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Glossary

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AKBK	*Alat Kontrasepsi Batangan Kapsul* (Implant/Contraceptive Planted Under Skin)
AKDR	*Alat Kontrasepsi Dalam Rahim* (Intra-Uterine Devices)
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARROW	Asian-Pacific Resource and Research Centre for Women
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AWAM	All Women's Action Society, Malaysia
BPG	Balanced Population Growth
CBR	Crude Birth Rate
CDHS	Cambodia Demographic and Health Survey
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGFED	Research Centre for Gender, Family and Environment in Development
CCIHP	Centre for Creative Initiatives in Health and Population
CMDGs	Cambodia Millennium Development Goals
CPA	Complementary Package of Activity
CPFC	Commission for Population, Family and Children (Currently known as Department on Population and Family Planning – under Ministry of Health)
CPR	Contraceptive Prevalence Rate
D&C	Dilation and Curretage
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
FIGO	International Federation of Gynaecology and Obstetrics
FP	Family Planning
FRHAM	Federation of Reproductive Health Associations Malaysia
GP	General Practitioner
GRS	Government Rectangular Strategy
GSO	General Statistics Office
HC	Health Centre
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPs	Health Post
IBI	*Ikatan Bidan Indonesia* (Indonesian Midwives Association)
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICPD+15	International Conference on Population and Development after 15 years
IDHS	Indonesian Demographic and Health Survey
IDI	Ikatan Dokter Indonesia (Indonesian Medical Doctor Association)
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPPA	Indonesian Planned Parenthood Association
IUD	Intra-Uterine Device
JAG	Joint Action Group on Gender Equality
JICA	Japan International Cooperation Agency
LPPKN	*Lembaga Penduduk dan Pembangunan Keluarga Negara* (the National Population and Family Development Board)
MAC	Malaysian AIDs Council
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMA	Malaysian Medical Association
MMR	Maternal Mortality Rate
MNCCRH	Malaysian NGO Coordinating Committee on Reproductive Health
MOE	Ministry of Education
MOH	Ministry of Health
MOP	Ministry of Planning
MOWFCD	Ministry of Women, Family and Community Development
MPA	Minimum Package of Activities
MPFS	Malaysian Population and Family Survey
MVA	Manual Vacuum Aspiration
NCPFP	Commission for Population, Family and Children

NCWO	National Council of Women's Organisations
NFPCB	National Family Planning Coordinating Board
NGO(s)	Non-Government Organisation(s)
NRHP	National Reproductive Health Programme
NSDP	National Strategic Development Plan
O&G	Obstetrics and Gynaecology
ODs	Operational Districts
OSCC	One-Stop Crisis Centre
PAC	Post-Abortion Care
PHDs	Provincial Health Departments
PKK	*Pembina Kesejahteraan Keluarga*
PoA	Programme of Action
POGI	*Persatuan Obstetrik Ginekologi* Indonesia (Indonesian Obstetric Gynaecologist Federation)
PUS	Reproductive age couple
PUSKESMAS	Public Health Centre
RGC	Royal Government of Cambodia
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
RHIYVN	Reproductive Health Initiative for Youth in Vietnam
RHs	Referral Hospitals
RRAAM	Reproductive Rights Advocacy Alliance Malaysia
RTC	Regional Training Centre
SAVY	National Survey on Adolescents and Youths in Vietnam
SIS	Sisters In Islam
SMS	Short Messages Services
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TV	Television
UDHR	Universal Declaration of Human Rights
UKM	Universiti Kebangsaan Malaysia (National University of Malaysia)
UM	Universiti Malaya (University of Malaya)
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United General Assembly
UNICEF	United Nations Children's Fund
UPPI	University of the Philippines Population Institute
USD	United States Dollar
USM	Universiti Sains Malaysia (Science University of Malaysia)
UTI	Urinary Tract Infection
UXO	Unexploded ordnance
VAW	Violence Against Women
VINAFPA	Vietnam Family Planning Association
VND	Vietnam Dong
VNRHS	Vietnam Reproductive Health Survey
WAO	Women Aid Organisation Malaysia
WB	World Bank
WCC	Women's Centre for Change
WHF	Women's Health Foundation
WHCF	Women's Health Care Foundation
WHO	World Health Organisation
WRA	Woman of Reproductive Age
YAFS3	Young Adult Fertility Survey 3

Acknowledgements

ARROW TEAM

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CHINA
- Yunnan Health and Development Research Association (YHDRA)
- Shanghai Women's Health Institute
- Department of Women's Rights, Heilongjiang Women's Federation
- Peking University Women's Legal Aid Centre

INDIA
- Academy of Nursing Studies (ANS)
- Centre for Health Education, Training and Nutrition Awareness (CHETNA)
- Centre for Health and Social Justice (CHSJ)
- Rural Women's Social Education Centre (RUWSEC)

INDONESIA
- Women's Health Foundation (WHF)

LAOS
- National University of Laos

MALAYSIA
- Reproductive Rights Advocacy Alliance Malaysia (RRAAM)
- Federation of Reproductive Health Associations of Malaysia (FRHAM)

NEPAL
- Beyond Beijing Committe (BBC)

PAKISTAN
- Shirkat Gah

THE PHILIPPINES
- Reproductive Health Rights and Ethics Centre for Studies and Training (ReproCen)
- Likhaan Centre for Women's Health

THAILAND
- Southeast Asian Consortium on Gender, Sexuality and Health

VIETNAM
- Centre for Creative Initiatives in Health and Population (CCIHP)
- Research Centre for Gender, Family and Development (CGFED)
- Institute for Reproductive and Family Health (RaFH)

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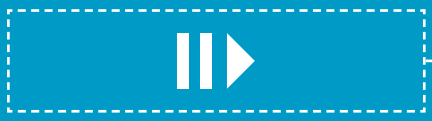


INTRODUCTION

INTRODUCTION

Sex and reproduction are contentious issues: the divide between those who advocate for granting greater individual autonomy and those who argue for greater social control is evident at all political levels. To confer rights connected to the issues of sex and reproduction, UN conventions and conferences, such as the Convention on the Elimination of Discrimination Against Women (CEDAW), Convention on the Rights of the Child (CRC), International Conference on Population and Development Programme of Action (ICPD PoA, also known as the Cairo conference), the Beijing Platform for Action (BPfA) and the Millennium Development Goals (MDGs) endorsed the concepts of reproductive health, reproductive rights[1] and sexual health.[2] However, the language of 'sexual rights' has not yet gained international acceptance.

Monitoring government commitment to international conferences and international covenants is a key activity of non-governmental organisations in holding governments accountable. This is especially crucial in the field of women's rights and women's sexual and reproductive health and rights (SRHR).

The ICPD PoA remains till today the leading international document which deals with women's SRHR. However, the implementation of the ICPD PoA is chequered: the PoA is sidelined by the Millennium Development Goals (MDGs); hindered by the Global Gag Rule, which was in force for eight years of the Bush administration and which hampered US development funding for abortion services in developing countries; and hampered by hostility to several dimensions of SRHR in many countries. Furthermore, in the last 17 years, programme implementers and policy makers in countries have changed, and the new cadre is not familiar with the vision and the commitments of the PoA, especially with regards to women's SRHR.

Changes in the region that affect the implementation of the PoA and women's sexual and reproductive health and rights

Fifteen years after Cairo, it is important to recognise developments external to the health sector that affect the implementation of the PoA:

- Health sector reforms, including the various forms of privatisation, and their impact on women's SRHR;
- The new aid architecture and funding mechanisms for governments and how these affect the health sector; and
- Decentralisation of governments and its impact on health policy formulation, programme implementation and service provision.

In addition to these, important developments emerged, such as the expanding definitions and understanding of sexual preferences, sexual identities and gender identities, and social

Box 1: Key Definitions

Reproductive Health

Reproductive Health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO)

Reproductive Rights

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (ICPD)

Sexual Health

Sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases. (adapted, UN)

Sexual Rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life. (WHO working definition)

movements in the Asian region advocating for the sexual rights of all human beings.

Further, paragraph 8.25 which specifies 'abortion, where legal' has limited application in changing prohibitive national laws and in extending access to abortion beyond the time-limit specified by the law. This hampers efforts to concretise women's reproductive rights in many countries.

SELECTION OF COUNTRIES AND INDICATORS

The SRHR monitoring project by the Asian-Pacific Resource and Research Centre for Women (ARROW) spanned 12 countries and 22 partners in Asia. These 12 countries have been identified as the priority countries for ARROW[3] through its organisational strategic planning process.

ARROW has working relationships with NGOs and CBOs operating in the field of sexual and reproductive health and rights in all of these 12 countries.

ARROW, with input and verification from partners, collected and analysed the cross-country indicators. ARROW's Programme Advisory Committee (PAC) recommended trend analysis as useful for monitoring progress.

The review of the ARROW ICPD+5 and ICPD+10 projects started in January 2007 with a review of the methods, processes and outputs of these two projects. This led to a refinement of the methods and processes of this ICPD+15 project, as well as the consolidation of the indicator data set.

In November 2007, ARROW held a regional meeting on SRHR research and monitoring where SRHR indicators were chosen, clustered and prioritised.

The strategic indicators which were applicable across countries, and for which comparable data was available, were taken into the regional indicator set in order to feed into the regional analysis.

Important references for the final consolidated indicator set include: ARROW's *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing*;[4] ARROW ICPD+10 monitoring indicators;[5] the Center for Reproductive Rights and ARROW's *Women of the World: Laws and Policies Affecting their Reproductive Lives;*[6,7] and the World Health Organisation (WHO) reproductive health indicators.[8]

ARROW'S SRHR MONITORING PROCESS AND OUTCOMES

In 2008, ARROW launched a sexual and reproductive health and rights monitoring partnership project, comprised of 22 national partners across 12 countries in Asia to generate evidence on the progress of governments in the region to the Cairo consensus. Monitoring government commitments to international conferences and international covenants is a key activity of NGOs in holding governments accountable. Especially when progress in the area of SRHR is hampered by political hostility, monitoring becomes an essential activity. Monitoring is also a means of highlighting the non-recognition of rights of specific groups and of specific issues.

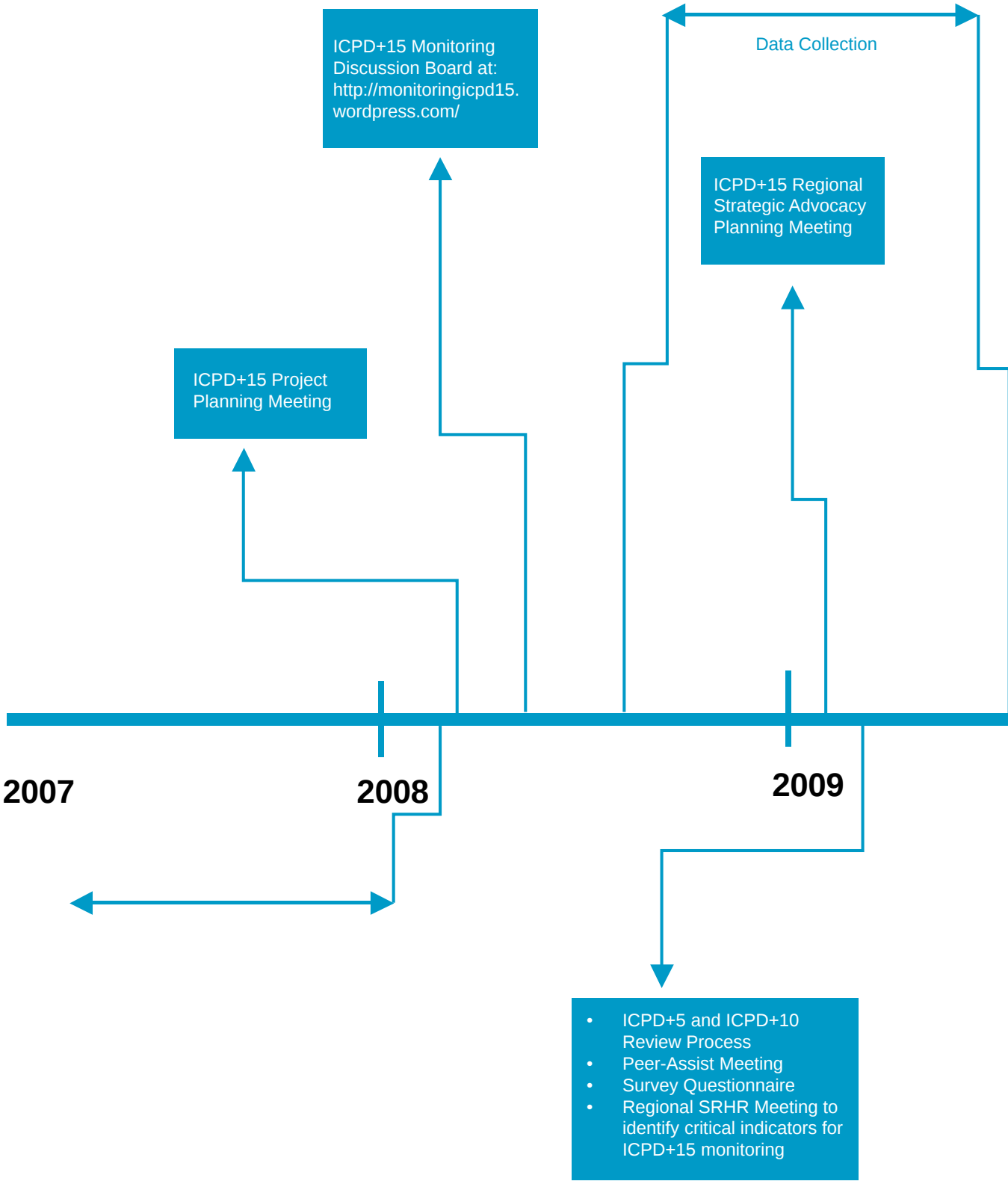
ARROW and her partners decided that it was imperative to press forward and tackle the three big compromises of Cairo: acceptance of privatisation of health service provision; negation of issues of sexuality and sexual rights; and an erasure of abortion as a method of family planning. These three compromises have hampered SRHR advocates, in the long run, of establishing the concepts of the universality of sexual and reproductive rights and of creating universal access to sexual and reproductive health.

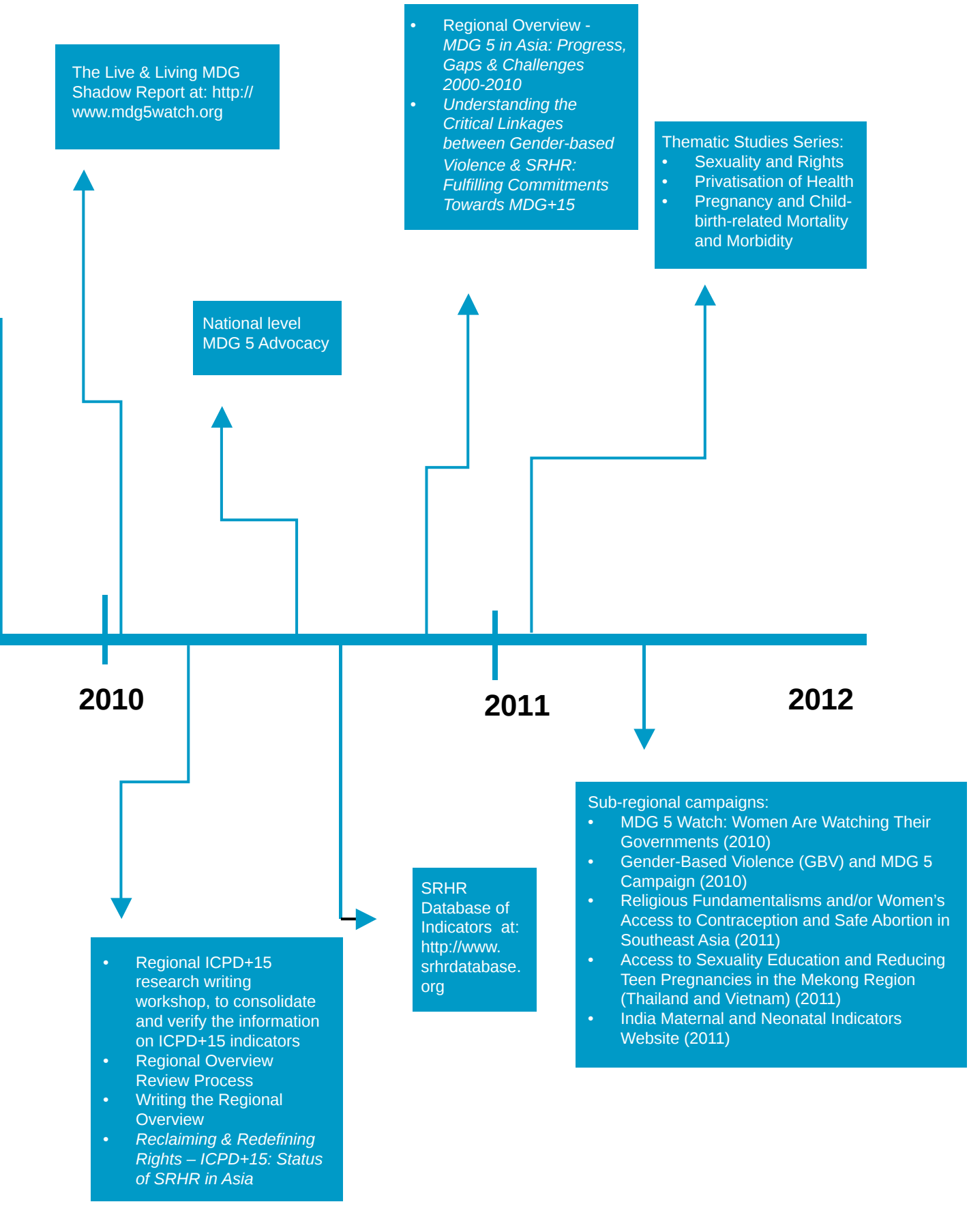
From 2008, ARROW's national partners and commissioned researchers studied the topics most crucial to them while ARROW, with input and verification from partners, collected and analysed the data necessary to generate the regional overview, published in October 2009, *Reclaiming and Redefining Rights – ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia.*

Amongst the national partners, Reproductive Health Association of Cambodia (RHAC) chose to look at the barriers to contraceptive use in Cambodia. On the other hand, Yayasan Kesehatan Perempuan (Women's Health Foundation) looked at the twin issues of decentralisation and its impact on contraception access in Indonesia, and unsafe abortion in Indonesia. National partners Reproductive Rights Advocacy Alliance Malaysia (RRAAM) and Federation of Reproductive Health Associations of Malaysia (FRHAM) jointly examined access to contraceptive information and services, SRHR education for youth and legal abortion in Malaysia. In the Philippines, Reproductive Health Rights and Ethics Centre for Studies and Training (Reprocen) chose to look at contraceptive use of young people in selected urban poor Manila communities. Finally, Shirkat Gah looked at barriers to safe motherhood in Pakistan, including access to contraception and safe abortion services.

The diagram below shows the historical development of ARROW and partners' ICPD+15 monitoring project conceptualisation and implementation from 2007-2012.

Diagram 1




The Live & Living MDG Shadow Report at: http://www.mdg5watch.org
Regional Overview - *MDG 5 in Asia: Progress, Gaps & Challenges 2000-2010*
Understanding the Critical Linkages between Gender-based Violence & SRHR: Fulfilling Commitments Towards MDG+15
Thematic Studies Series:
Sexuality and Rights
Privatisation of Health
Pregnancy and Child-birth-related Mortality and Morbidity
National level MDG 5 Advocacy
2010
2011
2012
Regional ICPD+15 research writing workshop, to consolidate and verify the information on ICPD+15 indicators
Regional Overview Review Process
Writing the Regional Overview
Reclaiming & Redefining Rights – ICPD+15: Status of SRHR in Asia
SRHR Database of Indicators at: http://www.srhrdatabase.org
Sub-regional campaigns:
MDG 5 Watch: Women Are Watching Their Governments (2010)
Gender-Based Violence (GBV) and MDG 5 Campaign (2010)
Religious Fundamentalisms and/or Women's Access to Contraception and Safe Abortion in Southeast Asia (2011)
Access to Sexuality Education and Reducing Teen Pregnancies in the Mekong Region (Thailand and Vietnam) (2011)
India Maternal and Neonatal Indicators Website (2011)

FORMAT OF THIS THEMATIC STUDY

Within the Asian context, it was critical to ascribe concrete indicators to the concepts of reproductive autonomy and reproductive rights to enable a better understanding and assessment of reproductive health and reproductive rights issues.

The first chapter of this book shares the regional findings for a selection of reproductive autonomy and rights indicators across 12 countries. These indicators range from indicators on fertility rates, contraception use, unmet need, reasons for non-use, emergency contraception and access to safe abortion services.

The subsequent chapters share the country case studies on specific issues of reproductive autonomy and rights at the national levels.

The second chapter shares the barriers to contraceptive use in Cambodia. Cambodia continues to record a high maternal mortality rate (MMR) – one of the highest in the southeast Asia region. Low Contraceptive Prevalence Rates (CPR) of 27% in 2005 (modern methods), and high prevalence of unsafe abortions (20-29% of maternal deaths are due to unsafe abortion) are crucial factors contributing to the high maternal deaths.

The Cambodia case study aims to study the following: a) factors for poor acceptance of modern contraceptive methods, and b) the estimated costs for improved and expanded Sexual and Reproductive and Health (SRH) care. Poor decisionmaking power of women with regards contraception, fear of complications and side effects (especially infertility), and health workers' poor knowledge and counselling on contraception have been identified as main factors contributing to the poor acceptance and non-use of modern contraceptive methods in Cambodia.

The third chapter deals with access to contraception within a decentralising system of governance and health service provision in Indonesia. The ICPD PoA highlighted the role of decentralisation, recommending that government should promote community participation and the empowerment of communities in reproductive health services by decentralising the management of health programmes.

Decentralisation was seen as a means of enhancing health system responsiveness to local needs to enhance sexual and reproductive health services. However, the present case study carried out in Bogor District in Indonesia tell a different story. Problems in the implementation of the decentralised family planning programme, governance, recruitment systems and lack of rights-based framework in implementing comprehensive SRH services currently plague the SRH service delivery in Indonesia.

The fourth chapter deals with access to safe abortion services in Indonesia and looks at examining the motivations of women seeking abortion services in Jakarta, the attitudes of health providers towards women seeking abortion and the impact of existing policies and practices in limiting access to safe abortion services.

The fifth chapter monitors the extent to which specific ICPD agreements made by the Malaysian government have been achieved in the areas of reducing unwanted pregnancies, fulfilling unmet need for contraception (especially in the light of a stagnant contraceptive prevalence rate for almost 30 years), examining the barriers to contraceptive use, increasing access to legal abortion, decreasing repeat abortions and improving provider training.

The sixth chapter focuses on contraception and abortion, with the cross-cutting themes of gender, social equality and equity; safe motherhood; sexual and reproductive health and rights, HIV and AIDS and STIs in Pakistan. Shirkat Gah has opted to address the need for Safe abortion services – including Post Abortion Care (PAC) and the unmet need for contraception – in view of poor maternal health indicators and a high incidence of induced abortion, including unsafe abortion within the country.

The final chapter looks into the reasons for the low level of contraceptive use among sexually active youth in selected urban poor communities in Metro Manila, with a focus on the accessibility of young people to family planning information, services and supplies and their knowledge about contraception.

This study also presents the policy and legal situation vis-à-vis raising awareness about young people's sexual and reproductive health and rights. This study also seeks to establish that lack of effective access to FP information and services among Filipinos in general and young people in particular are due mainly to the absence of a government policy to provide the full range of safe and legally acceptable family planning methods. The seventh chapter addresses abortion in Vietnam and looks at the probable causes, behaviours and solutions. This study also examines the issue of access to contraception for specific groups, especially young, unmarried women, access to safe abortion services and post-abortion care, as well as the need to change patriarchal societal norms.

DATA SOURCES FOR THIS THEMATIC STUDY

Data sources for this report are: Demographic and Health Surveys (DHS) or comparable national studies such as family or population surveys, Human Development Reports (HDR 1995-2009), World Abortion Policies – UN database, WHOSIS Global Database, Ministry of Health data from respective countries, country population census reports, country year book of statistics, United Nations Department of Economic and Social Affairs (UNDESA), policy briefs from Guttmacher Institute and scientific papers from international and national journals.

Endnotes

1 *The term 'reproductive health' was first developed by institutions, such as the World Health Organisation, in the early 1980s. However, the term 'reproductive rights' was initially first used in feminist meetings in the late 1970s and was clearly defined in the International Women and Health Meeting (IWHM) of 1984. Petchesky, R.P. (2003) Transnationalising Women's Health Movements. In Global Prescriptions: Gendering Health and Human Rights (pp.4). London, UK: Zed Books.*

2 *The term 'sexual health' has been defined as early as in 1975 by WHO. WHO Technical Report Series Nr. 572. (1975). Education and Treatment in Human Sexuality: The Training of Health Professionals: Report of a WHO Meeting. Geneva.*

3 *The Asian-Pacific Resource and Research Centre for Women (ARROW). (2006). Strategic Planning Meeting Report (18-20 April 2006) (Unpublished). Kuala Lumpur, Malaysia: ARROW.*

4 *Abdullah, R. (2000). Framework of Indicators for Action on Women's Health Needs and Rights after Beijing. Kuala Lumpur, Malaysia: ARROW.*

5 *ARROW. (2005). Monitoring Ten Years of ICPD Implementation, The Way Forward to 2015: Asian Country Reports. Kuala Lumpur, Malaysia: ARROW.*

6 *The Centre for Reproductive Rights (CRR). (2004). Women of the World: Laws and Policies Affecting Their Reproductive Lives, South Asia (pp.142). New York, USA: CRR.*

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8 *World Health Organisation (WHO), Department of Reproductive Health and Research. (2006). Reproductive Health Indicators: Guidelines for Their Generation, Interpretation and Analysis for Global Monitoring. Geneva, Switzerland: WHO.*

CHAPTER 1

ACHIEVING REPRODUCTIVE AUTONOMY IN ASIA: HOW FAR HAVE WE COME?

By Sivananthi Thanenthiran and Sai Jyothirmai Racherla
Asian-Pacific Resource and Research Centre for Women (ARROW)[1]

Providing reproductive health (RH) services is an important commitment in the ICPD Programme of Action (PoA). The ICPD PoA defines the components of reproductive health to include family planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal 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,[2] 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 and AIDS which should always be available, as required; and active discouragement of harmful practices, such as female genital mutilation.

The PoA recommends that the full range of reproductive health services should be an integral component at the primary health care level: the level of health care system which is accessible to most of the population, especially women. However, this is not to limit the full range of services *only* to the primary health care.

The ICPD PoA extensively covers contraception and family planning:

- removal of demographic targets (Paragraph 7.12);
- universal access to a full range of safe and reliable family-planning methods (Paragraphs 7.16 and 7.23);
- safer, affordable, convenient and accessible information and services (Paragraphs 7.19 and 7.23);
- free and informed choice, quality of care and service, privacy and confidentiality (Paragraph 7.23).

These paragraphs of the ICPD PoA refer to the right of individuals and couples both to services on contraception and self-determination to regulate fertility.

In this review, we look at the population policies of the 12 countries. The provision of reproductive health services and the spirit in which these services are delivered are determined by these policies.

The countries' policies, their views on fertility levels and access to contraceptive methods warrant an overall, general review.

Of the 12 countries, nine countries view fertility as 'too high.' China, Malaysia and Thailand view fertility as 'satisfactory.' The population policies in the nine countries is to lower fertility levels, while China and Thailand state that they would like to maintain current fertility. Malaysia cites no intervention in their policy on fertility.[3]

It would be interesting to ask if the countries which aim to lower 'fertility' have actually shifted the paradigm from demographic goals to women's empowerment.

India's 2000 National Population Policy, for instance, intends to achieve a smaller family size through incentives and sanctions. One of these is particularly striking as it has implications on democratic representation: Section 8, Promotional and Motivational Measures for Adoption of the Small Family Norm, point (xvi) reads: "The 42nd Constitutional Amendment has frozen the number of representatives in the parliament (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026."[4]

The Chinese government continues to implement its one-child policy. The government sets strict family size limits and uses very strong measures, including substantial financial incentives and penalties, to ensure compliance.[5]

A recent study that ARROW commissioned in Indonesia documents that 'sweeping' methods are still being used: mobilisation by elite women and men during recruitment of potential acceptors to join mass-campaigns for implants, IUDs and female sterilisation. These mass campaigns are carried out without any assurance of quality: 300 women are served by four general physicians. This is particularly troubling and signals a return to more coercive population controls policies and methods.[6]

Meanwhile, in the Philippines, there is no stated policy on population. Although the state is constitutionally secular, the Catholic church continues to influence policy in their area of special interest: reproductive health and women's access to reproductive health services. Former President Gloria Macapagal Arroyo had delegated all family planning programmes and policies to local governments.

On the one hand, this has empowered local governments to take up the cause of women's access to reproductive health services: one of the most outstanding examples is Aurora province where the Governor passed an RH ordinance, which provides family planning services, including condoms

and male sterilisation. On the other hand, this has also allowed local governments – for example, that of the largest capital city – to infamously ban contraceptives from city health services.[7]

A substantial challenge still remains in the region. Where services are available, it is questionable whether these services respect the rights, choices and decision-making processes of women (both as individuals and within couples). Where services are not available, it is questionable whether these women (both as individuals and within couples) have any real choice to exercise.

I. CONTRACEPTION

The politics of birth control have been so embedded within the psyche of the region that there are women's NGOs who feel that contraception has been regarded in turn as a tool of the North, big pharma, racist eugenicists, Malthusian environmentalists and economists.

We find it important to recognise that "[b]ecause of demographically driven politics, the effectiveness of contraception in preventing unwanted pregnancy sometimes appears to have become important only for the purpose of reducing high population growth rates. This is probably the single most important cause of feminist suspicion of methods like contraceptive vaccines, implants and injectables. Thus, something intrinsic to the purpose of contraception and that women very much need from contraception can come to be identified – by those who support women's right to contraception – as a negative quality."[8]

However, there are other groups that feel that modern contraceptive methods offer women a range of choices of fertility control that are effective and safe and this in itself is empowering.

In this section, we examine total fertility rates (TFR), wanted fertility rates, contraceptive prevalence rates (CPR), contraceptive provision, non-use of contraception, unmet need, male contraception and informed choice on contraceptive use. Many of these indicators on contraception represent a convergence of health and human rights indicators.

These indicators are a reflection of the extent to which women have the means to control their fertility. They are also indicative of the health risks posed to women by unwanted fertility (which can lead to unsafe abortions in the absence of legal services), high fertility, maternal deaths and maternal morbidity.

i. Total Fertility Rates

Total Fertility Rates (TFR) signify the average number of children a woman in each country would have in her lifetime if the current fertility rates remained constant. TFR across all 12 countries fell between 1995 and 2005 as shown in Table 1 below. The decline was steep in Cambodia, Lao PDR, Nepal, Pakistan and Vietnam. In China and Thailand, the TFR dipped below replacement levels in 2000

Table 1: Total Fertility Rates in 12 countries in Asia-Pacific

NAME OF THE COUNTRY	TOTAL FERTILITY RATE		
	1995	2000	2005
Bangladesh	3.4	3.3	2.7
Cambodia	5.3	4	3.4
China	2.46 (1990)	1.80	1.83
India	3.39	2.85	2.68
Indonesia	2.8		2.6
Lao PDR	6.7	5.8	3.6
Malaysia	3.6	3.2	2.9
Nepal	4.64	4.1	3.1
Pakistan	5.4		4.0
Philippines	3.7		3.3
Thailand	2.1	1.7	1.8
Vietnam	3.9	2.6	2.3

Source: Country Demographic and Health Surveys (DHS) and Human Development Reports (where country DHS is not available) Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal DHS: 1996, 2001, 2006; Pakistan DHS: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2008; Vietnam DHS: 1997, 2002, 2005; China UNDP HDR: 1995, 2000, 2007-8; Lao PDR UNDP HDR:1995, 2000, 2007-8; Malaysia UNDP HDR: 1995, 2000, 2007-8; and Thailand UNDP HDR: 1995, 2000, 2007-8.

and then rose again slightly in 2005.

Fertility reduction trends by schooling levels of women and urban areas of residence have been noted in Pakistan, the Philippines and India. In Pakistan, fertility has declined for most for women who attained at least middle level schooling.By place of residence, the fertility decline is higher in urban than rural areas.[9]

In the Philippines, the marked inversion between fertility and educational levels can be seen as women who have no education have 6.4 children, more than twice as many as those who are college or higher educated (2.7) – taking the mean number of children ever born to women aged 40-49.[10] The TFR are 2.8 for women in urban areas compared with 3.8 for women in rural areas.[11]

In India, fertility in rural areas is 3.0 children per woman, much higher than in urban areas where the replacement level fertility rate is 2.1 children per woman. The greatest differentials in fertility are by wealth and education. At current fertility rates, women in the lowest wealth quintile will have two children more than women in the highest wealth quintile.[12]

Fertility reduction trends vary greatly between regions and states within a country. For example, in India: “Fertility rates are at or below the replacement level of 2.1 children per woman in 10 states: Delhi, Himachal Pradesh, Punjab, Sikkim, Goa, Maharashtra, Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu. In contrast, fertility rates are highest in Bihar and Uttar Pradesh, where at current fertility levels, a woman would have about four children during her lifetime.”[13]

ii. Wanted Fertility Rates compared to TFR

With respect to rights around contraception, ARROW has compared TFR with wanted fertility rates in the 12 countries surveyed. Overall, although TFR have fallen across all countries in the region, wanted fertility rates[14] are still substantially lower than total fertility rates. These rates represent the level of fertility that would have prevailed in the three years preceding the survey if all unwanted births had been prevented.

In almost all the countries, there was a significant difference between TFR and wanted fertility rates as shown in Table 2.

The differences between wanted fertility rates and TFR were highest in Nepal where women were having 55% more children than they wanted to have; in Bangladesh, India and the Philippines women were having 42%, 41% and 37.5% more children than they wanted to have; while in Indonesia women were only having 18% more children than they wanted to have. Hence in the first four countries mentioned women are having less control over their fertility than they themselves desired. The Country DHS also provide information on how these

Table 2: Wanted Fertility Rates and Total Fertility Rates in 2005

NAME OF COUNTRY	TOTAL FERTILITY RATE 2005	WANTED FERTILITY RATE 2005	PERCENTAGE DIFFERENCE
Bangladesh	2.7	1.9	42%
Cambodia	3.4	2.8	21%
China	1.7	-	
India	2.68	1.9	41%
Indonesia	2.6	2.2	18%
Lao PDR	3.6	-	
Malaysia	2.9		
Nepal	3.1	2.0	55%
Pakistan	4.0	3.1	29%
Philippines	3.3	2.4	37.5%
Thailand	1.8		
Vietnam	2.3		

Source: Country Demographic and Health Surveys. Wanted fertility rates are only available where there are DHS. Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2008; Vietnam: 1997, 2002, 2005

differences are further enhanced between groups of women according to education quintiles, wealth quintiles and area of residence.

In Pakistan, large gaps exist between the TFR and wanted fertility rates for women in rural areas, women with lower levels of education (primary and secondary levels in comparison with tertiary levels) and women in the lowest wealth quintile.[15] And in Nepal, large gaps exist for women living in rural areas, lowest wealth quintiles and for women without education.[16]

In the more remote areas of Nepal the gap in unwanted births was also greater for women who live in the mountainous regions compared to women living in the valley.[17] Women with lower education or are uneducated, who are poor, who live in remote areas and rural areas face the greatest challenge in controlling their own fertility.

Socio-economic inequities are closely inter-linked with higher rates of unintended births and it is important to ensure access to contraception to all groups of women.

iii. Contraceptive Prevalence Rates

Although the ICPD PoA does not specifically cover the issue of CPR, this is an important indicator to look at and many interesting trends are evident. According to WHO, the "contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time."[18]

The highest CPR is noted in China (90.2%), Vietnam (78.5%) and Thailand (71.5%). The lowest CPR is noted in Lao PDR (38.4%) and Pakistan (29.6%). The other seven countries have CPR that range between 40%-61%.

China and Thailand rank highest in the use of modern contraception methods and although Vietnam has the second-highest CPR, it also has a high proportion of traditional method users. Traditional methods generally have higher failure rates and hence lead to more unplanned pregnancies.

In Vietnam, the two main methods of contraception are IUDs and traditional methods. This leads to the question of whether the range of contraceptive methods is actually available for women to choose the method most suited to them. Or whether despite a high CPR, women are not being empowered enough to exercise the control over their fertility that they so desire.

Within contraceptive methods it is interesting to compare figures for reversible and permanent methods of contraception. Permanent methods of contraception are most highly used in China, India and Thailand. Table 3 shows that in the 12 countries surveyed, China has the highest CPR of 90.2% and the most popular methods used were IUD (49.7% of all methods) and female sterilisation (34.5% of all methods).

Male sterilisation (7.42% of all methods) is also comparatively high in China. India, an equally populous country, has a CPR of 56.3%, although female sterilisation is highest in India within this region – 66.25% of all methods. Thailand has the third highest rates of female sterilisation, 34.26% of all methods. Nepal also has a large proportion of sterilisation – female sterilisation comprising 37.91% of all methods and the highest rate in the region of male sterilisation (13.1% of all methods).

In countries that strongly implement population control policies such as China and India, permanent methods and long-term methods such as sterilisation and IUDs are favoured. Targets for permanent methods in all four countries are women.

Pill users form more than 50% of all contraceptive users in Bangladesh; and more than 40% in Lao PDR and Thailand. Injectables users number more than half of all users in Indonesia.

We found it notable, when looking at CPR, that as fertility rates keep dropping, women shoulder the burden for contraception as almost all methods target only women. This means that the burden of suffering from side-effects also falls on women. Male involvement, wherein men as equal and supportive partners, as stipulated in the ICPD PoA, seems to have had limited headway in all 12 countries in the past 15 years.

iv. Male contraception as % of total contraception

Male contraception methods mainly comprise condom usage and male sterilisation. Table 4 shows that the rates for male contraception are abysmally low in all 12 countries.

Although it is crystal clear that when ranking contraceptives according to their ability to protect against infection, condoms are the safer choice and are the only method which provides dual protection,[19] condom usage continues to be low in all 12 countries.

Condom usage is highest in Pakistan (22.97% of all contraceptive methods); stands at around 9-11% of all contraceptive methods in Nepal, Malaysia, India and the Philippines; and is lowest in Indonesia, Thailand and Lao PDR.

Table 3: Contraceptive Prevalence Rates and method selection

Name of the Country	Any method	Any modern method	Pill users as proportion of all contraceptive users	IUD users as proportion of all contraceptive users	Injectables users as proportion of all contraceptive users	Norplant/ Implant users as proportion of all contraceptive users
Bangladesh	55.8	47.5	51.08	1.61	12.55	1.25
Cambodia	40.0	27.2	27.5	4.5	19.75	0.5
China	90.2	90.0		49.7	1.6	0.33
India	56.3	48.5	5.5	3.0	1.7	
Indonesia	60.3	56.7	21.8	10.2	53.2	
Lao PDR	38.4	35.0	41.40	7.5	27.6	
Malaysia	54.5	29.8	24.5	7.1		
Nepal	48.0	44.2	7.29	1.45	21.04	1.66
Pakistan	29.6	21.7	7.09	3.37	3.37	0.33
Philippines	51.6	41.5	28.5	6.1	9.1	
Thailand	71.5	70.1	43.21	1.67	15.52	
Vietnam	78.5	56.7	8.02	48.02	0.5	

Name of the country	Condom users as proportion of all contraceptive users	Female sterilisation users as proportion of all contraceptive users	Male steralisation users as proportion of all contraceptive users	Any/other traditional method users as proportion of all contraceptive users
Bangladesh	8.06	8.96	1.25	14.87
Cambodia	7.25	4.25	0.25	32
China	5.76	34.5	7.42	0.2
India	9.26	66.25	1.77	13.85
Indonesia	1.49	6.1	0.6	5.97
Lao PDR	2.08	12.2		8.85
Malaysia	9.72	11.74		45.3
Nepal	10	37.91	13.1	7.9
Pakistan	22.97	27.7	0.33	26.7
Philippines	11.2	6.0	0.1	19.6
Thailand	1.95	34.26	1.39	1.9
Vietnam	7.38	7.51	0.63	27.7

Source: Country Demographic and Health Surveys.
Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2008; Vietnam: 1997, 2002, 2005 Lao PDR Reproductive Health Survey 2005 World Contraceptive Use 2007: China; Malaysia; Philippines; Thailand

Although Pakistan has a very low CPR rate, it is surprising to note that condom usage in Pakistan forms 22.97% of all contraceptive methods.

In Cambodia, despite increasing HIV prevalence in new infections among husband-wife/intimate partners (husband-to-wife-transmission is the main route of HIV transmission, causing two-fifths of new infections), use of male condom stands at 7.25% among all contraceptive methods.[20]

In Cambodia, condom use between husband and wife is culturally viewed as implying mistrust and makes it difficult for the propagation and popularisation of the method, although it is much needed.

In Lao PDR, condom usage contributes just 2.08% overall of all modern methods.[21] In Thailand, the figure is even lower – 1.95% among all contraceptive methods.

In the Philippines, earlier surveys showed that men object to their spouses practising family planning, and very few of them use condoms, or take the responsibility of contraception. They also tend

Table 4: Male contraception as percentage of total contraception

NAME OF THE COUNTRY	CONDOM USERS AS PROPORTION OF ALL CONTRACEPTIVE USERS	MALE STERILISATION USERS AS PROPORTION OF ALL CONTRACEPTIVE USERS
Bangladesh	8.06	1.25
Cambodia	7.25	0.25
China	5.76	7.42
India	9.26	1.77
Indonesia	1.49	0.6
Lao PDR	2.08	
Malaysia	9.72	
Nepal	10	13.1
Pakistan	22.97	0.33
Philippines	11.2	0.1
Thailand	1.95	1.39
Vietnam	7.38	0.63

Source: Country Demographic &Health Survey(s).
Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2003; Vietnam: 1997, 2002, 2005 Lao PDR Reproductive Health Survey 2006 World Contraceptive Use 2007: China; Malaysia; Philippines: 2008; Thailand

to prefer having more children, unlike the vast majority of married women (81 %) who wanted either to space their next birth or to limit childbearing altogether."[22]

Male sterilisation is highest in Nepal and in China, and in all other countries forms a negligible number. In Thailand, male sterilisation is low despite government attempts to promote male contraception by providing vasectomies free of charge at government hospitals.[23]

In all 12 countries male contraception is at appallingly low rates, and is nowhere near the desired ideal of having both men and women sharing equal responsibility over sexual and reproductive health decisions as couples.

v. Contraceptive use: Informed choice

Informed choice of family planning methods is an important rights indicator. However it has not been commonly regarded as an important aspect of the service provided with the contraception method. Informed choice includes: information on the full range of methods, including traditional and male methods; information on side-effects of all methods and the appropriate course of action; and information on the efficacy of each of the methods. However, data are not available for many countries for this indicator.

Information on the full range of methods was not commonly disseminated. In India, "less than 30 % were ever informed about other types of family planning methods,"[24] In Pakistan, only "38% of users were informed of other methods available."[25]

Information on side-effects and appropriate courses or action was given to few users. In India, "only about one-third of modern contraceptive users were informed about the side effects or problems of their method, and only one-quarter were told what to do about side effects."[26] On the other hand, in Nepal, "56% of current users were informed about side effects and problems of methods used, [and] 51% of the users were informed about what to do if they experienced side effects,"[27] while in Pakistan "33% of modern method users were informed about the side effects or problems of the method and 29% were informed about what to do if they experienced side effects."[28]

Information on the efficacy of all the methods seems to be missing, with the exception of information on the permanent effects of sterilisation, which was given to 81% of women undergoing sterilisation in Nepal.[29]

Method of contraception is also a factor in the provision of information to users. In Pakistan, it was noted that "IUD users are more likely than users of other methods to be informed about side effects, what to do if they experience side effects, and about other methods available."[30] Similarly, in India, it was noted that "IUD users were most likely to be provided with each of the three types of information, and users of female sterilisation were least likely to be provided with this information."[31] These data imply that there

is considerable room for improvement in terms of providing women with information about family planning methods.

Informed choice in India is noted as being consistently higher in urban areas, and is somewhat more common in private than in public medical facilities.[32]

Providers' biases appear to affect the availability of information to users in Vietnam: "Providers' biases in favour of IUDs were often evident, with other methods mentioned only if a client did not want to use an IUD. Many clients felt that they had not received sufficient information about contraception and were eager to ask questions to the assessment team members interviewing them."[33] And in Thailand: "in some cases, women's choices have been found to be steered by the health personnel involved in distributing the contraceptives or determined by the method being campaigned by the Government at that time."[34]

Recent research in Vietnam also shows that low quality of family planning counselling and also post-abortion counselling has limited the choice of women and couples.[35,36]

vi. Unmet need for contraception

The accepted definition of "[u]nmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception."[37] The concept of unmet need is an important one because it assesses the 'need' for contraception based on whether and when a woman wants a child or another one rather than focusing on government limits on family size.

The limitation, currently, is that the DHS calculates unmet need based on a sample of married, heterosexual women and not single, unmarried women and this does not accurately capture the extent of unmet need in a country.

Another limitation is that it assumes all users as having their need 'met,' including women with infertility and secondary infertility. However, many women may be using a contraceptive method not of their choice due to provider bias or government policy as earlier discussed and this constitutes an 'unmet need' too.

It is also important to keep in mind that contraception is primarily focused on pregnancy prevention. There is also an urgent unmet need for disease/ infection prevention which is not being considered. Nevertheless, it is still useful to look at these numbers.

Table 5 shows that unmet need has been declining in all countries, where data are available. Unmet need is highest in Lao PDR, followed by Cambodia, Pakistan, Nepal and the Philippines. Unmet need is lowest in Vietnam and Indonesia.

Differentials of wealth, area of residence, age and education are all important correlations to unmet need.
Unmet need is lowest among wealthy women in

Table 5: Unmet need for contraception 1995/ 2000/ 2005

NAME OF THE COUNTRY	UNMET NEED		
	1995	2000	2005
Bangladesh	19.4	15.3	17.4
Cambodia		32.6	25.1
China			
India	19.5	15.8	12.8
Indonesia	9.2		8.6
Lao PDR			27.3
Malaysia			
Nepal	31.4	27.8	24.6
Pakistan	28.0		24.9
Philippines	20		22.3
Thailand			
Vietnam			4.8

Source: Country Demographic and Health Surveys.
Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2008; Vietnam: 1997, 2002, 2005.

Bangladesh[38] and in India: “Unmet need for both spacing and limiting decreases with an increase in wealth quintiles.”[39]

Unmet need is higher in women living in rural as compared urban areas in Pakistan,[40] India[41] and Lao PDR.[42] Even in Vietnam, which has a high CPR, unmet need is higher for women living in the more remote areas in of the country: unmet need is “highest among women in the Central Highlands (12.3%). It is lowest among women in the Red River Delta (3%) and the Mekong River Delta (4%).”[43]

Unmet need is also highest among the youngest age group of women (15-19 years) in Vietnam[44] and the Philippines.[45]

Unmet need for spacing purposes is higher among younger women in Pakistan[46] and India,[47] while unmet need for limiting births is higher among older women in Pakistan.[48]

Unmet need is lowest among women with the most education and does not vary much among those with lower levels of education in Bangladesh.[49]

In Cambodia, unmet need is almost uniform across all age groups and total unmet need is 25%.[50] Unmet need in the Philippines is highest in Bicol and the Autonomous Region of Muslim Mindanao.[51]

One of the most common reasons given by married women with an unmet need for not using contraception is associated with the supply of methods and services and within this category, concerns about the side effects, health consequences and inconvenience of methods were the most prominent reasons. The prevalence of these concerns is particularly high in South and Southeast Asia.[52]

If most unmet need is caused by women’s concerns about side effects, health consequences and inconvenience of methods of contraception, it is also important to look closely at other reasons for non-use of contraception.

vii. Non-use of contraception

Table 6 shows many different aspects that result in non-use of contraception. The fertility-related reasons are highest in all countries but these numbers include women who do not want to use contraception because they do not need to: because they are not having sex, having infrequent sex, are menopausal, are infecund, or are post-partum amaenorrhic; or because they want to have children.

The issues around non-use of contraception for women who need to use contraception are very real. A key issue that emerges for women in Indonesia is that fertility is still seen as something ‘fate’ deals out rather than a matter of exercising choice. This is also true in Pakistan although, here, fate is seen as something dealt by God (5%).

Religious opposition on use of contraception is a decisive factor in shaping contraceptive behaviour (or rather lack of it) in Pakistan, a Muslim country, (28.4 + 5%). In the Philippines, a Catholic country, opposition to use is a much smaller factor than would be normally assumed (9%).

Opposition to contraceptive use by husband is a key factor in Lao PDR, Pakistan and Indonesia.

In Cambodia and in the Philippines, method-related reasons rank highly for non-use of contraception and, in both countries, health concerns about the methods are the primary reason. Similar concerns are mirrored in Indonesia and Lao PDR.

Hence it is imperative to recognise that concerns about methods and concerns about fertility are important: “Uncertainty about the consequences of interfering with fertility is probably ages old and not easily dispelled.”[53]

viii. Emergency contraception

Emergency contraception, or post-coital methods of contraception, have been available since the 1960s and 1970s in a number of countries. However, their potential to reduce unintended pregnancies and abortions are yet to be realised.[54] Post-coital methods are not currently counted within the contraceptive prevalence rates, which measure current use of contraception. However, it is used within the ‘ever use of contraception’ data within the DHS methodologies.

The Bangladesh DHS does not mention emergency contraception. In comparison with the other methods of contraception, knowledge of emergency contraception remains low and in all countries where men were surveyed, knowledge among men was almost double those of women.

In the ever-use of emergency contraception, all countries also registered low usage of emergency contraception. This is most probably due to low knowledge and lesser accessibility.

New studies show that from looking at information from current non-users of contraception, increasing awareness of emergency contraception and increasing the number of methods that cater to post-coital contraception will have the greatest impact on unmet need. Post-coital methods can address needs of women who have infrequent sex but do not interfere with intercourse or involve male partners.[55]

Table 6: Reasons for non-use of contraception

NAME OF THE COUNTRY	FERTILITY RELATED	FATALISM	OPPOSITION TO USE	RESPONDENT OPPOSED	HUSBAND OPPOSED	OTHERS OPPOSED
Bangladesh	74	14.6	8.3	5.3	3.0	0
China						
Cambodia 2005	46.6		2.0	1.2	0.6	0.2
India		5.9		5.5	4.4	0.3
Indonesia 97		19.9		7.0	8.2	0.1
Lao PDR 05	2.1	1.6			9.7	0.2
Malaysia						
Nepal	65.4	1.2	11.9	0.6	3.2	0.3
Pakistan 2006				7.7	9.9	0.4
Philippines 2008	49.9		9	2.8	3.2	0.1
Thailand						
Vietnam	17.2				0.5	2.0

NAME OF THE COUNTRY	RELIGIOUS PROHIBITION	LACK OF KNOWLEDGE	METHOD RELATED	HEALTH CONCERNS	FEAR OF SIDE EFFECTS
Bangladesh	3.8	0.3		1.7	3.7
China					
Cambodia 2005	0.1	0.7	42.1	35.8	4.0
India	5.0	0.4		5.0	4.3
Indonesia 97	0.5	0.2		11.3	11.9
Lao PDR 05				11.8	
Malaysia					
Nepal	6.6	0.7	17.3	6.8	10.0
Pakistan 2006	28.4+5.0	0.8		3.6	5.4
Philippines 2008	2.9	0.6	39.2	20.9	13.9
Thailand					
Vietnam		1.9		6.7	2.9

Source: Country Demographic and Health Surveys.
Bangladesh DHS: 1993-4, 1999-2000, 2007; India DHS: 1992-93, 1998-99, 2005-6; Nepal: 1996, 2001, 2006; Pakistan: 1990-91, 2006-7. Cambodia DHS: 2005, 2000, 1998; Indonesia DHS: 2007, 2002, 1997; Philippines DHS: 1993, 1998, 2008; Vietnam: 1997, 2002, 2005 Lao PDR Reproductive Health Survey 2005.

Summary

In all countries, women with lower or no education, poor women, women who lived in remote, hard-to-reach areas had less access to contraception and hence, less control over their fertility in comparison to their educated, wealthier, urban counterparts. Socio-economic inequities are closely inter-linked with higher rates of unintended births and it is important to ensure access to contraception to all groups of women. There is much progress to be made in improving women's access to contraception and usage. Progress on contraception still seems to be driven by population policies rather than women's empowerment.

Informed choice on contraception methods and side-effects have not been emphasised in service provision and hence have been very poorly provided in all countries. However, this is most probably the one factor that would be able address the causes of unmet need such as concerns about side effects, health consequences and inconvenience of methods of contraception as well as non-use of contraception due to opposition.

Across all 12 countries, it is important to consider the effect that migration has on fertility reduction, although it has not been extensively documented within the DHS, even from Indonesia, the Philippines and Bangladesh, which are prime suppliers of

Table 7: Knowledge of emergency contraception and ever-use of emergency contraception

NAME OF THE COUNTRY	KNOWLEDGE - ALL WOMEN/EVER MARRIED WOMEN	KNOWLEDGE- ALL MEN	EVER-USE OF EMERGENCY CONTRACEPTION ALL WOMEN/EVER MARRIED WOMEN
Bangladesh	-	-	
Cambodia (2005)	4.9		0.1
China			
India	10.8	20.3	
Indonesia (2007)	6.3		0.3
Lao PDR			
Malaysia			
Nepal (DHS 2006)	7.4	16.8	0.1
Pakistan	17.8		0.9
Philippines	9.7		0.3
Thailand			
Vietnam			

Source: Country Demographic and Health Surveys.
Cambodia DHS: 2005; Indonesia DHS: 2007; India DHS: 2005-6; Nepal: 2006; Pakistan: 2006-7. Philippines DHS: 2008.

large numbers of migrant workers. In Nepal, it has been documented that "[f]ertility reduction [is] also influenced by internal and external displacement of people due to political insurgency as well as migration..."[56] Across all the countries, the low numbers of both male sterilisation and of condom use reflect the gender power imbalance in negotiating the responsibility of bearing the burden of both pregnancy prevention and disease prevention.

Cultural and gender norms about roles and values of men and women in sexual relationships and perceptions about male and female sexuality all play a key role in these low rates. It may also be important to remember that DHS deal with married women, and condom use within a marriage may signify a lack of trust between partners, and hence, has a different value associated with it in the responses that women may have given to their surveyors.

Across all countries, knowledge of and use of and access to postcoital methods of contraception remain low. Post-coital methods may reduce unmet need in the region significantly and programmes and policies need to be crafted around this method in order to meet women's needs.

II. ABORTION

Although abortion is one of the most contentious issues within the ICPD PoA, it is regarded as an integral component of reproductive health services.

Paragraph 8.25 speaks of the need to reduce the recourse to abortion through contraception, of pre-and-post abortion counselling, of where abortion is not against the law, such abortion should be safe; and that at the very least all countries should have access to services for the management of complications arising from abortion.

As the ICPD PoA was negotiated between the countries, some compromises with regards to abortion appear within the ICPD PoA itself. The compromises can be located in the following paragraphs on abortion:

- 7.24, which does not recognise the role of abortion in limiting births;
- 7.6, which limits service provision to the prevention and management of abortion complications;
- 8.19, which talks of abortion prevention but not of provision of safe abortion services;
- 8.22, which again talks only of service provision to treat abortion complications.

However, one year later, the women's movement was able to take it one step further in the 4th World Conference on Women in Beijing in 1995 where in the Beijing Platform for Action, Paragraph 107 (j) and (k) adopted Paragraph 8.25 in full with the addition of "consider[ing] reviewing laws containing punitive measures against women who have undergone illegal abortions." This also enabled the shift in

framing abortion from a public health perspective, to a human rights perspective and gave women's groups an opening to frame abortion within a rights perspective.

One of the biggest challenge for many women across the globe is access to safe, legal abortion. This is one of the shortcomings of the ICPD PoA: "access to safe, legal abortion [is] not recognised as part of reproductive health and rights; [in] deference to national laws; where illegal, [requiring] treatment of complications only."[57]

Despite Cairo and Beijing, a benchmark has yet to be set that establishes the right to safe and legal abortion as a good indicator of the status of women within the country; of their autonomy and their agency; and of respect for their bodily integrity.[58] Legality in each country context indicates public acceptance of fertility control, of women's need for abortion, of the limitations of contraception and contraceptive use, and of women's right to decide the number and spacing of their children, as well as public respect for and acknowledgement of women's responsibility as mothers.[59]

The deference to national laws has two different aspects. One, in countries where access to abortion is difficult, this deference puts many women and women's organisations in a bind: it is difficult to advocate and fight for something that is considered 'illegal,' especially when laws governing abortion may be covered under different sections; may be difficult to interpret; may be contradictory; and may be obfuscatory.

Furthermore, there is an absence of an international standard of a universal right to abortion which provides credence to this issue. Two, in countries where abortion is legal and available upon request, most national laws usually stipulate a time frame, i.e. within 12 weeks or 16 weeks. This deference to these 'legal' time-limits make it difficult to advocate for second trimester abortion services and for the provision of services for second trimester abortions.

In both situations, access to abortion should be viewed primarily as a human right. The Centre for Reproductive Rights defines restrictions on access to abortion as discrimination: "Freedom from discrimination is enshrined in every international human rights document.

Since only women need abortion services, restriction of access to abortion services is viewed as discrimination against women."[60] While contraceptive use increases in the region, abortion is a woman's only means of exercising her right to decide on the number and spacing of her children and governments have to make these services safe, legal and accessible to women.

It is important, at the +20 review of ICPD, to recognise abortion both as a public health issue and a human rights issue. It is important to view access to abortion in as humane and just a way as possible: "women have abortions for only one reason – because they cannot cope with a particular pregnancy at a particular time. This can never be said enough. They may regret the reasons, but this does not alter the fact that abortion is the correct decision for them and necessary in the circumstances of their lives."[61] And it is important to create policies, laws and procedures, which enable and empower women to enact these choices.

In this section, we examine the legal status of abortion in the 12 countries; changes in the law since ICPD; the extent to which the abortion law is known and acted upon; the incidence of unsafe abortion and percentages of maternal deaths attributed to unsafe abortion.

i. Legal status of abortion in the region

There are different levels of permissibility with regards to abortion in the 12 countries studied. National laws create or restrict legal access to abortion. The grounds upon which abortion is legally permitted are usually 'additive' – when abortion is permitted for a more liberal condition, it is generally also permitted for the more restrictive conditions as the Table 8 shows. There is adequate evidence to show that restrictive legislation on access to abortion is associated with a high incidence of unsafe abortion. There may be also discrepancies between the wording of the law and its application.[62]

The aspects of abortion being legal and safe are intertwined: "Making abortion legal is an essential component of making abortion safe…. Legal changes need to take place if safety is to be sustained for all women. Safety is not only a question of safe medical procedures being used by individual providers. It is also about removing the risk of exposure and the fear of imprisonment and other punitive measures for both women and providers, even where illegal abortion is tolerated."[63] These aspects apply both in situations where abortion is unavailable or partly available, and also with regards to second trimester abortions in countries where abortion is already legal within certain time frames.

Government commitment to making abortion accessible to women must also be followed up in programme implementation through the provision of service, facilities and personnel trained on procedures. In some Asian countries—notably Cambodia, India and Nepal—abortion laws are liberal, but many pregnancy terminations are performed in substandard conditions.[64]

Table 8: Grounds on which abortion is permitted

COUNTRY	GROUNDS ON WHICH ABORTION IS PERMITTED						
	TO SAVE THE WOMAN'S LIFE	TO PRESERVE PHYSICAL HEALTH	TO PRESERVE MENTAL HEALTH	RAPE OR INCEST	FOETAL IMPAIRMENT	ECONOMIC OR SOCIAL REASONS	ON REQUEST
Bangladesh	×						
Cambodia	×	×	×	×	×	×	×
China	×	×	×	×	×	×	×
India	×	×	×	×	×	×	
Indonesia	×						
LAO PDR	×	×					
Malaysia	×	×	×				
Nepal	×	×	×	×	×	×	×
Pakistan	×	×	×				
Philippines	×						
Thailand	×	×	×	×			
Vietnam	×	×	×	×	×	×	×

Source: World Abortion Policies 2007 (UN)

Table 8 maps the grounds on which abortion is 'permitted' in the 12 countries. Among the 12 countries surveyed in the region, four countries, Cambodia, China, Nepal and Vietnam, have abortion available on request; one country, India, provides abortion on all grounds except on request; one country,Thailand, provides abortion on the grounds of rape/incest, and to preserve the life, the physical and mental health of women; and two countries, Malaysia and Pakistan, seem to be rather liberal on laws, although there are exceptions in practice. Only in Bangladesh, Indonesia and Philippines do the laws state that abortion is only permissible to save the life of the woman and in Lao PDR, to save the life and preserve the physical health of the woman.

However, there are huge variances in practice. These variances are due to the fact that practices such as 'menstrual regulation' fall outside the purview of laws on abortion; the law may be interpreted differently by different parties; providers who are not willing to perform abortion based on a lack of the understanding of the law or for personal, religious reasons; or hospital administrative policies which are not based on the understanding of the law.

In Bangladesh, although 'abortion' is only available to save the life of the woman, in the mid-70s, the government slowly started introducing menstrual regulation (MR) services as an option for early termination of pregnancy. "Menstrual regulation refers to the use of a syringe and cannula to extract the contents of the uterus up to 10 weeks gestation in order to restore menstruation. During the last 20 years, menstrual regulation services have been extended throughout Bangladesh and the government has trained over 10,000 physicians and other health care providers, primarily family welfare visitors, to provide menstrual regulation services."[65]

In Nepal, there are prohibitions on abortions done without the consent of pregnant women, sex selective abortions and abortions performed outside the legally permissible criteria.[66] Although the abortion law allows for a range of grounds including risk to the mother's health, abortion is usually perceived as illegal. The law on abortion is derived from the Islamic Qisas and Diyat Ordinance. Physicians are most often left with the discretion of performing abortions and they are usually reluctant to interpret the law liberally. Sometimes the doctors resort to second opinions or verify their decisions with medical boards consisting of three experts.[67]

In Malaysia, the Penal Code Amendment Act (1989) allows a medical practitioner registered under the 1971 Medical Act "to terminate the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the mental and physical health of the pregnant woman greater than if the pregnancy were terminated."[68] This is according to Section 312, of the Malaysian Penal Code. However, generally, government hospitals do not provide access to abortion services. Exceptions are two hospitals which offer services in cases of severe foetal malformation that indicate that the baby would not survive on delivery.

It is also important to understand the risk that both women and service providers take in seeking and

providing abortion services. In almost all countries, there are penalties.

Even among the countries which have legalised abortion, there are penalties. In China, 'unapproved' abortions result in admonishment, fines, revocation or denial of future birth permits and possible sterilisation for the woman.[69] In Nepal, the law punishes anyone who 'tricks' or 'provides incentives' to a pregnant woman to have a sex-selective abortion with imprisonment of up to one year.[70]

In Thailand, "a woman who induces her own abortion or allows another person to do so is liable to imprisonment up to three years or is fined up to USD146"; a provider is liable to imprisonment to of up to five years or fined USD244.[71] In countries where the abortion law is restrictive, such as Bangladesh[72] and Pakistan,[73] both the women who seek abortion and the service providers can be imprisoned for up to three years and fined. The sentence increases for second trimester abortions.

In the Philippines, the penal code prescribes penalties of imprisonment from 30 months to six years for any woman who causes or consents to her own abortion and imprisonment of two to six years for any person who intentionally causes an abortion with the consent of the woman.[74]

Surprisingly enough, in India, the penal code prescribes penalties for both woman and provider of up to seven years of imprisonment and fines.[75] The similar is true in Malaysia.[76] This is in contradiction to the legal status of abortion itself.

In Bangladesh, India and Pakistan, the penalties are more severe for second trimester abortions. In all countries, penalties are more severe for abortions performed without the consent of the woman and abortions which result in the death of the woman. Both of these penalties target service providers.

ii. Changes in law/policy on abortion since ICPD

In recent years, many countries have been addressing abortion in laws and policies.

In Cambodia, in 1997, concerned with the high MMR brought about by the unsafe conditions in which illegal abortions were generally being performed, the government decided to introduce abortion legislation to regulate the procedure formally. It hoped that the legislation would reduce the MMR by one half by 2010. Moreover, it depicted its proposed legislation as a measure designed to improve the social welfare of the population. Despite some opposition from those who argued that the country's Buddhist traditions do not allow the legalisation of abortion, the proposed legislation was enacted in early October 1997.[77]

In Vietnam, abortion and menstrual regulation have been officially allowed by the Vietnamese Government since 1989 when it approved the Law on Protection of People's Health. Women's rights to gynaecological checks-up and treatment and abortion and menstrual regulation as stipulated in Chapter 8 (Family Planning and Mother and Child Health) Item 1, Article 44 reads: "Women have the right to abortion and menstrual regulation at their will and to gynaecological checks-up and treatment and health checks up during pregnancy and child delivery services at health facilities."[78]

In 2002, India adopted legislation aimed at improving access to safe abortion facilities by moving authority to approve facilities from the state level to the district level. The law, which is intended to simplify the approval process for new facilities, also increases criminal penalties for providers and facility owners who operate without approval.

In Nepal, it was only in 2002 that "abortion [was made] legal without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds. Under the [previous] law, abortion was prohibited altogether."[79]

In Thailand, it was only in 2005, that the Medical Council amended a regulation governing the medical profession's conduct with regard to abortion. "The regulation provides a standard interpretation of the criminal law provision on abortion, which permits the procedure when a woman's life or health is in danger and in cases of rape.

According to the new regulation, 'health' is defined to include mental health as well as physical health. The regulation clarifies that abortion may be performed in public or private health facilities not only to protect a woman's life and physical health and in cases of rape, but also when a pregnancy causes harm to a woman's mental health and in cases of foetal impairment."[80]

In Indonesia, it was only in September 2009 that the law was amended again recently, and stipulates that only women whose lives are in danger or those that have been raped can have an abortion.[81]

iii. Extent to which abortion law is known, accepted and acted upon by health providers and the public

Lack of knowledge about abortion laws – among women and among service providers – continues to be an issue in Nepal, Pakistan and India.

Table 9: Regional estimates of unsafe abortion

Region	Unsafe Abortion		
	Number (rounded)	Incidence Rate (per 1000 women aged 15-44 years)	Incidence Ratio (per 100 live births)
Asia	9 800 000	11 (20)	13 (18)
South Asia	6 300 000	18	16
South-east Asia	3 100 000	23(27)	27(31)

Source: Unsafe abortion Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003 (World Health Organisation)
Note: No estimates are shown for the East Asia region where the incidence is noted to be negligible, and South-east Asia does not include Vietnam and Singapore where abortion is legal and relatively accessible.

In Nepal, although the law stipulates that abortion services should be available on demand for the duration of the first 12 weeks in general, and in cases of rape until 18 weeks and any duration if the life of the mother is under threat – only one in three women in is aware that abortion is legal.[82] Just over one in two women mentioned that they know of a place where abortions are carried out.[83]

In Pakistan, inadequate awareness of the law, including on the part of doctors and the conservative social milieu, has proved to be a strong barrier to abortion. There is confusion and reluctance to carry out induced abortion. There are no established guidelines for the medical profession mandating such permission.

Physicians are cautious in their application of the abortion law, particularly in their reading of the term 'necessary treatment,' and will provide abortions only when the pregnant woman suffers from a serious medical ailment, even though the statute itself does not state that the 'treatment' must be related to physical health.[84]

In India, only 29% of informal providers know abortion is legal.[85]

Lack of service facilities and staff trained in abortion methods is an issue in Cambodia, although the law is liberal. Health services in Cambodia are not highly developed and much of the population lacks adequate access to these, particularly at the in-patient level. Additional health personnel who have the proper training to perform abortions safely are also needed. With such obstacles to overcome, it is likely that, at least in the short run, many abortions will still be performed in unsafe conditions by unskilled persons.[86]

Service provider attitudes to unmarried adolescents undergoing induced abortions and the quality of care afforded to them is an issue in China. A study by "SIPPR on 1,927 family planning providers in eight provinces endeavoured to learn about the attitudes of family planning providers towards sexual behaviour and induced abortion among unmarried adolescents. The survey showed that 60.7% and 88% of service providers disagreed with premarital sexual behaviour and induced abortion respectively."[87]

Lack of knowledge about the abortion law is an issue which has seen a burgeoning of abortion services in the private sector in Malaysia. Anecdotal evidence suggests that abortion services are easily available in the private sector for a cost, where physicians are more likely to form opinions to the advantage of women. All forms of abortion services, except for medical abortion, are available.

These services are for the most part, safe. This may explain the low number of maternal deaths due to abortion (one to five deaths a year) – a number which is quite trustworthy as Malaysia is one of the rare countries which investigates each and every maternal death. However, abortion services are not available even for victims of rape and incest and cases of foetal malformation in the government hospital system, which has almost universal coverage for the country's population.

iv. Unsafe abortion and percentage of maternal deaths attributed to unsafe abortion

The ICPD PoA locates abortion and strategises about it in the context of public health.[88] Table 9 shows the regional estimates of annual incidence of unsafe abortion and associated mortality in 2003.

The rates, ratios and percentages show the relative health burden of unsafe abortion in the specified regions. Unsafe abortion is negligible in East Asia and in some developing countries of other regions where abortion is legal and relatively accessible (for example, Vietnam). Hence, in these countries all procedures are safe.[89] In South Asia, the abortion

rate was 27 per 1,000 with 18 unsafe and nine safe abortions per 1,000. South-east Asia had the highest abortion rate in 2003 – 39 per 1,000 (23 per 1,000 unsafe and 16 per 1,000 safe); most of the safe abortions in this area occurred in Vietnam.[90]The incidence of unsafe abortion still continues to be a pressing problem in the region. Unsafe abortion is a major factor contributing to maternal mortality.

Unsafe abortion continues to be a major factor in maternal deathsin the region. Mortality due to unsafe abortion for the South-east Asia is estimated at 14% of all maternal deaths,[91] and South Asia, at 13%.[92]

In Bangladesh, abortion contributes to 8% of maternal deaths.[93] However, another study has found that between 1996-1997, nearly 26% of all maternal deaths were estimated to be a result of abortion-related complications. At this time, almost half of the reported abortions resulting in complications were performed by untrained birth attendants through the insertion of a foreign object into the uterus, most commonly a root or stick. If services had been available for women to obtain a medically approved abortion from a trained provider, nearly 84% of the deaths would probably have been prevented.[94]The impact of menstrual regulation services on reducing maternal mortality and abortion-related deaths has been significant in Bangladesh, although determining and understanding the extent of this impact has been difficult due to the scarcity of data on abortions.

Despite the safety and increased availability of MR procedures, women in Bangladesh still lack access to these services based on differences such as location and financial status, and many women, despite access, still seek a traditional provider because of the convenience. Additionally, as many as 33% of women seeking a MR are rejected—most often the result of a late gestational age. Most of these rejected women will still obtain an abortion even if the abortion is not achieved through a medically approved procedure. These women are at a greater risk of complications that could result in death; yet, the magnitude of this risk remains undocumented.[95]

The Pakistan Demographic Health Survey 2006-07 notes that 6% of maternal deaths are attributed to complications of abortion (either sepsis or haemorrhage). However, very few deaths were reported to follow an induced abortion and from the verbal autopsy history it was quite difficult to make a distinction between induced abortion and miscarriage.[96] Another national study estimated that 890,000 induced abortions occurring annually, with the estimated annual abortion rate of 29 per 1000 women aged 15-49. “If women of reproductive age were to experience this rate over their lifetime, the average Pakistani woman would experience about one abortion in her lifetime.”[97] Additionally, this study also estimated that 197,000 women were admitted annually to public medical facilities and private teaching hospitals for the treatment of complications of induced abortion.[98]

In India, abortion was legalised in 1972; however, legalisation has not ensured access to safe abortion services for Indian women. Eight percent of all maternal deaths are attributed to abortions, translating to 11,000-15,000 deaths due to unsafe abortion annually. There are no established national level mechanisms for the monitoring and evaluation of maternal mortality and morbidity resulting from unsafe abortion.[99]

In Nepal, abortion complications and ante-partum haemorrhage account for 5% of maternal deaths.[100]

In Indonesia, complications from abortion are believed to be responsible for 15% of maternal deaths in Indonesia.[101] Another survey quoted that “of the 750,000 to one million abortions each year in Indonesia, 89[%] were among married women and 11[%] were among single women. It is estimated that 70[%] of women who have had an abortion were trying to abort using traditional herbs (*jamu*), traditional massage, or an object, or sought an abortion from a traditional healer (*dukun*) before coming to the clinic.

This is a cause of concern because these attempts can be life threatening and dangerous for women’s health. Another 1997 study in Indramayu-West Java showed that 40[%] of village women who sought abortion services (mostly unsafe abortions) were unmarried adolescents.”[102]

A base-line survey, conducted by the Demography Institute, for 15-19 year-olds in four provinces of Indonesia (East Java, Central Java, West Java and Lampung) in 1999 indicates that 61% have unwanted pregnancies, with 12% of them undergoing abortion and 70% of these performing the abortion themselves, while 10% are assisted by traditional helpers to perform the abortion.Only 7% make use of professional medical assistance.[103]

In the Philippines, pregnancy with abortive outcome contributed to 9% of maternal deaths in 2000.[104] In Malaysia, unsafe abortion accounts annually for one to five deaths in the last 10 years according to the Confidential Enquiry into Maternal Deaths by the Ministry of Health.[105]

Common unsafe abortion methods used include inserting sticks, herbs, roots, and foreign bodies into the uterus. Other vaginal methods include pins, laminaria tents and fetex paste. Rural Medical Providers sell medicines for oral use to induce abortion. ANMs use intra-amniotic saline and intra-amniotic glycerine with iodine.

Orally ingested abortificients include, indigenous and homeopathic medicines, chloroquine tablets, prostaglandins, high-dose progesterone and oestrogens, liquour before distillation, seeds of custard apples and carrots. Invasive or surgical methods are tried by a minority of informal providers. The common instrument used is a curette, and occasionally a syringe, catheter or copper T.[106]

Summary

Estimates of the incidence of unsafe abortion continue to be high in the region as does the percentage of maternal deaths attributed to unsafe abortion. Although access to safe abortion services has been proved to be linked to a lower incidence of unsafe abortion (and lower percentages of maternal deaths due to unsafe abortion), progress on amending laws seems slow.

Five countries in the region provide for abortion on many grounds: China, Cambodia, India, Nepal and Vietnam. Where abortion laws are restrictive, it is important to look at how women's NGOs are working to amend these laws as is mentioned clearly in the Beijing Platform for Action.

It is also useful to note that abortion services for women are being provided safely through the private sector (as in Malaysia and Thailand), through the family planning methods of menstrual regulation (as in Bangladesh) and through private provision of medical abortion (as in South-east Asia).

In countries such as Lao PDR, the Philippines, Indonesia, Bangladesh and Pakistan, legal barriers continue to curb women's access to abortion, simply because there can be no services without laws.

In countries such as Malaysia, there are non-legal barriers such as hospital administration policies which, continue to curb women's access.

There is still a challenge in shifting the paradigm to provide abortion upon request, within the public health system in the countries with restrictive laws, although most countries have made some provisions for post-abortion care after ICPD.

In countries where abortion is legal, this is mainly for the duration of the first trimester with the exception of China, where the government permits abortion to be performed up till six months of gestation.[107] In these countries, second trimester abortions still prove to be a challenge in terms of legality, political support, the balancing between women's rights and pregnancy advancement, as well as empathy for both women and service providers. [108] In countries with liberal policies on abortion, such as Cambodia, India and Nepal, there are service barriers to accessing safe abortion. In these countries, many abortions are performed in substandard conditions, and governments must follow through on their efforts to provide safe abortion services.

III. CONCLUSION

From a review of reproductive health and reproductive rights indicators across the 12 countries, the following conclusions can be made.

i. Progress across the region is uneven and slow with regards to reproductive health and reproductive rights.

- No one country has made progress in every single indicator of RH and RR.
- Contraceptive prevalence rates are still low in many countries, but are high in countries which have strictly implemented population policies. The burden of contraception falls on women.
- Abortion policies take a long time to change. Progressive laws need to be backed up with service provision and quality of care.

ii. Political will of governments is crucial in making laws, allocating resources, and deploying trained staff.

- Political will of governments is a key factor for the achievement of reproductive health and reproductive rights outcomes. When governments decide to reduce fertility, as seen in China, India and Indonesia, it is done. When governments decide to reduce maternal deaths in Malaysia and Thailand, it is done. When governments decide to provide access to safe abortion services, as in Vietnam and China, it is done.
- Once the issue is seen as being of prime importance governments create policies and programmes and deploy budgets and trained personnel and provide facilities and access.

iii. Access for marginalised groups is a concern across all countries.

- In all countries, women who are poor, less educated, live in remote areas and/or rural areas face greater difficulties in accessing services and realising the autonomy of their bodies. Tribal women, women from ethnic minorities, women from lower castes, and younger women are also marginalised. This happens regardless

of whether the service they require access to is contraception or safe abortion services. Reproductive health and reproductive rights are an issue of socio-economic equity as well as gender equity.

Endnotes

1 *Much of this content is taken from Chapter 3 on reproductive health and reproductive rights of 'Reclaiming & Redefining Rights – ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia,' which was written by this chapter's authors.*

2 *These are sexual health services presented under the reproductive health umbrella in the ICPD PoA.*

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13 *IIPS and Macro International. (2007). National Family Health Survey (NFHS-3), 2005-06: India: Volume I. Deonar, Mumbai, India: IIPS.*

14 *"These [wanted] fertility rates are [generally calculated in the same manner across all the country DH Surveys:] calculated in the same way as the total fertility rates, but unwanted births are excluded from the numerator. For this purpose, unwanted births are defined as those that exceed the number considered ideal by the respondent. Women who did not report a numeric ideal family size were assumed to want all of their births.*

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16 *Ministry of Health and Population (MOHP) Nepal; New ERA; Macro International Inc. (2007). Fertility. In Nepal Demographic and Health Survey 2006 (p.67). Kathmandu, Nepal: Ministry of Health and Population; New ERA; Macro International Inc.*

17 *MOHP Nepal; New ERA; Macro International Inc. (2007). Fertility. In Nepal Demographic and Health Survey 2006 (p.67). Kathmandu, Nepal: MOHP; New ERA; Macro International Inc.*

18 *Contraceptive Prevalence Rate (Percentage). (2008). Retrieved 5 August 2009, from the World Health Organisation (WHO) Website:http://www.who.int/whosis/indicators/compendium/2008/3pcf/en/index.html*

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CHAPTER 2

BARRIERS TO CONTRACEPTIVE USE IN CAMBODIA: A STUDY IN SELECTED SITES IN TAKEO AND SIEM REAP

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I. INTRODUCTION

In Cambodia, there is wide acknowledgement that the full implementation of The International Conference on Population and Development Programme of Action (ICPD PoA) is a critical pre-requisite for achieving the Millennium Development Goals (MDGs). The Millennium Declaration was adopted in September 2000 by all 189 member states of the United General Assembly (UNGASS), with world leaders agreeing to a set of time-bound and measurable goals and targets for combating extreme poverty, hunger, disease, illiteracy, environment degradation and discrimination against women. Commonly known as the MDGs, these goals have become widely accepted as critical to the global development agenda.

The Royal Government of Cambodia (RGC), as a UN member state, is firmly committed to bridging the gap between not only global commitments and national progress, but also to aggregate national and local development outcomes. Thus, to better reflect realities in Cambodia, using a participatory approach that included major development stakeholders, the RGC established the Cambodia Millennium Development Goals (CMDGs) in 2003. The CMDGs include the eight original MGDs and one additional goal (Number 9: De-mining, UXO[1] and victim assistance). In tailoring the UN MDGs to better fit the needs of Cambodia, the RGC implemented various national policies, such as the Government Rectangular Strategy (GRS) and the National Strategic Development Plan (NSDP).The GRS is a tool to implement the national development strategy and to meet the CMDGs, while the NSDP is a CMDG-focused plan that is updated and revised regularly based on the results of annual assessments carried out by the Ministry of Planning (MOP).

Many development indicators point in a positive direction in Cambodia. Educational levels have risen spectacularly in the last 10 years, and the gender gap in literacy is fairly narrow.[2] HIV prevalence among adults has fallen from a high of almost 3% in 1999 to an estimated 0.7% in 2009.[3] The infant mortality rate (IMR) has fallen from 95 to 65 deaths per 1,000 live births between 2000 and 2005 alone,[4] and the 2008 census estimates it at 60.[5] Under five mortality has fallen at approximately the same rate, while the decline of newborn mortality has been slower.[6]

The Ministry of Health (MOH) administers health services through Provincial Health Department (PHDs), Operational Districts (ODs), Referral Hospitals (RHs), and Health Centres (HCs) or Health Post (HPs). A number of national and international NGOs either support the government health sector (including health system strengthening), or provide separate services, or both. There is also a widespread but largely unregulated private-for-profit sector.

Reproductive health and maternal health are critical issues in Cambodia since maternal mortality and morbidity have significant long term negative economic consequences on households and on society. In some aspects, the health services mentioned have been reasonably successful in improving women's control over their fertility.

The United Nations report, *World Population Monitoring*, 2003 showed that in 1995 Cambodian women had a total fertility rate of 5.3. Since then, fertility levels have declined, with a TFR of 4.0 in 2000,[7] 3.4 in 2005,[8] and 3.13 in 2008.[9] The latter figure was confirmed by the 2008 national census,[10] the results of which have just been publicised. This sharp reduction has been every encouraging.

However, in the current period of national reconstruction in Cambodia, with falling IMR, increasing child survival rates, improving educational possibilities, and (until recently) steady economic growth, there is an increasing desire by people to further limit family size. This presents a number of challenges to the capacity of the Cambodian Sexual and Reproductive (SRH) health infrastructure. There are 1,022 public health facilities for 14 million people, 55% of whom are under the age of 20. In addition, while private SRH practice is widespread, regulation is weak or non-existent.

Among other things, this means that the capacity among service providers and information provided to clients varies widely. The full understanding of these issues is further complicated by the fact that data on funding for family planning (FP) are far less accessible than comparable data on HIV and AIDS funding. One possible reasons for this is that, despite the vertical nature of Cambodia's public health sector, it is difficult to identify government (and sometimes donor) funding, especially for FP activities, as such activities featured in numerous MOH budget lines.[11]

i. Current SRH overview

Despite the Government's firm commitment to SRH, Cambodia has in recent years failed to meet almost all of its SRH goals. Cambodia is thus not only one of the many countries that will not achieve the ICPD goal on maternal health, but maternal mortality ratio (MMR) has apparently not declined at all since the year 2000. By 2005, the ICPD and CMDGs targets were to reduce the MMR to below 125 and 343 per 100,000 live births respectively. The

2005 Cambodian Demographic and Health Survey (CDHS), however, found a MMR of 472 per 100,000 live births, not significantly different from the 2000 CDHS (437 per 100,000 live births), and recently confirmed by the 2008 census (461 per 100,000 live births).[12] This corresponds to a life time risk of dying from a pregnancy-related cause of 1 in 50.[13] One in 50 women in Cambodia, thus, has the risk of dying a maternal death.

In 2010, WHO, UNFPA, UNICEF and the World Bank estimated the MMR in Cambodia at 290 per 100,000 live births with a wide uncertainty interval between 180 to 480. According to this improved estimate, the lifetime risk of maternal death is 1 in 110.[14] Over one fifth of the illness-related causes of death of women in the age group 15-44 years were due to pregnancy-related complications.[15]

Cambodia also failed to reach the CMDG 2005 target of 60% skilled birth attendance. Although the National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010) recognises that "skilled birth attendance is crucial to reducing maternal and neonatal morbidity and mortality,"[16] a recent UNFPA report indicated that while demand for skilled delivery is high, access in Cambodia has been typically constrained by high costs and distance.[17] This meant that only 44% of births in 2005 were attended by skilled health personnel compared to 32% in 2000; and, only 66% of women with recent pregnancy, interviewed during the 2005 CDHS, had received any antenatal care, compared to 38% in 2000.

The high MMR is, thus, largely the result of low utilisation of key services, particularly in remote areas, due to limited geographic and financial access to these services, poor staff motivation and infrastructure, scarcity of midwives, shortfalls in basic materials and coverage of running costs, and insufficient coverage of Emergency Obstetric and Newborn Care.

It does appear as if the rate of facility birth is rising quite rapidly since 1-2 years back, probably as a combined result of increasing access to health equity funds for poor women, and a government incentive for health centre and hospital staff who assist births. The staff of a government health centre, since September 2008, has received an incentive of 15 USD for every live birth, and hospital staff receive 10 USD for a live birth.

The upsurge in births currently seen, on the other hand, now focuses on the need to improve the quality of birthing care provided. As an example, a recent national assessment of the quality of birthing care showed that the national average for correctly performed active management of third stage of labour at larger hospitals was only 11% (95 Confidence Interval); 2-19% are not drying the baby and not giving him/her to its mother were common, and that post-partum sterilisation was offered, very rarely.[18]

Abortion is legal at the woman's request before 12 weeks of pregnancy, but access in reality is limited, especially for poor women. All public facilities do not provide abortion services, and abortion is also carried out illegally in private practices, sometimes unsafely. Unsafe abortion is one of the major causes of maternal death, accounting for an estimated 20-29% of deaths.[19]

The 2005 CPR of 27.2% fell short of the 30% CMDG 2005 target, and was much lower than the ICPD framework. However, the rise seen does demonstrate significant progress towards these goals. It is worth recalling that in the 1980s – the first decade after the fall of the Pol Pot regime – access to modern contraception was almost zero, and there were hardly any trained health staff in Cambodia. Family planning services and modern contraceptives started to become available only in 1991, and the first contraceptive prevalence recorded in Cambodia was 7.0%, in 1995. The CPR – modern contraceptives only – increased steadily to 18.5% in 2000 and to 27.2 % in 2005.[20]

In spite of these gains in the CPR and in the use of FP, unplanned pregnancies remain very common in Cambodia: about a third of married women reported one or more unplanned pregnancies. Of married women interviewed, 25% reported an unmet need for family planning.[21]

These typically occur as a result of either never using FP, using a less reliable method, using it incorrectly, over-reliance on the protection afforded by breastfeeding or not breastfeeding exclusively, or discontinuing use of FP because of side effects/ health concerns.

Thirty-eight percent of women, who have stopped using a modern method of FP, report having had an unplanned pregnancy. The main reason cited by women, especially those under the age of 25, for non-use of FP was health concerns/fear of side effects. One major factor affecting the CPR is a common (but incorrect) belief in Cambodia that modern methods of FP can cause infertility, especially when used before having had at least one child.[22] It is quite likely that such incorrect beliefs are hindering many Cambodian women from practicing family planning or birth spacing, leading to the high rate of unplanned pregnancies, and contributing to low utilisation of quality maternal health and FP services.

Average age at sexual debut remains relatively high in global comparison, and sexual debut and marriage

often go hand in hand. Teenage pregnancies are, thus, comparatively rare. The recent census even showed a rise in the average age at marriage, the age of 22 for women and 23 for men.[23] Because of the different lifestyle, with earlier sexual debut and the occurrences of sex outside marriage, young people, thus, also need reproductive and sexual health services. Sexual trafficking and prostitution remain common in Cambodia.

II. OBJECTIVES

This research case study has two objectives:

1. To reflect on the estimated costs needed for improvement of sexual and reproductive services in Cambodia.
2. To understand the nature of the barriers to family planning presented by people's fear of side effects of contraceptive use.

III. METHODOLOGY

In order to achieve the two objectives of the study, both secondary data and some primary data were collected from difference sources. To learn the estimated costs needed for improvement of SRH in Cambodia, secondary data were collected from the most recently updated MOH information available on reproductive health costing.

To understand the nature of the barriers to FP presented by people's fear of side effects of contraceptive use, field interviews and focus group discussions (FGDs) were conducted with a total of 53 people (n=53).

Three FGDs were organised with 30 men and women of reproductive age (10 males and 20 females). Two of the FGDs were organised in a village in Takeo province, and the third in a village in Siem Reap province.

Also, to explore the nature of the barriers to family planning among women, especially young women, in-depth interviews were conducted with 18 women, eight of whom were under 25 years of age (later during the discussion, we found that five were first-time pregnant and three were FP non-users), and 10 of whom were women older than 25 (we found that those women had many children and six of them were FP discontinuers).

All male and female participants were randomly invited to attend the FGD or interview.

Five MOH staff and officers were also interviewed, two were midwives in the rural areas and three were officers in the health department in Phnom Penh. The field work was carried out from January to April 2009, in Takeo and Siem Reap province.

IV. FINDINGS

i. Estimated costs for SRH care

The MOH through the National Reproductive Health Programme (NRHP) suggests that affordability is the key issue in taking up FP, and the NRHP has committed to increasing the coverage of SRH services, and had identified the urgent need for a costing for SRH to meet the 2010 National Strategy for Reproductive and Sexual Health and the 2015 CMDGs targets. This commitment was translated into action by the MOH, with support from United Nations Population Fund (UNFPA) Cambodia. The resulting document, "Reproductive Health Costing, 2006-2015,"[24] provides the first comprehensive costing assessment for a national rollout of essential SRH services.

Data in Table 10 presents the total estimated cost of improving SRH services, starting at USD6,402,824 in 2006 to USD11,512,507 in 2010 and reaching USD16,459,704 in 2015 (at the current rate of personnel salary). Applying the ideal salary would convert the total cost to USD9,613,243 in 2006, to USD15,547,095 in 2010 and to USD22,393,691 in 2015.

The cost for Antenatal Care (ANC) in 2006 applies to the current coverage; while for costing from 2010 onward, specifically ANC, uses the ideal of 100% coverage.

Other related costs include the recruitment of additional midwives, and operational costs. At the current salary rate, budgeted costs were USD2,382,846 in 2006, increasing to USD2,762,372 in 2010 and reaching USD3,202,344 in 2015. At the ideal salary rate, costs would be USD3,732,846 in 2006, increasing to USD4,327,392 in 2010 and USD5,016,631 in 2015 (Table 11).

The investment costs needed for provision of the Complementary Package of Activities (CPA), the Minimum Package of Activities (MPA), the referral system, Regional Training Centres (RTCs) and management of the NRHP are equally important to the improvement of SRH services, totalling an estimated USD25,401,850 (Table 12). Table 13 summarises the total cost of improving SRH services to reach 2010 and 2015 targets.

Table 10: Total cost of drug and staff time at current and ideal salary rates, 2006-2015.

	COST AT CURRENT SALARY RATE			COST AT IDEAL SALARY RATE		
	2006	2010	2015	2006	2010	2015
Family planning	$2,497,559	$4,036,626	$6,036,975	$2,868,364	$4,631,645	$6,930,406
Emergency contraceptive	0	$3,856	$4,228	0	$9,606	$10,531
ANC*,delivery, PPC	$1,653,656	$3,164,940	$3,861,190	$3,504,135	$4,602,596	$5,682,562
Malaria	$77,623	$86,066	$100,558	$87,047	$96,513	$112,765
UTI&Mastitis	$61,259	$79,483	$100,950	$92,770	$118,413	$149,230
EmOC	$393,573	$1,008,052	$1,570,341	$531,347	$1,360,937	$2,120,155
CAC	$230,820	$643,829	$1,129,314	$278,741	$777,494	$1,363,770
Newborn care	$1,373,316	$1,908,098	$2,467,643	$2,012,785	$2,796,604	$3,616,854
PMTCT	$18,556	$95,052	$132,208	$18,896	$96,796	$134,638
STIs	$41,000	$190,029	$407,824	$67,451	$312,761	$671,388
RTI	$67,660	$310,344	$662,062	$165,582	$759,501	$1,620,254
Sub-Total RH cost	$6,402,824	$11,512,507	$16,459,704	$9,613,243	$15,547,095	$22,393,691

The highest cost related to improving SRH services is represented by FP services. However, the assessment demonstrated that increasing contraceptive use from 40% in 2006 to 60% in 2015 would significantly reduce the number of women requiring ANC, Delivery Care, Postpartum Care, Malaria Prevention and Treatment, treatment for UTI/ Mastitis, and newborn care.

Therefore, the reduction in costs for maternal health care and other costs related to pregnancy and birthing care can contribute significantly to budget savings.

Increasing the number of averted births is a proven way of reducing maternal deaths. The MOH report states that increasing CPR to 60% would avert about 2,600 maternal deaths in Cambodia in the period up to 2015. In 2015, with a CPR of 60%, at least 566 women's lives would be saved annually, which would be 28% of expected deaths if the CPR and MMR had remained at present levels (Table 14).

It was also demonstrated that changes in contraceptive method move towards an increased percentage of long term contraceptive use which would significantly reduce the number of births and also provide budget savings.

The annual cost per Woman of Reproductive Age (WRA) of improved access to SRH services towards the target 2015 level would imply an increase from USD1.71 in 2006 to USD2.75 in 2010 and to USD3.59 in 2015, using current salary levels.

At the ideal rate of salary, this means that the cost per WRA would increase from USD2.56 in 2006 to USD3.72 in 2010 and to USD4.88 in 2015 (Table 15). Such budget estimates for SRH programme expenditure can be compared to, for instance, the government health budget per capita at a provincial level and below, but excluding national level expenditure. This budget level is currently at USD15 per capita.

ii Understanding the barriers to family planning

These are the barriers that were identified and emerged in the group discussions.

Table 11: Other costs related to improving reproductive health services, 2006-2015

	COST AT CURRENT SALARY RATE			COST AT IDEAL SALARY RATE		
	2006	2010	2015	2006	2010	2015
Pre service training for additional midwives	$316,570	$366,992	$425,444	$316,570	$366,992	$425,444
In service training	$778,396	$902,375	$1,046,099	$778,396	$902,375	$1,046,099
Salary for additional midwives	$156,720	$181,681	$210,618	$1,387,200	$1,608,145	$1,864,280
Operational costs of the NRHP	$187,000	$216,784	$251,312	$254,200	$294,687	$341,623
Operational costing for the RH/MCH unit of the PHDs	$147,840	$171,387	$198,684	$163,200	$189,193	$219,326
Operational costing for the RH/MCH unit of the ODs	$332,640	$385,621	$447,040	$369,600	$428,468	$496,712
Cost of outreach activities	$463,680	$537,532	$623,147	$463,680	$537,532	$623,147

Table 12: Investment cost, 2006-2015

	COST AT CURRENT SALARY RATE			COST AT IDEAL SALARY RATE		
	2006	2010	2015	2006	2010	2015
Investment cost of CPA,MPA, referral systems, RTC and NRHP	$25,401,850					

Note: RH costing includes 15% for distribution, 15% for wastage and 3% for inflation. Other costs include 3% for inflation.
1. Cost for ANC in 2006 estimated based on current practice in Cambodia; 2010-2015 costs are based on the Gold Standard of WHO.
2. At present, antenatal care nationwide does not include all procedures recommended by WHO as an "ideal antenatal care package."

Source: Table 11, 12 and 13 were extracted from Ministry of Health. (2007a). *Reproductive Health Costing 2006-2015.* Cambodia: National Reproductive Health Programme, Ministry of Health.

Table 13: Total cost of SRH Programme, additional midwives, operational cost for NRHP, Reproductive Health/Maternal and Child Health at Provincial Health Departments and Operational District, and investment costs

	COST AT CURRENT SALARY RATE			COST AT IDEAL SALARY RATE		
	2006	2010	2015	2006	2010	2015
Sub-total cost of RH services (Table I)	$6,402,824	$11,512,507	$16,459,704	$9,613,243	$15,547,095	$22,393,691
Sub-total cost of other activities (Table II)	$2,382,846	$2,762,372	$3,202,344	$3,732,846	$4,327,392	$5,016,631
Total cost	$8,785,670	$14,274,879	$19,662,048	$13,346,089	$19,874,487	$27,410,322
Investment cost of CPA, MPA, referral system, RTC and NRHP (Table 3)	$25,401,850					

Source: Table 13 was extracted from Ministry of Health. (2007a). Reproductive Health Costing 2006-2015. Cambodia: National Reproductive Health Programme, Ministry of Health.

Table 14: Number of births when CPR constant at 40% and when CPR increases to 60%, and estimated MMR due to reduction of births (stimulated)

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Births with CPR constant at 40%(1)	426,984	442,062	456,969	471,272	484,626	498,378	511,283	523,519	535,300	546,831
Births with CPR increase to 60%(2)	426,984	432,424	436,289	438,095	437,451	438,602	437,887	435,413	431,370	425,912
Number of averted births due to increase in CPR(3)	0	9,638	20,680	33,177	47,175	59,776	73,396	88,106	103,930	120,919
Ratio of births averted to births with CPR increase to 60% (4)=(3)/(2)	0	0.022	0.047	0.076	0.108	0.136	0.168	0.202	0.241	0.284
Maternal deaths averted due to lower birth rate (assuming constant MMR)	0	45	99	156	222	263	344	415	490	566

Source: Table 14 was extracted from Ministry of Health. (2007a). Reproductive Health Costing 2006-2015. Cambodia: National Reproductive Health Programme, Ministry of Health.

Table 15: Per capita cost and per WRA cost at current and ideal salary rates

	2006	2010	2015
Total population	$13,987,374	$15,110,000	$16,450,000
Total WRA	$3,747,980	$4,181,710	$4,584,350
2006 ANC AT CURRENT PRACTICE,2010-2015 WITH GOLD STANDARD, AND CURRENT RATE OF SALARY			
Total cost	$6,402,824	$11,512,507	$16,459,704
Cost per capita	$0.46	$0.76	$1.00
Cost per WRA	$1.71	$2.75	$3.59
2006 ANC CURRENT,2010-2015 GOLD STANDARD, AND IDEAL SALARY			
Total cost	$9,613,243	$15,547,095	$22,393,691
Cost per capita	$0.69	$1.03	$1.36
Cost per WRA	$2.56	$3.72	$4.88

Source: Table 15 was extracted from Ministry of Health. (2007a). Reproductive Health Costing 2006-2015. Cambodia: National Reproductive Health Programme, Ministry of Health.

a. Accessibility

A majority of men and women in the FGDs stated that both short-term methods (e.g., condoms, injectable and daily pill) and long-term methods of family planning services (e.g., intrauterine devices [IUD]) are accessible in their communities.

"*In the health centre in this community there are pills, injections, condoms and IUDs. If we want a surgical method we can go to the hospital in the province*." **–** Married woman over 25.

b. Affordability

All men and women demonstrated knowledge in modern contraceptive methods, particularly pills, condoms and injections, and perceived that they were easy to use and very affordable. Regarding IUDs, men and women thought that they were also affordable. A few women stated that IUDs were more suitable for those who enjoy better living conditions, and do less heavy work.

c. Health concerns

A range of health concerns relating to the use of FP was emphasised during the group discussions. In the community, at home and in the village, some men get information or rumours on health concerns from their wives or close relatives, while others get information from outside and convey to their wives; the women learn from other women and close relatives.

A variety of health concerns were highlighted during the discussion. These were, for example, weakness, getting hot inside, womb thinning, cancer, irregular bleeding, becoming increasingly thinner, having difficulty in getting pregnant and infertility. Both women and men in the group discussions were worried about being susceptible to illnesses related to side effects. However, the fear of these side effects was often due not only to health concerns, but also financial concerns.

A number of women and men suggested that the problems that could arise from these FP side effects would be expensive to solve. Combined with other misconceptions, the fact that some individual women may have little tolerance for side effects, and the fear of high treatment costs, many couples had chosen to stop using any contraceptive method.

One factor that may be contributing to this outcome was that midwives at Health Centres (HC) currently providing FP suggested that early use of birth spacing for young couples will lead to infertility after a couple of years.

"*I used an IUD for 2 years, then I heard about a woman who died who was an IUD user. I got scared and went to ask for removal of the IUD and took pills for several months only. Now I do not use any method*." – FP Discontinuer aged over 25

"*My wife was using pills because it is affordable for my family, but later on, her legs were paralysed and she could not walk. It took lots of money to cure this.*" – Married man

"*One of my close relatives used an IUD as her spacing method. As result, she had vaginal bleeding and this caused a serious health problem for her until she died. As for my family and relatives, we will never again use IUDs.*" **–** Married man

"*Based on my experiences, I observed that some of my young FP clients have become infertile after they used the modern methods for two or so years, especially for those who had not yet had a baby.*" – Family planning service provider

d. Informed choice

Based on FGDs and in depth interviews, it appears that decision-making on the use of FP methods very often starts at home. Typically the couple gathers information from relatives, friends, mass media, and sometimes from health care providers living in the same community.

Thus, some steps of the decision-making process have already been taken before the client arrives for consultation on FP. The women in the group discussion revealed that they have many times chosen a method before they came to see the health care provider.

"*I talked with my husband that I intended to use an IUD. So during the family planning consultation, the provider told me about the different methods*. *Then I chose IUD*." – IUD Discontinuer aged over 25.

"*When clients come for family planning services, I inform them at the counselling session of all methods which are available in this health facility. Then they decide the most preferred method."* – Family planning service provider

e. Cultural acceptance

The health care providers said that women can use any type of short-term or long-term method without the husband's consent, except for female sterilisation which does require the spouse's consent.

The consent is in writing and signed by the couple, both the husband and the wife. The discussion also raised a range of questions related to the cultural

acceptance of FP practices in the community. The findings are highlighted in the following description.

f. Role of media and community promotional activity

As revealed by the participants, women and men also learn the appropriate message on FP services through various media, including TV, radio spots and promotional activities in their communities. Some local organisations also play important roles in providing information and knowledge on birth spacing methods through their activities, such as 'edutainment.' These kinds of activities can improve the acceptance of the use of FP, however, as stated by the participants, these kinds of activities were still limited.

"*TV channels and local theatre is the most popular media to promote family planning methods. We can see and hear about condoms, pills, IUDs and so on*." – Married man

"*Health care providers came to promote family planning in the community. It was a promotional activity. We can have the services free of charge in the health centre. As a result many women in this community got the services*." – Married woman under 25

g. Interpersonal Channel

Normally rural people learn about the different types of FP information from trusted persons, including their friends, neighbours, and relatives. Participants in the FGDs also suggested that they tended to believe what those people tell them, including rumours.

"*A guy said that he often heard his grandmother advise her young granddaughters to not use the methods (pills or injectable) because their physical strength could not endure the side effects of the drugs. But for himself, he can use it instead of his wife, using either condoms or withdrawal.*" – Young married man

h. Role of religious beliefs and culture

Cambodia is predominantly a Buddhist country, and Cambodians generally respect the laws of Buddhism. There are 3,731 pagodas in the country and at least, half of them are located in rural areas. Each pagoda has around 200-500 families who are its followers.

The revitalisation of Buddhism in Cambodia provides multiple opportunities to support reproductive health and rights, including HIV prevention, in impoverished communities still struggling with the traumas of the recent past.[25] As discussed by the participants during the FGDs and personal interviews, religion plays little or no role in using any method of FP.

"*We adhere to Buddhism; the head of the pagoda or religious leader in our community has not said anything about birth spacing*." – Married woman over 25

iii. Interview results

All young women interviewed were able to identify a range of modern methods of contraception, including short-term and long-term methods. The common fears expressed by young women were around the side-effects of these methods, especially regarding possible infertility, delayed fertility return after discontinuation and other types of health concerns. Misconceptions were common among the young women interviewed and appeared to be propagated by the key figures in their community; for example, husbands, mothers, relatives, older women, women who experienced side effects and health care providers.

Through the analysis of the interviews with women, it appears that the husband is the most important person in making decisions on the use/non use of contraceptive methods. Reportedly, young married couples discuss contraceptive use; most often women consider the husband to be the decision-maker since he is responsible for the finances of the new family. In this study, we discovered that the young married women, who are not using FP, most often reported that men were the ones who enforced the fear of side effects on women. The idea of a gender hierarchy which establishes that men are superior to women in the decision-making process is perceived by most women; tradition obliges women to remain obedient to their husbands.[26]

"*My husband advised me that I should not use any method…He told me about the side effects*." – A pregnant woman aged 19 years

The other key sources of influence upon women's decisions around FP were identified as the older persons in the family. In Cambodian society, the oldest person in the family, for instance, the mother or mother-in-law, can typically direct significant parts of the decision-making in the woman's family. From discussions with young pregnant women, we found that their mothers-in-law or older sisters often warned them against the use of modern contraceptive methods, due to fear of side effects.

Women reported that if they experienced difficult side effects, it would become a cause of concern not only for the husband, who would need to bear the cost of medication or treatment associated with the

side effects, but also for the other family members and relatives.

"*I cannot make the decision by myself because my mother and mother-in-law told me about the side effects and I just got married only eight months ago. I will not use any method; I will wait till after the first or second child*." – Pregnant woman aged 23 years

The other main barrier regarding the use of contraceptive methods among interviewed women was the experiences cited by other women, the infertility problem among women in their community, and misconceptions provided by health care providers who are deemed to be knowledgeable persons in the community. These factors strengthen the women's belief in the popular myths related to contraceptive use.

"*I see a woman who cannot get pregnant in this community…also I was told by a health provider in the referral hospital that newly married women should not use any modern method.*" – Non-user of FP aged 23 years

"*I heard that a woman developed a tumour in her uterus after using FP. Thus, I decided not to use any method*." – Non-user of FP aged 24 years

The interviewed women stated that fertility after marriage is a vital attribute of their femininity. Women face the threat of divorce from their husbands if the problem of infertility arises. Through discussions with older women, it was made known that infertility is a woman's problem. Most often, it leads to marital conflict, including disputes, extramarital relationships and divorce.

"*I am afraid of [the] inability to conceive…My husband would take another woman if I cannot bear children. I see this happen in this community, the man left his wife to remarry with another woman and the first wife was abandoned.. It is a shame for women. All women want to have a family with only one wife and one husband*." – Mother of 2 children, aged 22 years

V. DISCUSSION

Large proportions of babies born in Cambodia are unplanned, and sometimes, are unwelcome. Women and men have the right to access contraceptive counselling and provision in this country. The development goals of the country highlight the need for increasing contraceptive use, and the particular demographic pattern after the genocide in the 1970s further underlines this need. The current study sheds some light on the bottlenecks to more widespread contraceptive usage. In principle, knowledge and perceptions among the general public, and among health staff, is one major bottleneck. Underlying this issue is the under-funding for contraceptive care and for providing correct information.

This study also reflects how family members (husbands, mothers and other relatives) impose their fear of side effects on young women and thus, influence their decision-making, especially around FP prior to a woman's first pregnancy. However, women in both the young and old age groups generally suggested that the use of modern contraceptive methods is appropriate for those who already have one or two children. The main misconception and fear affecting women's decisions on FP is the perceived risk of infertility, especially by the younger group. This is because infertility in couples often leads to marital conflict. Inability to conceive typically brings shame to a woman's honour and status. Misinformation about the side effects of FP, thus, impedes women's abilities to effectively use FP, especially young women.

A major challenge is, therefore, to meet the need for proper counselling and follow up; to correct misconceptions, and to address fears or concerns about contraceptives and their side effects; to provide knowledge in a clear, logical and client-focused way; and to instil confidence in the effectiveness and safety of modern contraceptive methods.

The mission of the MOH is to ensure equitable and high-quality health care for all people of Cambodia through targeting resources, especially to the poor and to areas of greatest need. The national health policy asserts that all people in Cambodia, regardless of gender, age, residence, or financial ability, should have access to good health care and information.

There are no parity-related restrictions, requirement for parental or spousal consent, prescription requirements, or other policies or restrictions that limit access or choice of contraceptives. However, the full range of FP service is still inaccessible to many Cambodians, since the FP activities of the public sector suffer from a lack of decentralisation of financial, technical and human resources. Currently, the client costs for contraceptives vary, paradoxically being least favourable for long-term methods, notably sterilisation. Our study somewhat contrasts with the MOH assessment in 2005, that noted financial concerns for the user influenced access to and choice of contraceptive method, notably long-term methods (IUD and female sterilisation).

The slight difference in results can be due to real changes since 2005 or due to differences in sample (rural/urban, mode of sampling). It could also be caused by the fact that disinterest in contraception

– in spite of not wishing to become pregnant – overshadows the actual constraints in real/financial access. The results merit further follow-up, e.g. by extra questions in the upcoming 2010 CDHS.

The recent 2008 census results[27] showed how Cambodia – with its characteristic population pyramid with a band, reflecting the Pol Pot genocide (Figure 1) – also reflected the decreasing fertility as evidenced by the narrowing base of the pyramid. The census report remarks how Cambodia is now at the beginning of a demographic transition as it is moving from a 'young population' to an 'intermediate age' population, and is already seeing a falling dependency rate – with fewer children to feed but not yet a big aging group.

The proportion of the population under 15 years of age fell from 42.8% in 1998 to 33.7% in 2008. This favourable period of lower dependency is usually called 'demographic bonus' and it comes once in the evolution of a country from low to middle/high income. Experiences from other countries have shown the national economic and development gains of trying to accelerate the entry into the 'demographic bonus period' and once it is occurring, it is used (i.e., for systematic efforts in the education field). Hence, there are economic arguments for increasing real access to contraception in Cambodia today.

Clearly, there are also health arguments. The desire for smaller families requires more and better contraceptive counselling and provision, otherwise many women/couples will resort to (unsafe) abortion. Many people want fewer children, but only a limited group can currently access the means to do so.

As shown, the costs of improved contraceptive counselling and provision are not out of the financial reach of the Government. For comparison, one can note how the national HIV and AIDS programme in 2006 expended 46.3 million USD, 6 million of which came from the national government.[28]

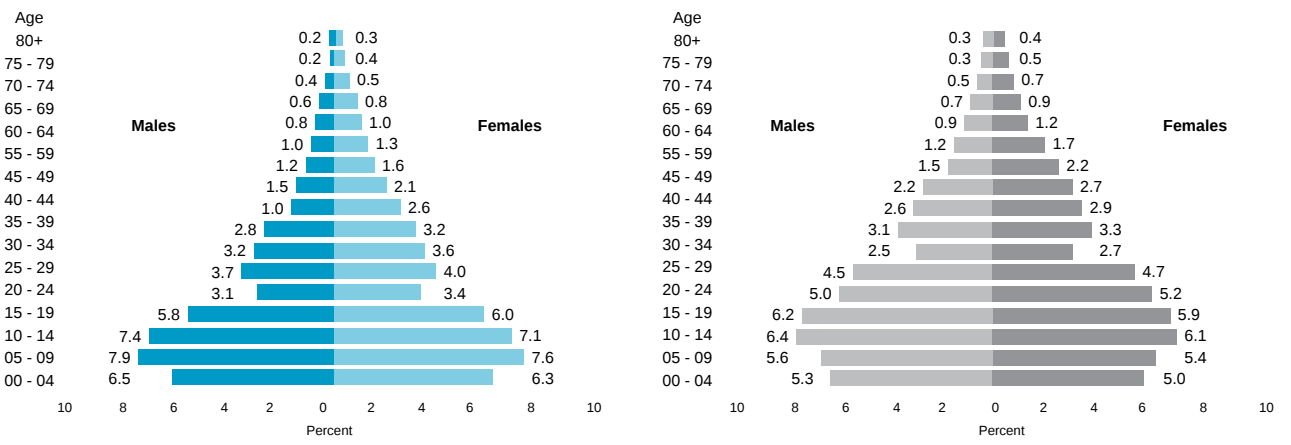
In comparison with other major government expenditures, an expanded budget for enhanced FP access and uptake in Cambodia in order to make motherhood safer is, therefore, feasible and realistic, especially, in this currently donor-favoured country. Right now, the country is facing a predicted decline in contraceptive availability and as the main donor of contraceptives, Germany (GTZ), has announced that it will end this support in 2013.

Instead, a *rising* government investment, reaching USD27 million annually in 2015 would help prevent at least 25% of maternal deaths, would help ensure the human and reproductive and sexual rights of married women and men – the right to access knowledge on and provision of modern contraceptive methods – and to move towards sustainable development for the nation.

VI. CONCLUSION AND RECOMMENDATIONS

This study found no obvious barriers to contraceptive uptake due to accessibility, affordability or informed choice. Instead, it found that the main barrier to using contraceptive methods among women, including young women, was the fear of side effects. The decision on the use of FP made by young women is usually heavily influenced by men/husbands, and other family members. It is therefore essential that husbands/influential persons become more involved

Figure 1: Population pyramid of Cambodia, 2008 census



Source: National Institute of Statistics. (2009). General Population Census of Cambodia 2008.Cambodia: National Institute of Statistics, Ministry of Planning.

in FP programmes, and also, in learning more about modern contraceptives.

Moreover, incorrect information from health providers unskilled in this field is a factor that can negatively influence the decision-making of the potential FP clients. The limited broadcasting time by mass media on contraceptives is also a crucial issue that can affect the right for access to information, for women and for men, and may limit their use of the methods.

Importantly, resource mobilisation is a priority to generate sufficient funds to support key reproductive and sexual health initiatives, to meet the ICPD goal of achieving universal access to reproductive health.

Recommendations

1. The MOH should provide continued education through contraceptive counselling and provision for birth spacing providers;
2. Mass media campaigns should be undertaken by MOH and Non-Governmental Organisations (NGOs) working in the FP field, to correct misconceptions among the general public, and among health care providers at large, regarding the characteristics and safety of modern contraceptive methods, thereby helping to reduce the social discrimination of women;
3. National research should be conducted by MOH and NGOs active in FP, in order to further investigate the barriers to access, the side effects and preferences among women of difference age groups in Cambodia; and
4. Development partners should continue to contribute to the reduction of maternal mortality by continuing to fund interventions which target access to contraceptive services, both through training of service providers, by increasing the overall number of service providers, and by continuing to invest in safe motherhood strategies.
5. In addition, partners should continue to promote safe motherhood from the primary level upwards, including FP and distribution of contraceptive commodities.

Endnotes

1 *UXO = unexploded ordnance, i.e., landmines and similar devices.*

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CHAPTER 3

DECENTRALISATION AND ITS IMPACT ON CONTRACEPTION ACCESS IN INDONESIA: A STUDY FROM BOGOR

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I. INTRODUCTION

Family Planning (FP) programmes have made important contributions to improving women's reproductive health, in reducing maternal mortality and in reducing poverty. Central to effective FP programmes is the ability to measure and evaluate the usefulness of current strategies and the ability to anticipate client needs. The ICPD (1994) PoA highlighted the role of decentralisation, recommending that governments should promote community participation and the empowerment of communities in reproductive health services by decentralising the management of health programmes. Decentralisation was seen as a means to enhance health system responsiveness to local needs, to improve health system performance and to increase access to sexual and reproductive health (SRH) services.

As a result of decentralisation processes in Indonesia from 1999 to 2004, FP no longer comes under the direct control of the Central Government's National Family Planning Coordinating Board (NFPCB), but is now part of the administrative apparatus controlled by local governments.

After 2004, the 'authority' for providing health and FP services was transferred to more than 400 'autonomous' local governments. However, while such an administrative arrangement is broadly in line with ICPD recommendations, it appears that in West Java, decentralisation has complicated the environment of FP programme implementation as well as efforts to understand the effectiveness of current FP strategies.

According to Hayes (2008), one reason for this is that the borders between politics and programmes in Indonesia remain unclear at the local level. Despite central government commitment to decentralisation, national politics continue to play an important role in the distribution of authorities. Priority setting of the programmes was decided by the local parliament which consists of political party members.

This has led to FP managers across different levels of local as well as national government now having to find ways to coordinate their activities with one another without the 'rules of the game' being clearly prescribed.

However, while such an outcome might at first be read as a negative consequence of 'incomplete decentralisation,' and it suggests that key FP management challenges could be rectified through a further clarification of the nature of decentralised authority, this paper argues that underlying structural problems of the Indonesian Family Planning system obviate attempts at further administrative reform, and will continue to hinder improvements to the quality of SRH services, especially FP. It suggests that both centralised and de-centralised FP programme and policies in Indonesia have lacked sophisticated gender analysis, and thus, have failed to adequately address the needs for contraception, particularly in regard to preventing unintended pregnancies.

In responding to this situation, this paper will explore different sets of issues regarding the implementation of the family planning programme in the Bogor District since the enactment of Decentralisation. Before we can attempt this, however, we must first understand the circumstances affecting the current FP conditions and contexts, and their immediate histories.

The Indonesian government's establishment of a National Family Planning Coordinating Board (NFPCB) in 1970 demonstrated that FP had become a priority. During the Soeharto regime (1970-1998), the FP programme in Indonesia was supported by high-level political commitment from various sectors in the country; not only in the bureaucracy, but also by parliamentarians, informal leaders and religious leaders.

The purported philosophy of the programme was to shift the "Values of Society," designed to manage fertility in Indonesia so as to achieve a "Balanced Population Growth" (BPG). By using a cultural and religious approach, the FP programme attempted to institutionalise new values in family life and family development. Slogans such as "small-happy-prosperous family norm" and "two children are enough – both boys and girls are equally preferred" were popularly promoted.

In the 1980s, the authority of the NFPCB was enlarged to include activities around "family welfare and empowerment." The NFPCB sought to address issues of family prosperity and resilience through activities aimed at empowering families with children less than five years of age. The NFPCB would train local cadres, who would then facilitate families to come together in their own communities to gain information on how to raise young children and discuss other family issues.

NFPCB had recruited more than 200,000 PLKB (FP fieldworkers) to assist with programme implementation in the field. Beside the FP fieldworkers, the NFPCB relied on large numbers of field volunteers, most of whom were recruited from local women's organisations (called the PKK - *Pembina Kesejahteraan Keluarga*).

These volunteers were trained by the NFPCB to promote FP by increasing the numbers of new FP acceptors, while at the same time distributing pills and condoms and conducting local research. The data collection effort culminated with the

establishment of a national Family Welfare Data System (*Pendataan Keluarga Sejahtera*) in the 1990s. Designed and run by NFPCB, the system consisted of detailed annual questioning of 'every' family in Indonesia to assess the levels of family resilience and prosperity.[1]

By 2004, the NFPCB had grown into a huge centralised bureaucracy with offices in every province, district and sub-district in the nation, and its Family Welfare Data System was the only listing of household economic conditions for most of the country.

The success of the NFPCB's centrally planned and researched FP strategies might be reflected by the fact that from 1970-2004, contraceptive use in Indonesia went up from around 5% to nearly 60%.[2]

However, political upheaval in the late 1990s in Indonesia significantly changed the contexts within which FP programmes were developed and understood. Following the fall of Soeharto in 1998, many policies of his regime, including the FP programme, were severely criticised. Earlier coercive mass-FP campaigns were widely condemned, and the civil servants involved in the campaigns were accused of violating the human rights of the people, in particular women's rights.

To avoid further abuses of centralised power in Indonesia, new policies aimed at decentralising authority from the central government were quickly enacted with the issuance of Law No. 22/1999 on Local Government (this law was later revised into Law No.32/2004) and Law No. 25/1999 on Budgetary Balance between the Central and Local government. During this time, the NFPCB also reformulated its vision from establishing 'small families' to 'quality families.'

The two laws marked a significant departure from the previous policies in Indonesia. Law No.22/1999 states that the basic policy of decentralisation is to authorise local government to take care and manage the needs of the local community according to their own needs, ability and aspirations.

In regard to FP, decentralisation was considered to create opportunities for communities to participate in local-level planning, decision making and monitoring of SRH services through involvement in community-level management teams. It has been argued that decentralisation presents advantages as well as disadvantages as shown in Table 16.

Since the early 1990s, FP clients in Indonesia have been increasingly shifting from public to private medical practice. According to the 2002/3 Indonesian Demographic and Health Survey (IDHS) report, the rate of private FP usage is 62.5%, up from 22.1% in 1991.

This trend in privatisation is broadly consistent with the objectives of the *KB Mandiri* policy ('self-reliant family planning'), which was first introduced in 1989 by the Soeharto regime. At that time, the targets of 'self-reliant family planning' were upper-middle class women. When implemented, the subsidised FP programme benefited the private practices and the upper-middle class women and left out access to services for the poor.

Table 17 shows that the trend of 'other private,' such as community health post (*posyandu*) and FP post, is declining sharply. According to Strauss, et al. (2004), the trend towards the private sector was accelerated by financial crisis. But it should be mentioned that understaffing and underfunding are always faced by the public sector. These will constantly pose a challenge since the health budget is still very low.[3]

Table 16: Decentralisation: Advantages and disadvantages

ADVANTAGES	DISADVANTAGES
1. Capacity to improve efficiency and quality of care. 2. Under certain conditions, it can ensure greater equity. 3. Increase responsiveness of the health system to local needs. 4. Develop service delivery innovation and local adoption of service. 5. Improve inter-sectoral coordination. 6. Matching health services closely to local needs and preferences would increase allocative efficiency and improve quality of services from the user's perspective. 7. Fewer levels of bureaucracy, greater knowledge of local needs and greater accountability may increase technical efficiency.	1. Local levels of government may not necessarily support national priorities, making the implementation of national policies and delivery of public goods difficult. 2. Existing shortages of skilled staff may be exacerbated following decentralisation because the same pool of skills has to be spread thinly across decentralised units. 3. Human resources are generally scarce in developing countries and this fact reduces the effectiveness of the reform process. 4. Lack of a global strategy and poor coordination at local level may negatively affect resource gaps between jurisdictions.

Table 17: Source of supply for modern contraceptive methods (1994, 1997, 2002/03)

Source	1991	1994	1997	2002/03
Public	51.2	48.6	43.0	28.0
Private Medical Practice	22.1	28.1	41.9	62.5
Other Private[a]	26.7	23.1	15.1	9.4[b]
Missing	0.0	0.0	0.1	0.1
Total	100.0	100.0	100.0	100.0

Source: Indonesian Demographic and Health Survey, 1991-2003.
aThis includes 'community sources,' namely posyandu and family planning posts.
bThis includes 1.9% 'Other' in the 'Other private' category, consistent with the definition of 'Other private' in 1994 and 1997.

Table 18: Health outcomes and trends in Indonesia

KEY INDICATORS	NATIONAL	WEST JAVA (IN 2005)
Total Population, 2009 (in millions)	220	39
Population Growth Rate, 2003	1.4%	1.8%
Population Density, 2003	109	1129
Urban Population, 2003	42%	59%
Population <15 years of age, 2003	31.6%	29.4%
Total Fertility Rate (TFR), 2005	2.4	2.8
Contraceptive Prevalence Rate (CPR), 2000	60.3%	57.5%
Pills	13.2%	27%
Injectables	27.8%	55%
Implants	4.3%	3%
Intra-Uterine Device (IUD)	6.2%	6%
Female Sterilisation	3.7%	1%
Male Sterilisation	0.4%	0.6%
Condom	0.9%	1%
Traditional or Natural Methods	3.8%	2%
Unmet Needs	8.6%	9.9%
Average age for first marriage, 2003	19 years	18 years
Average age for first births, 2003	21 years	19 years
Crude Births Rate (CBR), per 1,000 population	23	22.6
Early childbearing, <19 years	10.4	14.7
Infant Mortality Ratio (IMR)	47	44
Maternal Mortality Ratio (MMR)	307 or 420*	103 (highest in West Java)

* Most recent estimate is from 2005 using more accurate estimation methods (WHO et al., 2008).[6] This data point is not comparable with the earlier years because different methods were used to estimate mortality rates.

Source: WHO Indonesia Website.

II. RESEARCH METHODOLOGY

i. Research objectives

Since the inception of the 22/1999 Act followed by the 32/2004 Act on Local Government and Decentralisation, the policies on FP have undergone several changes. Some local governments remain strongly committed to limiting the population growth rate, while others have relaxed their control over their FP programmes.[4] Based on this fact, the objectives of this research are:

1. To observe the process of decentralisation and the implications of the FP programme in the research area;
2. To map health-seeking behaviour related to contraception needs; and
3. To observe the intersection between health facilities provided by the government and private practices in fulfilling the demand of contraception.

More specifically, the research questions are:

1. Does decentralisation really make the health system responsive to local needs, particularly the fulfillment of contraceptive needs?
2. How far does the process of privatisation which started in the early 1990s undermine the public health system in the Bogor District?
3. What are women's needs (particularly poor women) in relation to quality health care and FP services? What are their aspirations?
4. Does decentralisation make the SRH service more gender-sensitive? Which services (the public or private sector) fulfil women's FP/SRH needs and aspirations?
5. What type of mechanism is provided for free insertions of implants and IUDs? Are there any special insurance programmes for the poor? Are women facing failure with implants and IUDs getting 'back-up services' from the government?

ii. Research framework

The advantages and disadvantages of decentralisation for Sexual and Reproductive Health (SRH) services have not been well-evaluated in Indonesia so far. Thus, a study which looks at the current situation of FP programmes in a decentralised district is a challenge. Conditions and contexts of decentralisation may represent a challenge in ensuring the delivery of FP services.

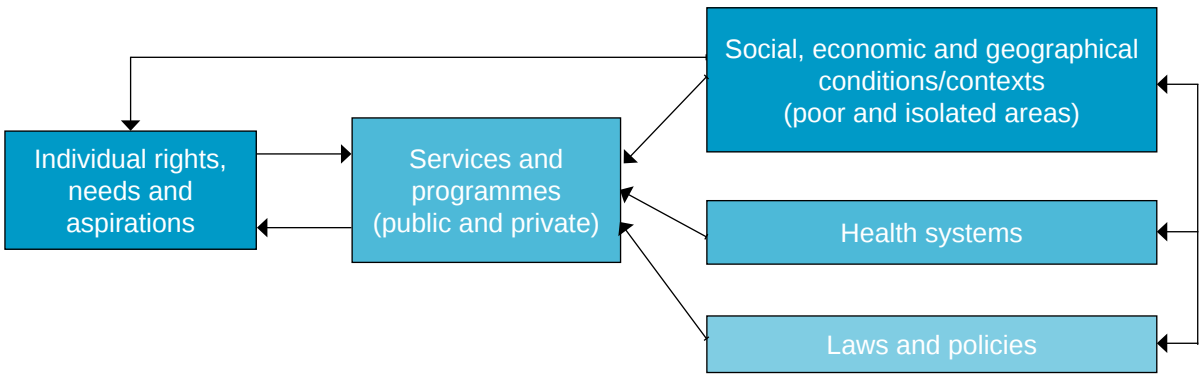
As mentioned earlier, FP managers across different levels of local as well as national government now have to find ways to coordinate their activities with one another without the 'rules of the game' being clearly prescribed (Hayes, 2008).[5] This means that the priority at the national level may differ from what has been implemented at the local level. This issue brings about the occurrence of variation in priority setting, budgeting and also in the staffing and FP performance at the local level. In addition, the borders between politics and programmes remain unclear at the local level. In other words, national politics continue to play an important role in priority setting to reduce MMR, but there is still a breakdown to relate to a process of strengthening an effective FP programme which can actually contribute to reducing the high number of MMR cases.

This study attempted to apply the framework shown in Figure 2:

a. Country context

Table 18 shows the country context in terms of health outcomes and trends in Indonesia.

Figure 2: Conceptual Framework



b. Study location

A single district of the Bogor municipality in the province of West Java (called *Kabupaten Bogor*) has been chosen as the research area. It was chosen based on a number of considerations:

1. The province of West Java is the second most populated province after East Java.
2. Of the 17 municipalities and nine cities located in the West Java province, Bogor Municipality is the most populated with 4,316,216 people.
3. In 2006, the Total Fertility Rate (TFR) of Bogor Municipality was the highest among all the municipalities and cities in West Java province. Respectively, the numbers of the three highest TFR in West Java are 2.8 in Bogor Municipality, 2.67 in Garut Municipality, and 2.64 in Bekasi; while nationally, it is 2.4.

Based on these factors, a single district of the Bogor Municipality has been chosen. Through a randomised sampling, Darmaga District was named the research area. Total FP acceptors in 2008 were stated: 10,769 acceptors and injectables were the most popular method of contraception (6,294 women used it). Pills were the second most popular method (used by 3,212 women). The rest of the women acceptors practised implants, IUD and sterilisation. Due to limited budget, the project team chose only five out of ten villages from the Bogor District. The five villages were located side by side at the West side of the Bogor District. Two of the five villages chosen as study sites are relatively isolated. They are situated far from the main road, which is the only road that leads to the farmer community.

The transportation cost to the public health centre is very high, making the reproductive health centre and other private practices inaccessible to poor women. One consequence of the remoteness of the villages and the high cost of transportation is that only 30% of birth deliveries are done with the help of a midwife; the rest are done by Traditional Birth Attendants (TBAs).

Table 19 shows that in four villages, poor households constitute at least 35% of all households, except in Bbk village, where only 21.6% of its households were classified as 'poor.' The classification of the households was made by NFPCB nationally, using 33 criteria (social and economic indicators).

In the study site, one public health centre was considered to provide services for the population of three villages (5,726 reproductive age couples), while one village midwife (who in the morning, works at a public health centre) is responsible for two villages.

iii. Research methodology

Considering the purposes of this study, a number of separate research activities were undertaken. These included gathering information and data on the effectiveness of reproductive health services, particularly in the form of accessible and affordable FP service for women. The research approach was a descriptive one, with both quantitative and qualitative analysis.

There are 10 villages in Darmaga District, but for this research five villages have been chosen in the study to represent all villages with various geographical conditions. The research sample was fixed at 500 reproductive age couples (PUS) scattered in all five villages, with a composition of 100 PUS per village. The sampling method made use of a random systematic order. A questionnaire was designed in order to interview the 500 respondents. The SPSS programme was used for the processing of all data gathered by 10 enumerators using the designed questionnaire.

In addition, five Focus Group Discussions (FGDs) were conducted. Four of these FGDs were held with local women's FP as clients, another one with health cadres and separately, with FP fieldworkers. One FGD was held with only men as participants in order to know their perceptions and practices in regard to FP programmes.

Table 19: Poor households in the five villages under study, 2008

VILLAGE	HOUSEHOLDS (ABSOLUTE NUMBERS)	POOR HOUSEHOLDS	
		(ABSOLUTE NUMBERS)	% (PERCENTAGE)
Cik	2020	778	38.51
Pet	2907	1077	37.04
Suk	2092	744	35.56
Pur	1573	484	30.76
Bbk	1848	400	21.64
TOTAL	10440	3483	(33.36)

Source: Annual Report on Population of the Bogor District Office, 2008.

In-depth interviews were also conducted, which involved 20 health providers from the government as well as the private sector. Observation was undertaken at some public health centres, private midwife practices and doctors' private practices. This sometimes led to interviews with providers around RH needs, such as:

1. FP problems,
2. how to keep continuing clients,
3. counselling on contraception and clients' sexuality problems, and
4. how to inform the clients about alternative FP methods.

III. FINDINGS AND DISCUSSION

This section covers the following points:

1. Decentralisation: Implications for the FP Programme
2. The Health-seeking Behaviour of Women in the Research Area
3. Do the Health Care Reforms Address Women's Needs and Rights?
4. Privatisation: How Far Does Private Practise Undermine the Public Health System?

i. Decentralisation: Implications for the FP programme

The data from the project survey in the five villages show that the total number of current FP acceptors is quite high at 73.8% compared to other West Java districts which are below 70%. Table 20 shows the survey findings based on interviews with 500 couples. Table 21 shows that most of the contraceptive supplies (except for injections) came from public health centres (PUSKESMAS). Unfortunately the annual report did not mention about the implants, which are regularly disbursed through a FP-mass campaign.

The project survey in the five villages also revealed the same picture as stated in the Annual Report on Population of the Bogor District Office, 2008. Table 22 shows that more women had been getting their contraception from the midwife private practice than from the PUSKESMAS.

The assistance during delivery in the study site still relied heavily on TBAs (38.0%) and midwives (51.1%), while 8.2% were helped by ob-gyn and 1.0% by general physicians. Surprisingly, 1.7% mentioned that they were assisted by relatives or others.

Given this situation, it is not surprising that most women who were assisted by a midwife (usually at their own practice) mentioned that with regard to FP matters they relied on the same midwife's private practices. However, many of them still felt that they did not get comprehensive education on FP from these midwives. Most respondents took the initiative to become FP acceptors as shown in Table 23.

Unmet need in the study area is very high, particularly among poor women who were determined not to get pregnant again but could not afford the high transportation cost to the PUSKESMAS. In turn, the PUSKESMAS staff never came to the community to disburse the needed contraceptives. When free service for inserting implants was organised, only certain 'elite' women received the service.

Based on observation and interviews, it can be seen that almost nothing has changed at the community level. For almost 25 years, women are better off remaining as active members of their community in organising health-related activities. Each month, a *posyandu* (a health post for under-5 children) opens in each neighbourhood and most under-5 children are brought to the *posyandu* for weighing. The only significant change to this practice emerged after May 2008 when pregnant mothers were also weighed. This is the result of a 2008 Decree from the District

Table 20: Being an FP acceptor (By village)

STATUS OF FAMILY PLANNING	VILLAGE					TOTAL
	BBK	CIK	PET	PUR	SUK	
Current FP acceptor	74	72	83	71	69	369
Have always been a FP acceptor	19	26	13	27	28	113
Have never been a FP acceptor	7	0	4	2	3	16
Others	0	2	0	0	0	2
Total	100	100	100	100	100	500

Source: Primary data from Project Survey, 2008

Table 21: Source of contraception (By type of contraceptives)

SOURCE OF CONTRACEPTION	TYPE OF CONTRACEPTIVES						TOTAL
	INJECTIONS	PILLS	IUD	CONDOMS	MOP*	MOW**	
PUSKESMAS	3200	2479	407	3	153	254	6496
Private	3855	882	263	-	5	-	5005
Total	7055	3361	670	3	158	254	11501

* Vasectomy
**Tubectomy
Source: Annual Report on Population of the Bogor District Office, 2008

Table 22: Source of contraception (By village)

SOURCE OF CONTRACEPTION	VILLAGES					TOTAL
	BBK	CIK	PET	PUR	SUK	
PUSKESMAS	1	59	34	14	15	123
Community Weighing Post	0	4	2	2	4	12
Health Cadres	1	2	1	3	1	8
Private Midwife Practice	70	30	39	53	47	239
Private Physician Practice	2	0	3	0	0	5
Private Hospital	2	1	1	0	0	4
Government Hospital	0	0	1	0	2	3
Other	24	4	19	28	31	106
Total	100	100	100	100	100	500

Source: Primary data from Project Survey, 2008

Table 23: The person who most influenced women in making the decision to become FP Acceptors (By village)

THE PERSON WHO INFLUENCED THE WOMEN	VILLAGES					TOTAL
	BBK	CIK	PET	PUR	SUK	
Her own initiative	59	65	79	56	64	323
Husband	12	12	6	24	2	56
Health Cadre	0	1	8	10	9	28
Midwife	2	4	2	7	5	20
Physician	0	0	0	0	2	2
Village head	0	2	1	0	0	3
Other	8	15	4	3	2	32
More than one answer	19	1	0	0	16	36
Total	100	100	100	100	100	500

Source: Primary data from Project Survey, 2008

Head which issued a directive that every *posyandu* should monitor the well-being of pregnant mothers (which includes their weight).

Despite this order, the *posyandu* were limited in their ability to achieve their objectives due to the fact that not all pregnant women came for weighing (based on interviews with some health cadres). This is because many of the poorer women had to continue working in the rice fields located far from the weighing post. In addition, the opening hours of the *posyandu* clashed with their working hours (9 a.m. to 11 a.m.). This is also true of PUSKESMAS which closes at 1 p.m. Besides, the 2008 Decree from the District Head did not include a mandate on promoting FP, which could have reduced the high maternal mortality incidence.

Although the policy of FP decentralisation was enacted more than five years ago, this system of FP fieldworkers and community volunteers (called health cadres) was expected to continue working as usual despite the number of FP fieldworkers which has decreased by half. After decentralisation, many of the FP fieldworkers, who are civil servants, were required to work for other units of the bureaucracy (often unrelated to FP matters). All FP fieldworkers who remained were male, while the health cadres in the community were mostly females.

Since decentralisation, a single FP fieldworker became responsible for two or three villages (covering a total of 14 kilometres from the village's centre). Poor infrastructure (especially poor roads) made their work very difficult. After decentralisation, motorcycles were no longer provided to FP fieldworkers though these were much needed transportations to reach some isolated villages. Below are the statements of two FP fieldworkers:

"Everything is still top-down, everything was dictated and instructed …at every monthly meeting we were instructed to reach a certain target of new FP acceptors … for example in neighbourhood A, the health cadre should get 11 women for implants and 8 IUDs … my work is dependent on the work of the health cadres who will recruit new FP acceptors from their neighbourhoods but only those who will use implants or IUDs." – Cipto, FP fieldworker, 43 years old

"The problem often faced by the health cadres when recruiting potential implants acceptor is … they often do not prefer the disadvantaged poor women, but approached first their own relatives or best friends who are not poor." – Kadir, FP fieldworker, 52 years old

The limited supply of implants dispersed every two months through the FP field workers was insufficient to fulfil the needs of FP acceptors. As said by the chief of the health cadre group of a neighbourhood:

"The number of free-of-charge implants … by the FP fieldworkers … were always limited ... many women who requested an implant could not get it … at the midwife private practice the implants are very expensive … it costs Rp. 200,000!" – Onih, health cadre, 44 years old

From the interview, it is known that the chiefs of the health cadre groups gave priority to their own relatives or close friends when disbursing free-of-charge implants. Indeed, the local government should be aware that in each village there is a hierarchy at every level. For every programme, the wealthy will take advantage of their position and take care of their own interests first.

Indeed, identifying the vulnerable and marginalised women is a very big challenge for all community-based work. Even when the poorest have been identified, they are often handicapped because they lack money to pay for the transportation fee needed to ferry them to distant district hospitals. Bogor District has no health facility that can perform vasectomy or tubectomy. Every six months, sterilisation is provided by an army hospital located next to Bogor District.

ii. Adjustment problems felt by local officials

Capacity-building and management training are prerequisites in the decentralisation process. These concepts, however, are not easily understood by local government officials who were made responsible for the FP programme after decentralisation. From interviews and FGDs with some of them, it is known that training for the FP fieldworkers was only conducted once during the 5-year decentralisation period. They were never trained on the topic of reproductive health and rights, how to take action to fulfil clients' needs in SRHR, or how to make decisions together and solve problems within the community. They were also not given the chance to learn about counselling or how to provide comprehensive FP information (including the effectiveness and side-effects of each method). One of them expressed his view as follows:

"Training is very important … almost four decades of centralised rule under Soeharto had an effect on people's ability to think critically. People could not think for themselves about their needs, did not know about their rights, or how to get organised on their own. Until now, the formation of women's group as health cadres was elitist. The rich/elite women in the village were considered as the leaders, but they often left out the disadvantaged women … the old system is still intact … nothing has changed except

less FP fieldworkers." – Local health official

Many FP executives at the local level (this also happened to the FP fieldworkers) have the notion that they do not need to report to the higher level (province and central) anymore. This was one of the reasons why the performance of FP programme implementation dropped.

Currently, the only opportunity to measure the performance of the FP fieldworkers is when they submit reports as a requirement for promotion. These reports describe the activities of the FP fieldworkers for a period of 6 months. Those who do not submit regular reports will have to wait longer for a promotion. This method of evaluation is executed by Bawasda, the only body which is responsible for supervising all sectors at the regional level. FP fieldworkers felt that this form of evaluation was inadequate and a local authority, who was interviewed, stated that the performance RH/FP programme could not be evaluated.

iii. The health-seeking behaviour of women in the research area

Several factors influenced the health-seeking behaviour of women. Many preferred to buy oral contraceptive pills over the counter. For injections, many went to midwives' private practices. Mass campaigns also influenced the decisions of women using implants and IUD. Though free-of-charge, very often they still experienced bad service.

Box 2 describes a case of mass campaign for tubectomy which shows that the government is not fulfilling the rights of freedom from coercion and violence (including malpractice). Although the woman was very disappointed, she still followed the advice of the doctor to use IUD. Two months later, she asked a private midwife to insert a 'guaranteed-5-year' IUD for Rp.350,000 (which is a third of her husband's salary).

For sterilisation, the government, in fact, has an allocation of Rp.300,000 for post-operative care. This amount is meant to cover any side-effects of the vasectomy or tubectomy. Unfortunately, nobody told her about the existing amount of funding for post-operative care. According to the health cadre who told us the story, ever since then it was very difficult to convince mothers to use IUDs. Once when the FP fieldworkers came to promote free-of-charge IUDs, only a few women turned up for the promotional campaign.

It seems that the FP fieldworkers had often asked the health cadres to help fulfil the needs of FP acceptors in the neighbourhood by supplying them with pills. The health cadres used to buy it over the counter from a pharmacist for Rp.1,500 per strip and sold it for Rp.2,500. The women were willing to pay for the pills since the transportation cost to the public health centre is Rp.20,000. It was also revealed that some traditional convenience stalls or herbalists in the more isolated neighbourhoods also sold oral contraceptive pills over the counter.

From several interviews, it is apparent that most women felt embarrassed showing their intimate organs to a health provider (even if, she is a midwife). This is one of the reasons why they use pills, injections or implants. No one told them that hormonal contraceptives would induce side effects on their body and affect their sexual life.

Box 2: Failure of sterilisation

One day, a 36-year-old woman, after having delivered three children, decided to undergo sterilisation at a programme organised by the authorities of the Bogor District. This sterilisation programme was targeted only at women and was organised three times a year.

Every time, 50-60 women were gathered using the neighbourhood structure.

They were told that the sterilisation services are free-of-charge. However, each woman must pay Rp.250,000 for the transportation cost.

This money was collected by the PKK. After getting permission from her husband who had filled in the consent form, she followed the coordinator of the programme in her neighbourhood to the place where the sterilisation would be done.

What happened? After the doctor performed the surgery, he could not find her tube since both were covered by fat layers.

She could hear the conversation between the health providers who were panicking.In the end, the doctor expressed his apologies to the woman for the unsuccessful sterilisation.

The woman told us that she was so disappointed since now she has big scars under her tummy. She never had these before though she had undergone three deliveries (all natural).

iv. Do the health care reforms address women's needs and rights?

The study shows that the demand for FP devices is high, although several interviews seem to suggest that the drop-out rate is also high. This high demand

Box 3: Unpopular IUDs

In one of the villages, IUD became unpopular ever since a story spread about a boy who was born with a tumour on his forehead. The boy's parents told everybody that the tumour was due to the IUD.

The woman could not understand how she became pregnant while using the IUD for several years. Due to the recession, they never brought the son (who was delivered by a TBA) to see the doctor for a medical check-up. When he was four-years old, the boy died.

Box 4: Health cadres should be role models

A health cadre from another village told us that the FP fieldworkers occasionally promoted IUDs, given away free. The health cadre would first insert the IUD inside an FP acceptor and weeks later her neighbours did the same. Two weeks later, 8 out of 10 women asked for the IUDs to be removed. The health cadre brought them to the health provider in to have the IUDs taken out. Due to this incident, IUDs became unpopular among women in several neighbourhoods.

for FP devices is partly due to the awareness of the women themselves, who preferred not to have many children since the cost of education for children is very high. This is expressed by one woman in an interview:

"I tried everything to avoid being pregnant again since I already have three children … education is very expensive … we cannot afford to have another child. I started using the pills when my first child was born … but when he was one-and-a-half years old, I got pregnant again because I forgot to take the pills regularly. After the second child was born I took the IUD, but after six months I asked the midwife to remove it because not only did my husband complain about the string he felt during intercourse, I also felt constant pain under my stomach when I work at the rice fields … I heard that if a woman has to work in the farming sector, IUD is not fit for them. Some months later, I tried injection as a FP method, but my menstruation did not stop the whole month … automatically I had problems with my sexual life … with my husband … so when the health cadre promoted implants, I used the opportunity to get the free three-yearly implant. After three years, I got pregnant again and after this third delivery I decided to have another implant … this time the five-yearly implant." – Ibu Susi, 35 years old

Box 5: Death due to unsafe abortion

Only some health cadres were willing to share the following story:

Nobody knew why the woman died suddenly after three days of high fever. After some weeks, the health cadre got to know that when the woman got pregnant, she was supposed to have gone for her next FP injection but had no money to visit a midwife. After discovering that she was pregnant, she went to a TBA to terminate her pregnancy. Unsafe abortion caused her death.

The data from the 500 respondents shows that almost 49.8% wished to stop having children but many of them, at the same time, were not using contraception, and 60% of them gave negative side-effects as reasons. This is an indication of a high unmet need. It seems that almost 90% of the women respondents had used at least one FP method, with 70% of them using at least pills or injections (please refer to Table 18).

Many women in the study stated that they tried very hard to space or limit their pregnancy. Despite this, both the public and private health facilities are mostly located at the only main road which is very far from their homes. It appears that many women who live far from the main road have no access to the public health centre since the only transportation is a motorcycle for rent at Rp.20,000 which is quite expensive (equivalent to the monthly tuition fee for two children).

v. Diversifying contraceptive methods

According to some midwives at the public health centre, the policy of diversifying contraceptive methods has already been implemented given that every month the supply of contraceptives (pills, condoms, injections and implants) is met.

The need for several methods of contraception was reported by the FP fieldworkers who got the information from the voluntary health cadres in each neighbourhood. The FP fieldworkers were still those who undertook the monthly report on the required contraceptives. Regarding diversifying contraceptive methods, it seems that the midwives already have

some understanding of the right to choose. In their own words:

"If a woman came to me first, I always asked her what type of contraceptives they prefer to have … After I had taken her blood pressure … and if it is high, she is obese and above 35 years old … then I advised her to use non-hormonal contraceptives such as IUD … but most women are very afraid of using IUDs … many rumours were spreading around … and most of them feel embarrassed to show their intimate organs to a stranger." – Midwife Ade, 30 years old

Another midwife, who was interviewed at her own practice, stated:

"Although I tried to explain almost all the methods, but still the ability of women to choose is limited … their understanding and awareness are still lacking. The choices they made were very often due to economic reasons … If free-of-charge implants were promoted in the neighbourhood … many of them would come to get the implants." – Local Midwife

The local women, especially those who belong to poor families, could only rely on the contraceptives methods, which were free of charge.

Through in-depth interviews, it is known that many women are not aware of the side effects of pills or injections on their bodies. In the words of one of the women:

"My neighbours and I had tried every FP method … pills, one-monthly injection, three-monthly injection, IUD … some of us even inserted implants … the midwives never explained to us why the one-monthly injection made my menstruation never stop, while the three monthly injection gave me a regular period …and so we just tried every method. According to Islamic teaching, intercourse is forbidden if a woman is menstruating, even just a spot of blood … irregular menstruation complicated my sexual life." – Ibu Ade, health cadre in Bbk, 43 years old

It is apparent that the right of the women and men to received accurate information on all the contraceptive methods and its side effects was not fulfilled by the local government. Actually, the FP fieldworkers should be responsible for providing information to those concerned. However, all of them are males and sexuality and reproductive health topics are mostly sensitive, difficult to discuss and considered separate for males and females. From several in-depth interviews, it is known that the local women had difficulties discussing SRH issues with the male FP fieldworkers.

Many women receive inaccurate information on SRH from their relatives and neighbours. For those who were assisted by TBAs during delivery, they received inaccurate information on SRH from these TBAs.

According to some health cadres, the FP failure in the study site is quite high which resulted in many cases of unwanted pregnancy.

According to them, incomplete understanding of methods resulted in FP failure. In terms of educating women, they were seldom provided with health information, especially when it comes to FP.

Information about FP (such as contraceptive methods, their side effects and usage) was provided to a certain extent by the health cadre. However, the health cadres were trained in reproductive health a long time ago (ten years ago), which means that the quality of information provided is no longer accurate and is often outdated.

Through several FGDs, it was revealed that emergency pills were not known according to the study conducted. This is actually contrary to the women's right to be informed on the latest SRH technology.

Table 24: Respondent's wish to have or not have another child (By village)

WISH TO HAVE ANOTHER CHILD	VILLAGE					TOTAL
	BBK	CIK	PET	PUR	SUK	
Yes	48	34	38	36	47	203
No, I wish to stop	43	59	47	51	49	249
It depends on my husband/wife	0	2	3	2	2	9
It depends on God's will	6	5	12	11	1	35
Other	3	0	0	0	1	4
Total	100	100	100	100	100	500

Source: Primary data frm Project Survey, 2008

When asked about it, some of the midwives answered:

"We are afraid that people, in particular the adolescents, will misuse it … it is against morality."

Their sexual lives should also be analysed since many couples in this study seem to have married at least twice. From the existing literature, it is known that this is the cultural norm in West Java Province. Talking about sexuality is not a taboo among them. One reason why the first marriage often ends in a divorce is because the community still practises arranged marriage.

The study shows that many got married when they were still under 16 years of age. Indeed, the Indonesian Marriage Law (dated from 1974) prescribes the minimum legal age for marriage to be 16 for women and 19 for men. Of course, there has been a substantial increase in the age of marriage over the years, but in this study, the median age at first marriage is still 18 years of age. Besides, teenage-married mothers contribute a total of 35% to the findings.

Table 26 shows that 34.6% of the respondents got married for the first time between the ages of 12-18 years. Evidently, a big part of those categorised in age group 26-32 years and 33-39 years married twice.

A question in the questionnaire about unwanted pregnancy and decisions around abortion received no answer. It seems that nobody is prepared to answer this type of question. The question is considered very sensitive. But through another question, we succeeded in getting a picture on the number of stillbirth experienced by couples interviewed. In total, 50 couples had experienced stillbirth.

Table 27 shows that the 3rd, 4th, 5th and above 5th pregnancy ended with stillbirth which is quite high (around 9.6%). This may be due, in part, to termination of the pregnancy by commonly available abortifacient herbs.

Male FP acceptors are still low (around 1.79%). This is very low compared to participation of women. According to Disdukcapil,[7] FP programmes and policy should be directed towards men, not just as supporters of FP but also as acceptors.

FP methods for men are limited to condoms and male sterilisation. The low level of male participation derives mainly from cultural factors involving the perception that FP is a matter for women. From an FGD in which only men participated, it is known that a lot of men do not want vasectomies because they are afraid that it will reduce their male sexual functions.

There is this view that "if you are not able to father a child, you are not a true male." The limited use of condoms derives from psychological factors and also the feeling that condoms are not practical. From the dialogue between male participants in the FGD, it was revealed that the FP fieldworkers seldom approached and/or encouraged the husbands to be active acceptors.

vi. Privatisation: How far does private practice undermine the public health system?

The trend towards privatisation started at the end of the 1980s and expanded in the early years of the 1990s. At that time, the direction of the population policy was changing as a result of globalisation, structural adjustment policy and the 'graduation policy,' which show declining donor support.

Table 25: Marriage and childbearing in Indonesia and at the study site (2007/2008)

FACTS ABOUT MARRIAGE AND CHILDBEARING	NATIONAL	STUDY SITE
Median age at first marriage*	20.2 years	18 years
Median age at first birth*	21.9 years	19 years
Percent of TFR attributed to birth by ages 15 – 19	11%	N.A
Percent of birth to women <20 attend by skilled personnel**	58%	40%
Teenage married mothers	10%***	35%

* Taken only from ages 25 – 29.
** If not attended by skilled personnel, many still delivered with the help of Traditional Birth Attendants (TBAs).
*** Percentage of women aged 15 - 19 years who began bearing children in 2002/2003 IDHS.
Source: Primary data from Project Survey, 2008

Table 26: Respondent's age during first marriage (By village)

AGE DURING FIRST MARRIAGE	VILLAGE					TOTAL
	BBK	CIK	PET	PUR	SUK	
<12	0	0	0	0	1	1
12 - 18	10	37	51	44	31	173
19 - 25	72	55	42	48	54	271
26 - 32	18	8	7	7	12	52
33 - 39	0	0	0	1	2	3
Total	100	100	100	100	100	500

Source: Primary data from Project Survey, 2008

Table 27: Number of stillbirth/s according to the respondents' number of children

RESPONDENT'S NUMBER OF CHILDREN	THE CONDITION OF THE NEWBORN		
	STILLBIRTH	BORN HEALTHY	TOTAL
0	1	0	0
1	1	80	81
2	7	162	169
3	17	105	122
4	12	45	57
>=5	12	59	71
Total	50	450	500

Source: Primary data from Project Survey, 2008

These reforms were premised on the Government cutting subsidies, including health and family planning. The reforms in the 1990s started with the opening of semi-private FP clinics which were supposed to become increasingly self-reliant. This chain of FP clinics targeted the middle-class women who were considered as self-reliant clients. This category of women was willing to pay for the FP devices and services. Since Indonesia is still understaffed in terms of medical and paramedic personnel, several midwives from the public health centres were contracted to manage the FP clinics. In addition to this, some people in several communities were trained for the social marketing of some contraceptive methods.

For some years, a private distribution network was established to sell pills and condoms to the women in the community. However, the distribution network lasted for only a short period of time. It disappeared when the donor stopped their support. Today, FP pills can be bought over the counter at many pharmacists, traditional convenience stalls (*warung*), or herbal stalls at the study site.

NFPCB is not the only institution undergoing structural adjustment policy. The Ministry of Health (MOH) is opening more doors for doctors and private midwife practices. The number of private practitioners, both doctors and midwives, has grown, with a total of 9,866 private doctor practices and 36,172 private midwife practices. Most of them are also government personnel who supplement their incomes by running a private practice in the evening.

Almost every midwife who has her own private practice is a member of the Indonesian Midwife Association. This association for midwives is a very strong one and regularly conducts training for quality assurance. Upon completing all competency tests, a midwife's private practice is officially registered and is supposed to run according to *bidan delima* (high competency) operational standards. Unfortunately, these *bidan delima* who provide health services at the public health centre (including FP) do not deliver the same high standards there as the services provided at their own practice. One of the board members of this midwife organisation has this to say about the inconsistency of services provided:

"We felt always that we as midwives were treated badly by the doctors at the public health centres, as

well as at the district hospitals … Every day we need to take care of the patients who come to the public health centre since the doctors were not always there. However, they always restrict our authority and consider us as "second degree" citizens. It is better to concentrate on our own practice because if we give high quality services, the women will follow us and come to our own practices … our midwife organisation which has 54,000 members conducts regular training for increasing the quality of services … once a midwife graduates from this training, and after her practice has been evaluated, she will be certified as bidan delima*."* – Midwife

Box 6: Death during delivery of twin babies

Ani, 38, died one hour after delivering her twin babies in May 2008. Her husband came from a poor peasant family and their house is located very deep in a valley and far from the main road.

For several years, she relied on the FP pills which she bought from a health cadre, but once she forgot to take it and subsequently became pregnant. During her pregnancy, she only experienced antenatal care once at the public health centre – at about 12 weeks – but nobody told her of her potential to carry twins.

When the process of labour started, her husband asked a TBA from the same ward to help her. After several hours of labour, she was moved using a truck and, after almost 40 minutes of driving on a damaged road, she reached a midwife practice.

Though she could have reached a nearer midwife practice (which was also a private practice), the family decided not to do so because of high tariffs. Though the midwife tried hard to help Ani, she died one hour after delivering a pair of healthy twins.

According to Hayes (2008), the precise details are complicated because the public-private distinction in Indonesia is not clear-cut with many private practitioners also working in the public sector.[8] Lubis' study in 2003 investigated the self-reliance of the private sector and how much it relies on indirect or hidden government subsidies, for example, the 'leakage' of subsidised FP commodities from the public sector to the private practices.[9]

Table 28 shows the FP commodities at the study were distributed not only to the poor women but also to the middle and upper class women (according to the monthly district report for January 2008).[10] Box 6 presents a case study story taken from several interviews and FGDs. In this case study, it is clear that Ani's health-seeking behaviour was influenced by the decision of others (husband, mother-in-law and the neighbours) and economic factors. The family brought the woman in labour to a distant midwife practice and had to go through a heavily damaged road for almost 40 minutes to reach a midwife practice known to offer a special low tariff for poor women.

When questioned by the local health cadre as to why he had brought his wife to this distant midwife when another midwife practice was located only 25 minutes away from his home, the husband answered:

"We are very afraid of the high tariff … everybody here knows that she is very expensive … we did not know about the special letter to get discounts for the delivery at the public health centre … and we had no time to arrange it." – Ani's Husband

This case study illustrates at least two failures in the FP programming. Had the mother gone regularly for antenatal care, she would have known that she was expecting twin babies and would have delivered at a hospital.

However, during the difficult labour, the couple perceived that such an option remained too expensive for them to consider. Because they had no access to antenatal care during the pregnancy, the system of getting a special letter from the sub-district head was not known to Ani or her husband.

IV. CONCLUSION AND RECOMMENDATIONS

i. Conclusion

The ICPD Programme of Action highlighted the role of decentralisation, recommending that the government should promote community participation and the empowerment of communities in reproductive health services by decentralising the management of health programmes.

Decentralisation was seen as a means of enhancing health system responsiveness to local needs and health system performance. Decentralisation was expected to function as a tool for improving access to SRH services.

The premise to build a new local infrastructure which could address local needs and constraints as well as to bring the gender-sensitive RH/FP services closer to the community has not yet become a reality.

Table 28: The FP commodities disbursed according to types of household (By government or private practices)

		TYPES OF HOUSEHOLD			
FP METHODS	POOR	MIDDLE CLASS	UPPER CLASS		TOTAL
	Govt*	70	104	233	407
IUD	Private	1	14	246	261
	Govt	57	99	81	237
MOW	Private	-	-	-	-
	Govt	30	62	61	153
MOP	Private	-	-	5	5
	Govt	23	70	40	133
Implant	Private	-	-	1	1
	Govt	1182	915	713	2816
Injection	Private	101	595	3118	3816
	Govt	1905	352	90	2347
Pill	Private	14	66	771	815
	Govt	2	1	NA	3
Condom	Private	NA	NA	NA	NA

Note: Govt = Government
Source: Periodical Report on FP commodities, January 2008

The questions for this study were:

1. Does decentralisation really make the health system responsive to local needs, particularly the fulfilment of women's contraceptive needs?
2. Does decentralisation make SRH services more gender-sensitive?

From the data collected from the Bogor District it can be concluded that decentralisation does not make the quality of SRH services better. During this transitional period, the underlying structural problems of the FP system were never reviewed to make it more gender-sensitive in addressing the needs for contraception (in particular, the need to prevent unwanted pregnancies). During 2004-2007, the total number of medical and paramedical personnel was still not calculated. According to the PUSKESMAS Workforce Guideline,[11] there should be at least 78 health personnel. Currently, there are 45 health personnel and since 2007, there were no labourants at any of the PUSKESMAS in the Bogor District. Indeed, decentralisation in the Bogor District presents special challenges to FP programmes.

There are a range of problems with the current FP programme, governance and recruitment systems in Bogor. The old system for recruiting new potential FP acceptors, which relies on the voluntary health cadres in the community, remains in use. Understaffing of the FP fieldworkers is alarming; new FP fieldworkers cannot be recruited while half of them are pensioners. The FP programme is still not integrated fully in a comprehensive SRHR programme which still does not exist at the Public Health Centres. Besides, the local government hospital still organises SRH programmes vertically. Currently, FP programmes have to compete for funds with other priorities at the district level. Indeed, in May 2008, there was a decree enacted by the District Head with the aim of reducing the high MMR, but the decree never mentioned the importance of FP programmes which actually can reduce the incidence of maternal mortality if the overall number of pregnancies is reduced.

The FP programme should be seen as one component of a comprehensive SRHR programme and services which should be implemented based on a rights-based framework. It is obvious that almost all bureaucrats at the Bogor district still have no clear understanding of the rights-based framework in implementing comprehensive SRH services and do not see the correlation between an effective FP programme and reducing MMR.

It seems that the Bogor District policy on population after decentralisation is not clear and leaves it up to the women themselves to use the existing structure as given by the central NFPCB. In the first years after decentralisation was enacted, FP programmes became part of the district civil registration office which is under the Ministry of Interior Affairs. After five years, a Bureau on Women's Empowerment was established and FP programmes were moved

under the supervision of the head of this bureau. Uncertainty in regard to their positions made the FP fieldworkers' situations not optimal. Besides, they said the contraceptive supply became irregular. In the first three years after decentralisation, the NFPCB still supplied the contraceptive but it gradually decreased after five years. It was thought that the needed contraceptive will be supplied by the fund from the local government treasury. Since the local government budget must be endorsed by the district parliament (whose members did not see FP programmes as a priority), the allocated budget for FP programmes is relatively low.

It seems that local decision-makers very often do not prioritise contraception largely because they believe that contraceptives should be the individual's responsibility and not the state's.

According to them, FP should be about self-reliance. Besides, certain characteristics of authorities influence local decisions about supporting SRH services at the local level, especially those who are non-health elected leaders or conservatives who do not see the importance of FP.

Moreover, following decentralisation, lack of clarity on how different bodies relate to each other for implementing SRH services and FP programmes was also observed. Unfortunately, several district health authorities emerged as significant impediments to the effective implementation of SRH services and FP programmes.

Commodity flows, procurement and disbursal of supplies became a problem. Before decentralisation, NFPCB supplied all the contraceptive methods. Currently, the FP authority at the Bogor District still receive some contraceptive supplies from NFPCB which are stored in a special warehouse, while the rest are bought using the local treasury fund. The supplies are bought from the free-market. This would affect, among other things, the availability of contraceptives and essential drugs for SRH needs. The type of contraceptive which are bought depends on the priority of the FP authorities.

The monthly district meeting at the district office is still used as a forum to monitor the notification activities for collecting data on maternal deaths as mandated by the new Decree of the district head. This is again the same mechanism used during the Soeharto era for 25 years to gather all the potential FP acceptors in the neighbourhood. Currently, the FP fieldworkers are using the monthly district meeting which invites all *Posyandu* health cadres to help them recruit new acceptors for a certain method, once a month for implants and once every three months for sterilisation.

Currently, decisions on the supply of contraceptives are left to the judgement of the FP fieldworkers and are presented during monthly meetings at the district office. Based only on irregular meetings with other health cadres, a FP fieldworker will make his own judgment about the required contraceptives. In other cases, he will simply accept all the supply given by the agency which is responsible for the contraceptive supplies. This agency will send the supplies to the public health centre, which in turn will distribute them to the village midwife or use it for FP mass campaigns.

Unreliable reports on the demand for certain contraceptive methods will have an impact on the fulfilment of high unmet needs, such as the cases of women who preferred to use implants but could not get it. The Public Health Centres still targeted FP acceptors according to types of contraceptive.

Some women who had undergone sterilisation or experienced an insertion of implants or IUD were unsatisfied with the performance of the doctors or midwives. In the absence of a mechanism to file complaints, most of the women who actually faced malpractice end up having their rights undefended.

No government or local institution is responsible for dealing with the impact of malpractice on women during sterilisation or insertion of implants. It seems that there is no state or local government regulation that controls the activities and performance of doctors and midwives, particularly on the end result of sterilisation, IUD or implants provided during a mass FP campaign programme in the study site.

The regulation and control on standard of care and performance is a government responsibility. According to a FP fieldworker, nobody will control their performance if they were working at a Public Hospital or Public Health Centre.

Assessment of care regarding FP programmes was never conducted. There is no specific institution that was responsible for the monitoring and evaluation of the implementation of FP programmes at the Public Health Centre or at other FP mass-campaign programmes, which were organised and implemented beyond the PUSKESMAS structure.

The need for new policy-making strategies concerning protection for women from malpractice when accessing FP services should be fulfilled. It seems that the government is reluctant to control the performance of the medical profession. Control over private midwife practices was conducted only by the midwife association but it is only limited to the registration status of their practice.

Certain measures should be implemented by the government to maintain at least minimum standards for the FP programme. In the Bogor District,

BAWASDA is the only institution which monitors all government implementing agencies, and even then only the administrative aspects and not the quality of SRHR services.

The quality care of the PUSKESMAS should be valued based on two indicators, namely:

1. The compliance rate, which measures steps taken by a health provider according to the standard operational procedure; and
2. Client's satisfaction.

It is also difficult to monitor the quality of care given by the private sector. Private medical practices often do not prescribe follow-up services since clients typically pay cash for a service and the doctor/midwife no longer feels responsible for subsequent problems, such as in cases of tubectomy or vasectomy failure which results in unwanted pregnancies.

Currently, the doctor/midwife cannot be blamed for contraceptive failure. Besides, there is no proper referral system among the private practices or between private practices and the public health sector. There is also no health insurance for poor women.

The 'revitalised' FP programme which was launched two years ago by the NFPCB attracted significant criticism due to the fact that it does not address the new demographic realities of today and tomorrow as mentioned in Hayes (2008) and Hull (2008).[12]

Currently, the FP programme managers work independently of each other, working on separate programmes such as the ARH programme, Under-5 children programme and others. There is no holistic SRHR framework to refer to in the event of FP failure or to solicit for special back-up funding. Due to the lack of an overarching administrative system responsible for FP, local FP providers were never held accountable for FP services performed.

ii. Recommendations

a. Government

1. There is an urgent need to change the outdated existing Health Law No.23/1992 and Law No. 10/1992 on Population and Prosperous Family.
2. The newly drafted law on health which was jointly prepared by women's NGOs and parliamentarians since the year 2000 should be enacted. By having a new Health Law which defends women's SRH rights, the government is obliged to provide high quality, gender-sensitive women's reproductive health services aimed at fulfilling all specific health needs of women. The new Health Law should guarantee women's rights to decide freely about their sexuality and fertility, and their right to be accurately informed, while assuring them of the availability of contraceptives and free access to FP services and methods for the economically poor women and men.
3. To enhance and strengthen the capacity and competency of the health personnel by investing more in the public health centres. For the clients' convenience, opening hours of the PUSKESMAS should not be limited up to 1p.m. in the afternoon.

b. Local government

The scenario at the Bogor District should be characterised by:

- a strong political commitment to FP;
- adequate resource allocation;
- development of unified SRHR programmes with a rights-based framework, and
- investment in the health workforce.

The cornerstones of this approach will include:

- strong community involvement (including strategic networks and alliances);
- good mechanism for filing complaints; and
- excellent FP rehabilitation services.

1. Unfortunately, this is not always understood by the politicians in the Bogor District since they tend to prioritise physical investments which have a direct impact on the local revenues than investing in social development.
2. With more than 4 million people and with a TFR of 2.89 in Bogor District, prioritising FP programmes is a must. Currently, the reason why FP is not prioritised is because it will not contribute to the local government revenues. The local government should change their paradigm, because effective FP programmes can reduce the high MMR in Bogor District.
3. FP programmes should be integrated by using the District Head Decree to accelerate the quality of MCH with the aim of reducing MMR, because effective FP will reduce unwanted pregnancies and in turn will lower the number of unsafe abortions.
4. Women's perspectives need to be factored into local planning to fulfil women's SRHR. Local planning should be guided by MMR and IMR (Hull, 2008).[13] By reporting all maternal and infant mortality cases, the causes of mortality will be known. In turn, direct action in overcoming barriers for providing specific services (such as safe abortion and other much needed SRH

services) can be effectively implemented. The effort to reduce the high MMR (the highest in the West Java Province) should be framed according to a human rights framework, which involves using a holistic strategy which aims to fulfil effective FP. If people were able to have the number of children they wanted at the times they choose, an estimated 25-40% of maternal deaths could be averted, the number of abortions would be reduced, and the health of women would improved.

5. Long term investments in human capital are of great importance, and basic social services such as education and health (including FP) need to be prioritised as a prerequisite for advancement of a nation.
6. Increase the number of new female FP motivators who have high quality communication skills and good knowledge of SRHR (in particular FP in a rights-based framework). Good collaboration between the FP fieldworkers (FP motivators) and the village midwives should be initiated in order to serve the local women better.

c. District Head

1. The District Head should be responsible for the establishment and execution of the following activities:

- Integrating population issues into sustainable social-economic development.
- Implementing the FP programme in collaboration with the district health office in order to be part of a broader SRHR plan of action. The public health centre should not charge user fees for FP since more than 38% of the families in the four villages belong to poor families. The public health centre should be subsidised for SRHR services and not be forced to generate revenues for the District Treasury.
- Developing and implementing FP programmes as a component of SRHR programmes which use a rights-based framework. Public and private institutions in a sub-district should develop RH/FP strategies together in order to include every woman and man.
- Increasing SRHR services in poor, difficult, remote and isolated areas by introducing mobile teams, which come twice a month visiting the community at a suitable time (after working at the rice fields) to serve the male and female clients. Through this, the RH/FP services can be delivered to the community and wards (neighbourhoods).
- Developing human resources and enhancing the managerial capacity of FP staff or managers. The quality of counselling should be enhanced by training the staff on sexuality and human rights.
- Enhancing IEC activities for the purpose of changing reproductive behaviour.
- Organising and monitoring the implementation of the RH/FP services and establishing a mechanism for clients to file complaints in order to protect and fulfil their right to obtain RH/FP services of the highest quality.
- Promoting programmes on gender equity in reproductive health. By following programmes which involve both wife and husband, a couple will learn that SRHR is very important and understand that both of them should respect and protect each other from harmful diseases or side effects. Both would be aware that their FP rights are the responsibility of the state as duty bearer.
- Promoting male acceptors and involving them in peer education on SRHR organised by the community. The local women have yet to realise that to maintain good SRHR, their husbands' responsibility and involvement in this matter is important.

2. The one-year activity of notifying all pregnant mothers and all maternal deaths as ordered by the District Head Decree should be followed by analysing the reasons for death. By analysing the data, we can see the correlation between FP failure (60% of women seek abortion) and unsafe abortion practices which in turn contribute to a high MMR. Several studies show that unsafe abortions contribute 15-305 of the MMR.

3. The head of the Bogor District should look to the issue of early marriage since many female adolescents still marry at the age of below 16 years. Once they marry, they are expected to bear children right away and that contribute to the high percentage of teenage married mothers (35%). Most of them have minimal education, limited access to RH/FP services, and are left on their own to manage their fertility since their homes are isolated, far from the main road.

d. Community

1. At the community level, several initiatives could be implemented:

- Conduct communication skills training for the health cadres (*Posyandu*) so that they will be better able to provide information on FP and RH issues. Training should also include counselling skills so that they can counsel women on issues such as sexuality, gender, and violence against women.
- Provide incentives for the health cadres as a token of appreciation for their work.
- Attract male potential acceptors by accepting them in peer education which provides

information and skill-building in SRH (including FP, sexuality, STIs, HIV and AIDS, violence against women and other gender-sensitive issues).
- Involve religious leaders (male and female) in several capacity-building activities in order to make them more open-minded so that they will not impede the implementation of FP programmes.

e. Medical professionals

1. Medical professionals must:

- be more gender-sensitive in providing RH/FP services;
- refrain from commercialising RH/FP services;
- enhance their knowledge in terms of understanding various health issues (such as sexuality, gender, violence against women and STIs/HIV and AIDS);
- enhance their communication skills in order to serve their patients better; and
- set up a mechanism for patients to file complaints in order to improve their SRH services.

Endnotes

1 *Levels of poverty ranged from the very poor, called 'pre-prosperous,' through various levels of affluence culminating in the 'prosperous 3+.' The immense size and scale of the NFPCB data system was dramatically demonstrated during the Indonesian monetary crisis of 1998-2000, where it was used to target interventions to poor families because it was the only listing of household economic conditions for most of the country.*

2 *National Family Planning Coordinating Board (BKKBN); United Nations Population Fund (UNFPA) Indonesia; The Philippines NGO Support Program, Inc (PHANSuP); International Movement of RH Managers and Advocates (IMRHMA). (2008). Redefining Family Planning through Decentralisation: 2nd International Conference on Reproductive Health Management (ICRHM)Emphasis on Family Planning. Retrieved 15 July 2011, from Aids Alliance Website: http://www.aidsalliance.org/includes/Publication/Reproductive_health_mgnt_conference_rpt.pdf*

3 *Strauss, J; et al. (2004). Indonesian Living Standards: Before and After the Financial Crisis, Evidence from the Indonesia Family Life Survey. Singapore: RAND Corp.*

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CHAPTER 4

UNSAFE ABORTION IN INDONESIA: THE URGENT NEED TO REFORM POLICIES

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In light of Paragraph 8.25 of the Programme of Action of the International Conference on Population and Development (ICPD PoA), which states: '... All governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern... In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complication arising from abortion...,' consider reviewing laws containing punitive measures against women who have undergone illegal abortions. – ICPD, Cairo, 1994[1]

I. INTRODUCTION

Unsafe abortion is one of the great neglected health care problems, and it a serious public health concern as well as a threat to women during their reproductive years (15-49 years of age). Though it is illegal in Indonesia, abortion is surprisingly common. Though accurate data does not exist, researchers estimated that about two million abortions occurred in Indonesia in 2000 (Utomo, 2000).[2,3]

This number was derived from a study of a sample of health care facilities in six regions, and it included an unknown, though probably small, number of spontaneous abortions (miscarriages). However, this is the most comprehensive estimate currently available for the country. The estimation translates to an annual rate of 37 abortions for every 1,000 women within the reproductive age (15-49 years). When comparing the abortion rates of other countries in Asia, this rate in Indonesia is quite high. Regionally, approximately 29 abortions occur for every 1,000 women of reproductive age.

However, abortion is more than just a medical 'statistic' and a threat to the well-being of women. It is also a contested political and moral issue. The word 'abortion' typically evokes a mixture of emotions in all of us, irrespective of our level of involvement with the issue, or the degree of concern shown by the societies in which we live. Sadly, many discussions on abortion are marred by a confrontation between two extreme positions, the pros and cons.

On one extreme, there are those who believe that the embryo or foetus must take absolute priority over a woman's personal decision regarding her own body. This position typically ignores the rights of women, disregarding not only the circumstances and quality of women's lives, but also the lives of earlier children, and the baby's own future. On the other extreme, there are those who give absolute priority to women's rights to decide for themselves whether to continue or terminate an unwanted pregnancy, irrespective of the level of physical advancement of the foetus. Both sides typically refuse to listen to the arguments of the other, resulting in a prolonged and unresolved debate.

Typically, those who do not have advanced knowledge and understanding about abortion, and who refuse to sympathise with the reasons women decide to abort their unwanted/unplanned pregnancies may consider the decision as 'immoral' or 'selfish,' or judge it as a 'sin.'

Most of these people expect a 'healthy' woman to carry her child to term unless her life is at immediate risk. However this argument is based on a false premise. If we are support the World Health Organisation (WHO)'s definition of 'health' as not just the absence of illness, abortion can be seen more than just an issue affecting a woman's physical and medical state, but also her psycho-social well-being. From this perspective, abortion is also closely linked to other factors affecting the psycho-social health of women, and is thus, related to issues of gender inequality in a society.

i. The need to define abortion

Abortion is usually defined as the abnormal termination of pregnancy, spontaneous or induced. According to the International Federation of Gynaecology and Obstetric (FIGO), spontaneous abortion is defined as the termination of pregnancy without external intervention, which could be caused by a disease in pregnant women or genetic defects in the embryo. It is basically a medical problem that affects a woman's physiological health, although it may also involve social and psychological consequences for both the woman and her family.

Induced abortion, however, according to the Ethics Committee of FIGO, is described as "the termination of pregnancy using drugs or surgical intervention after implantation and before the conceptus (the product of conception) has become independently viable" (Scenker and Cain, 1999).[4]

WHO has established foetal viability at twenty-two completed weeks of gestation, or the weight of five hundred grams. The termination of pregnancy when a foetus is below that limit is defined as an abortion, while termination beyond that limit is considered premature birth.

ii. Safe and unsafe abortion

WHO defines Unsafe Abortion as the procedure of terminating an unwanted pregnancy either

by persons lacking the necessary skills or in an environment that do not meet the minimal medical standards, or both (WHO, 1992).[5] On the other hand, Safe Abortion is a medical or surgical procedure of pregnancy termination, performed by a well-trained professional with the necessary resources, in a suitable medical environment. This is considered safe as it poses little risks to the women.

These definitions are important to clarify the perception that abortion is simply the 'killing of a baby.'

This study by the Women's Health Foundation (WHF) is critical because unsafe abortion is still a threat to women's health and survival. Fifteen years after ICPD, no serious action has been taken in Indonesia to respect and protect women's rights concerning abortion, and to prevent unnecessary mortality and morbidity due to unsafe abortion.

Although the Indonesian Government signed the ICPD agreement in Cairo, in 1994, the government has yet to meaningfully demonstrate its commitment. Indonesian women should not wait any longer for their sexual and reproductive rights.

iii. Research site

This research took place in a top referral public hospital, and an associated training and research facility in Jakarta, Indonesia.

Both institutions requested anonymity, but they were quite helpful in providing information. Both institutions have a long history in providing inexpensive reproductive health services. In the past, the training and research facility had also been well-known as the associated research centre of WHO.

iv. Clinic status and brief history

Since 2003 this clinic has been working closely with NGOs for women. The NGOs provide assistance to the clinic in order to promote better quality services by providing counselling training to the clinic's staff members (midwives, nurses and other administration staffs) and to develop an information dissemination video on SRHR, and to conduct a clients' satisfaction study.

II. OBJECTIVES AND METHODOLOGY

In order to advocate to governments to take concrete and speedy action to meet the promises they made in ICPD PoA, Beijing Platform of Action and in relation to the MDGs, the Asian-Pacific Resource and Research Centre for Women (ARROW), together with 12 country partners, conducted several studies to assess the current situation of SRHR. Indonesia chose to study the situation of unsafe abortion as this was seen as a critical SRHR issue at the national level along with access to contraception in the context of decentralisation settings in Indonesia.

For this purpose, the WHF chose a top referral and teaching hospital in Jakarta. This hospital was chosen due to its reputation for excellence, and because it is regarded as a benchmark for many hospitals in Indonesia, especially with regard to its use of the latest medical technologies.

There is no official estimation of abortion provided by the government. However, several studies related to abortion had been conducted from 2000-2008. Most studies attempted to describe the reasons for the high abortion demand in Indonesia, and focused on women's needs and feelings, including their reasons for having an abortion.

Other studies tried to estimate the number of abortions that have been a threat to women's health. Budi Utomo et al (2000) estimated that 2 million abortions were carried out in Indonesia annually;[6] Pradono et al[7] predicted that 12% of all pregnancies ended with abortion; Azrul Azwar (Kompas, 2002) estimated that up to 40% of abortion will contribute to maternal death (MMR).[8]

This study seeks to expand the focus of research beyond the needs of the women, which includes exploring the quality and management of abortion services, and providers' attitudes towards abortion, under the absence of legal protection concerning abortion.

i. Research questions

1. What motivates the women in Jakarta to seek induced abortion services? Why do they want to terminate their unwanted pregnancy rather than placing the child for adoption after giving birth?
2. What is the attitude of health providers towards the needs of abortion seekers?
3. What is the role of existing abortion policies and practices in limiting access to safe abortion?

ii. Objectives

The objectives of the study were:

1. To examine the motivations behind women seeking induced abortion services in Jakarta, Indonesia;

2. To examine the attitude of health providers towards the needs of women seeking abortion; and
3. To examine the impact of existing abortion policies and practices in limiting access to safe abortion.

iii. Methodology

This research adopts qualitative and quantitative methods that applied through a clinic-based approach. Several methods have been used in order to achieve the above objectives. We used the records of client from a specific clinic in a top referral public hospital in Jakarta to document data of clients who came for abortion services during the month of October and November in the year 2008.

Besides that, seven clients were also interviewed to explore their needs and feelings with regard to abortion. Several health care providers were interview (obstetricians and gynaecologists, medical practitioners, midwives and counsellors) in order to know about policies regarding abortion services in this hospital, and the views and attitudes of these health care providers to abortion. We completed these tasks by observing the entire abortion service experience (in the waiting room, counselling session, procedure room and post-procedure room) provided by the medical team.

The following are the steps that were taken in the data collection process:

- Collection of 502 patients' records (as secondary data) during the month of October and November 2008 in the teaching clinic located in Jakarta;
- Interview of seven women who came for abortion services before they underwent the procedure; and
- Interview of medical providers (obstetricians and gynaecologists, doctors/general practitioners and midwives) in December 2008;
- Interview of decision makers at the hospital/ clinic and the chair of the Indonesian Society of Obstetry and Gynaecology in December 2008 and January 2009 respectively; and
- Conduct of observations at the clinic by focusing on the client flow and the abortion method used by the providers.

III. FINDINGS AND DISCUSSION

i. Secondary data

a. Client overview

The study of 502 clients showed that the majority of women who obtained an abortion at the clinic fitted a certain profile:

- Marital status: 92% of the clients were married, but this is due to the fact that only married women are allowed to have an abortion in this clinic. Abortion care at this hospital is only provided to single women under special psycho-social circumstances (i.e., rape, incest, or in any type of physical danger).
- Education: The overwhelming majority of the clients were educated (251 high school graduates; 177 with a Bachelor Degree; 2 clients with a Masters and/or Doctoral Degrees), yet they were unable to prevent themselves from unwanted pregnancies. This seems to indicate that there is a serious lack of knowledge and information regarding sexuality and contraceptive methods.
- Occupation: More than half of the clients studied were housewives (288), 24 clients worked as government officers, 132 in the private sector, 18 were running their own business, while the rest were students.
  Almost 75% of the clients' husbands worked in the private sector or had their own business. This finding revealed that this group earned

Table 29: Occupation profile of couples

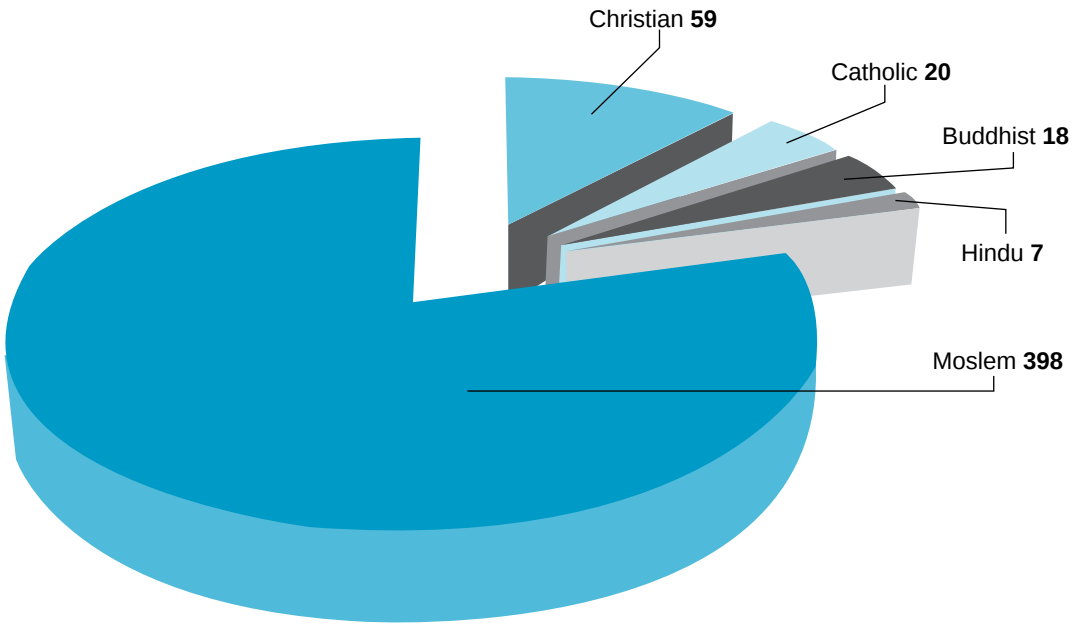
OCCUPATION	HUSBAND	WIFE
Unemployed/Housewife	25 clients (5%)	288 clients (58%)
Civil Servant	41 clients (9%)	24 clients (5%)
Private Sector	261 clients (57%)	132 clients (26%)
Entrepreneur	79 clients (17%)	18 clients (4%)
Military/Police	16 clients (4%)	-
Student	1 clients (0%)	25 clients (5%)
Other	34 clients (8%)	8 clients (2%)

Note: Seven women were accompanied by husbands
Source: Client records

above average incomes, and explained how they could afford access to safe abortion care for their partners. On average, a safe abortion costs 1.5 million rupiah (USD130). The minimum wage in Jakarta is around 1 million rupiah a month. Of the total 502 women whose records were examined, table 29 provides occupation profiles of 495 women clients and the remaining seven women clients were not accompanied by husbands.

- Religion: Despite the fact that the doctrine of most Indonesian religions often teaches that abortion is a sin, Indonesian women who seek abortion come from all religious backgrounds. Figure 3 shows the religious profiles of the women.
- Reasons for Unwanted Pregnancy: The majority of clients were still having intercourse and did not plan to get pregnant, yet they failed to utilise effective contraceptives. Further research needs to be done to explore reasons why women are not using contraceptives. There is a question as to whether it is due to lack of education and information or whether this decision is due to any other significant personal reasons? Major reasons cited by the women for unwanted pregnancies include: a) a lack of thinking and awareness around use of contraceptives as a means to avoid unwanted pregnancies, b) women did not go to the family planning clinics, c) the failure of methods, especially the traditional methods used by the couple failed, and d) improper and irregular use of contraceptive methods.
- Reasons for Abortion: Slightly more than half of the clients sought abortion care because they felt that they had enough children, had too many children or their youngest child was still too young. These women typically have made a decision that they do not want to have any more children. Unfortunately, this decision was not supported by the practice of using effective methods to avoid unwanted pregnancy and unnecessary abortions. Based on the characteristics of the clients studied, we can see that 60% sought abortion because they already had too many children or their youngest child was still very small; 21% wanted an abortion because of contributing psycho and social factors; 8% due to chronic illness; 10% because they considered themselves too old; and, there was one rape case.
- Prior abortion seeking behaviours: Similar to other findings, the data showed that prior to obtaining safe abortion, 56% of women had tried to end their pregnancy via harmful methods which may have had endangered their lives. Women often try their own way to end their pregnancy. The majority of these women still used traditional herbs, while others bought medicines without consulting medical providers. These women sometimes did not realise that

Figure 3: Religious belief of clients



Source: Client records

taking drugs, which are not for the purpose of safe medical abortion, may endanger their lives as well as their foetus.Additionally, 76% of women had tried to end their pregnancy on their own. Only 11% had tried to approach medical personnel to help them before going to the clinic. (See Figure 4.)

- Number of prior abortions: Out of 502 clients studied, 58 women (about 12%) had at least one abortion before.
- Contraceptive choices post-abortion: All of the women surveyed did not plan on becoming pregnant immediately after their abortion. Out of all the contraceptive methods made available to them, IUD was chosen by 60% of the women. It is interesting to note that even though 57% of the women never want to get pregnant again, only 2 women chose sterilisation. A total of 20 women did not opt for contraception post abortion. (See Figure 5.)
- Feelings after the abortion: After the procedure was completed, the majority of the clients felt relieved and happy. However, a small number remained feeling uneasy about their decision. Only 2% regretted their decision to end their pregnancy. It is interesting to note that no one reported feeling that "they have committed a sin." (See table 30.)

ii. Primary data

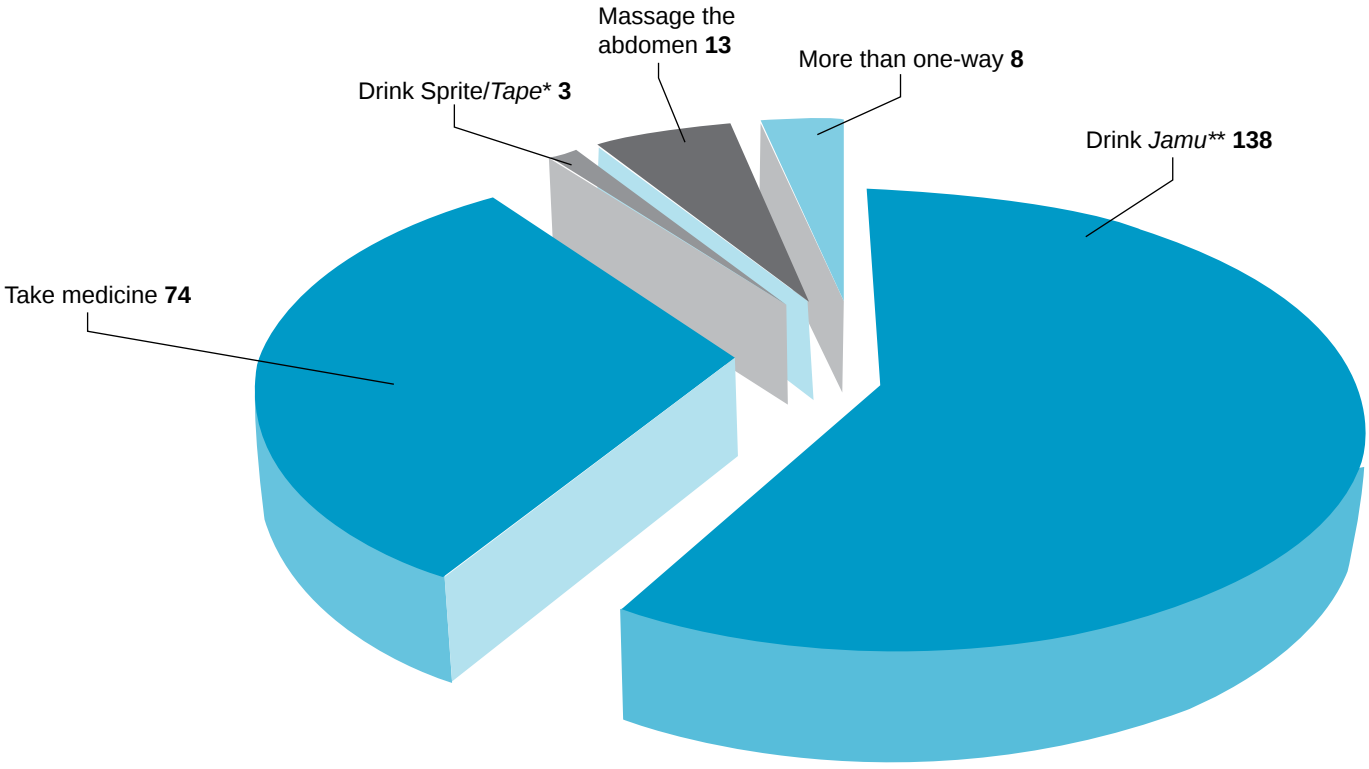
a. Interview with the clients

Despite the fact that abortion is still illegal, stigmatised and highly restricted, women continue to seek their own ways to stop their unwanted pregnancy even though they often must risk their own life. The illegality of abortion does not stop women from trying to terminate their pregnancy.

Boxes 7-9 are stories of women from various backgrounds, who decided to terminate their unwanted pregnancy. Women undergo abortion for various reasons. The cases presented below provide an insight into the reasons for abortion among the women interviewed in this study. These experiences point to the lack of access to contraceptive services, lack of affordable and quality contraceptive services, domestic violence, and risks associated with using traditional contraceptive methods among the reasons for seeking abortion. (See Boxes 7 and 8.)

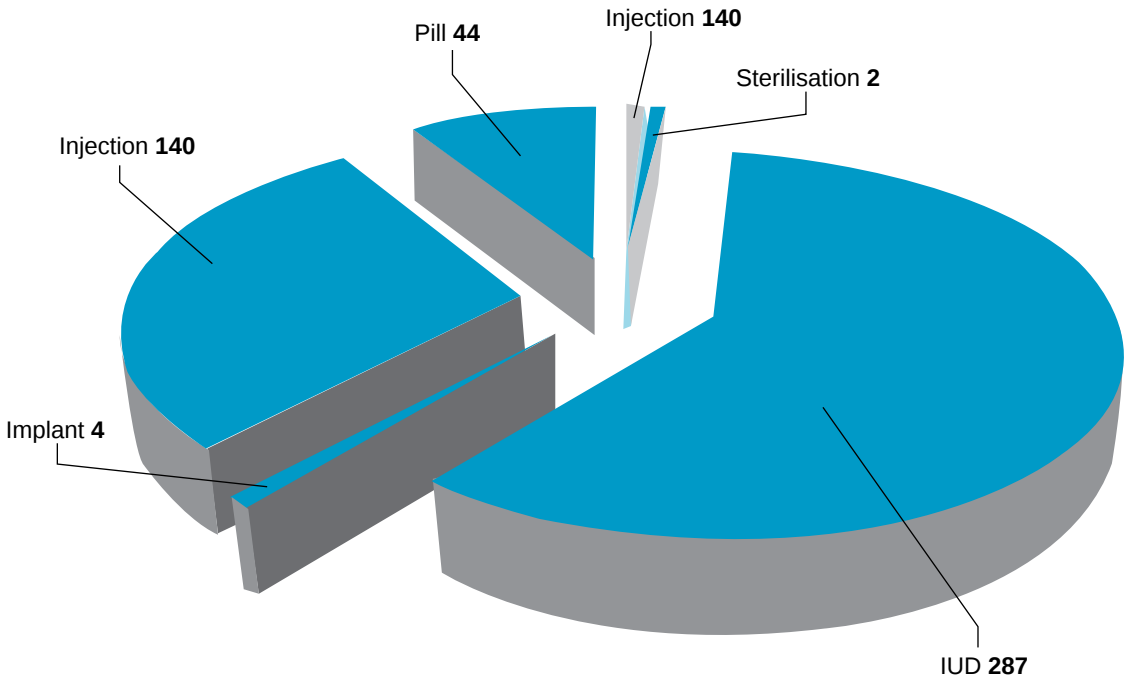
Many women still rely on natural methods to prevent their unwanted pregnancies. A large number of them lack comprehensive information regarding reproductive health including contraceptive methods

Figure 4: Methods for self-induced abortion



Notes:
* *Tape* is fermented cassava
** *Jamu* is a generic term for herbal medicine.

Figure 5: Post-abortion contraceptive choices



Source: Client Records

Table 30: Feelings after the abortion

Happy	352 clients (70%)
Indifferent	69 clients (14%)
Sad	30 clients (6%)
Regret	11 clients (2%)
No response	40 clients (8%)

Source:Client Records

as they only believe that natural methods are quite effective. Quality reproductive health information is very difficult to obtain, resulting in many failures in the use of contraceptives, and unwanted pregnancies and abortion. (See Box 9.)

b. Interviews with the providers (obstetricians and gynaecologists, doctors and midwives)

iii. Abortion policy and its outcomes

a. A history of policy change

Policy setting around abortion is the role of the Head of the Obstetric and Gynaecology department, usually with the support of some senior and influential ob-gyn doctors. In the 1980s, ob-gyn candidates were required to learn how to provide safe abortions. Many different techniques were taught, including the use of methods to perform late-gestation abortions. During their internships, ob-gyn candidates often had to perform abortions due to the high number of women coming to the clinic for abortion services, not only from Jakarta but from others cities in Indonesia.

After 1992, under the Health Law No. 23/1992, a person caught performing an abortion without strong reasons (e.g., to save the life of a woman), could be imprisoned up to 15 years, or fined a maximum of 500 million rupiah (approximately USD50,000).

As a result of this regulation, abortion services could not be made a compulsory training requirement for ob-gyn candidates. They were free to choose whether or not they wanted to learn and perform abortions during their internship.

Since 2003, Indonesian policies regarding abortion have become even more restricted. Abortion by request is prohibited in an emergency ward. However, doctors are allowed to perform Post-Abortion Care (PAC) services to clients who experience heavy bleeding or severe infections/ complication as a result of a miscarriage or an abortion (usually unsafe). Women, who come for an abortion without showing any danger signs as described above, will be refused, or if they insist,

Box 7: Case Study 1 – Many children, few options

Many children, few options

Mrs. Murni is 42, married, the mother of five children, and whose husband does not have a permanent job. When she first came to the clinic, her menstruation was nine weeks overdue. Eight months earlier, she had delivered a baby by way of a caesarean section, after which, she used 3-monthly injectable contraceptives. When she could not pay for an injection, her husband reverted to using condoms. However, on one occasion, when Mrs. Murni could not afford an injection and had intercourse with her husband without any protection, she became pregnant. Some weeks later, she experienced slight bleeding and began to feel unwell. This incident made her think about her unwanted pregnancy and thus, she decided to terminate the pregnancy:

"*I know abortion is a sin according to Islam, but I don't think we can afford to have another child since my husband's job is uncertain. I am also too tired now… I believe God will understand my problem and will forgive me…"*

She tried consuming five packs of traditional herbs (*Jamu*)with the trademark "*Kates*" (papaya), and 1 pack with the trademark "*Nanas***"** (pineapple). Later on, she supplemented her initial effort with another 5 packs of *jamu*/traditional herbs, "*Wayang*" (puppet) and ate two pineapples. However, her attempts at abortion failed, and she developed severe headaches, became very stressed and increasingly worried that the ongoing development of the foetus would result in it being impaired.

Finally, following the advice from her friends and a recommendation of a doctor from a public health centre, she went to the clinic. After the abortion procedure, Mrs. Murni no longer felt the acute stress symptoms and as a result of post-abortion counselling session, she decided to be sterilised. She hopes that through sterilisation her family would have a brighter future, and she will not have to worry about another pregnancy. However, before this could be achieved, she would have to somehow obtain the money for sterilisation services.

Box 8: Case Study 2 – Domestic violence and its effects

Domestic violence and its effects

Dwi, 33, works at a Management Consultant's Office and was married a year ago. Two months ago, she received a short message (SMS) from a woman who told her that she was seven months pregnant, and that her husband was the one responsible. When confronted, her husband denied the woman's story and became very angry and cruel towards Dwi. They quarrelled every day, and her husband even beat her. As a result, she applied for a divorce. While waiting for the process, Dwi suddenly realised that she had missed her period, and after testing, she knew that she, too, was pregnant.

"[I] just could not imagine the baby born without a father… I am so shocked. I hate him so much for betraying me… I am not ready to have his child …, …not ready to be a single parent…" (sobbing)

Later on, she decided to terminate her pregnancy by taking a concoction of medicines and traditional herbs. However, this abortion attempt failed. She subsequently became afraid that her attempt may have damaged the foetus, and having informed her husband about this possibility, he accompanied her to the abortion clinic.

After the abortion was completed, she felt very sad because in actually fact, she wanted to have a baby, if the circumstances surrounding her marriage had been different.

they will be referred to the teaching clinic to get treatment from ob-gyn candidates.

As a result, ob-gyn candidates in the teaching clinic may only observe two or three abortion procedures during their internship, and only in a special case, can they perform an abortion (with the permission and close supervision of their senior).

According to the candidates interviewed, however, they want to learn and become skilful in performing safe abortion, so that upon graduation, they are able to help women with unwanted pregnancies or miscarriages, especially in remote places. Under the present regulations, they are only able to master a limited range of knowledge, theories and skills pertaining to abortion, which makes them uncomfortable and less confident in carrying out an abortion. Despite the fact that many had expressed a deep sympathy for women carrying unwanted pregnancies, the lack of opportunity to develop abortion skills and knowledge while in training mean that they are unable to provide much practical help.

b. Who can perform the procedure?

At present, only a limited number of senior obstetricians and gynaecologists may perform induced abortion procedures. None of the interviewed health providers were willing to disclose what criteria are used in the selection of health provider allowed to perform abortion procedure or the name of person(s) who have the power as decision-makers.

c. Methods used

Although Dilatation and Curettage (D&C) has been, for many years, considered as an outdated method

Box 9: Case Study 3 – The 'risks' of natural contraception

The 'risks' of natural contraception

Asmi, 40, is married with three children and works as a hairdresser. She has never used modern contraceptives due to her fear of the side effects. She decided with her husband to use the 'calendar system' and, sometimes, condoms. However, due to a miscalculation in the 'calendar system,' she became pregnant.

In an attempt to terminate the pregnancy, she consumed traditional herbs called "*Kates*" (Papaya) and another brand called "*Banteng*" (Buffalo). Even so, the herbs failed, forcing Asmi and her husband to discuss whether to continue or terminate the pregnancy. Considering their limited finances and economic situation, they decided to terminate her pregnancy. Accompanied by her sister, she went to the clinic to access safe abortion services. She felt relieved when the procedure was successful, and immediately after that, she had an IUD inserted.

of abortion, due to the fact that it is responsible for higher than necessary levels of complication (e.g., perforation), the clinic still uses this method accompanied with the use of electric vacuum aspiration. This method is used instead of more practical Hand-held Manual Vacuum Aspiration (MVA) and plastic cannulas because it is much faster. When asked why they still use the method and the equipment, one practitioner said, "[B]ecause it's quicker, does not take a long time to finish (the procedure)…."

Medical abortion using mifepristine and misoprostol is considered to be safe and effective, and can be provided by mid-level providers. Nonetheless, accessibility to this procedure is still a dream for many Indonesian women. The lack of legal protection together with the various beliefs and perceptions of many health providers about abortion, make this method seem almost an impossible dream.

d. Client-treatment procedure

This clinic has been well-known for a long time as a 'legal' clinic for abortion, primarily due to the fact that the clinic was granted a special permission by Jaksa Agung (General Attorney) in 1920.

Besides, this clinic also provides many other reproductive health services, such as contraceptive methods, pregnancy care, post-natal care, pap-smear, testing and treatment of sexually transmitted infections (STIs) including HIV, counselling and testing, especially the infertility of women and violence against women.

When a client comes to the clinic, they have to go through the following procedure:

1. Registration at the front desk
2. Anamnesis/interview by a nurse/midwife to fill-up a recording card/client card requiring information in relation to the identity and personal background of the client, and service needed.
3. While waiting for the doctor or counsellor, clients will be invited, in small group to watch a video presentation containing sexual and reproductive health and rights (SRHR) information regarding: female and male reproductive organs and function, the process of menstruation, pregnancy, contraceptive methods, STIs, including HIV and AIDS, and abortion procedures. A trained midwife will facilitate a Question and Answer session at the end of the video presentation to facilitate a discussion and answer questions.
4. Pre-procedure: Physical examination by a midwife or a doctor (GP), to decide whether an abortion still can be performed if a limit of the gestation period exists. The clinic can only perform abortions up to 10 weeks gestation.
5. Pre-procedure: Counselling session is when a client (and any of her family members, friends or life partner) is invited for a session by a trained counsellor, who will explore her needs, motivation and feelings. The counsellor will also provide information about abortion procedures including possible risks, and discuss the variety of contraceptives that can be chosen to protect one's self from future (repeated) unwanted pregnancy. At the end of the counselling session, the client is encouraged to make her own decision after weighing the benefits and risks of the procedure. If she decides to terminate her pregnancy, she must sign an informed-consent form before the procedure can proceed further.
6. During the procedure: A well-trained nurse or a midwife will provide psychological support to the client, for instance, holding her hands and encouraging her to remain calm while the doctor performs the safe abortion procedures.
7. Post-procedure: A client will be led to a recovery room to rest for about 60-90 minutes. When she appears calm, a nurse/midwife can start asking how she feels, and if she feels alright, a discussion about what to do upon returning home (the client has to know about the possible danger signs) and how to use her chosen contraceptive method correctly.

The above client-treatment procedure is not always followed. When the clinic is busy or the doctors have other emergencies, parts of the procedure may be skipped (typically, counselling and/or video presentation). Failing to follow this procedure will result in the loss of important information/knowledge crucial for clients to make an informed decision.

iv. Looking back: A brief history of the legal status of abortion

This study also reviews some documents as follow: The first penal/criminal code regarding abortion was issued by the Dutch Government in the 19th century due to the high death toll of Indonesian women who had unsafe abortions. However, while the penal code was issued to protect women against unnecessary death due to unsafe abortion, the lack of safe and effective medical technology and equipment at the time meant that abortion procedures were often still conducted as trial and error experiments by untrained personnel.

Significantly, the Dutch law that criminalised abortion is still occasionally applied by the Indonesian police in unusually problematic cases of medical professionals who go beyond the boundaries of the approved practices. This matter, however, is rarely used in a routine-like manner, but as a catalyst to investigate, charge, and punish the thousands of non-professionals who still carry out pregnancy terminations in Indonesia. Under the penal code, the references regarding abortion address "other people" who intentionally aid women to terminate their pregnancies.

In the late 1970s there were a number of efforts initiated by the Indonesian Medical Association (IDI) and Indonesian Federation of Obstetrics and Gynaecologists (POGI) through seminars and meetings to push for a policy that will make safe abortions more accessible for women. Even though a national policy was not achieved, significant progress was made.

During one of the workshops in Bali organised by the Indonesian Planned Parenthood Association (IPPA), which is affiliated to the International Planned Parenthood Federation, the Minister of Health announced that he was willing to let IPPA's clinics provide abortion services as long as the health providers were careful in executing the procedures comprising counselling sessions and monitoring systems as part of the procedures. Subsequently, for about 10 years, safe abortion could be accessed in 10 IPPA clinics spread across Indonesia. Unfortunately, a series of policy changes in IPPA in 1993, followed by the closing of the IPPA model clinic in Jakarta, resulted in the resignation of some key figures, consequently questioning the capability and credibility of IPPA in leading advocacy efforts for safe abortion.

In 1992, a Health Law (No. 23/1992) was issued, but a conflict ensued between two groups of medical professionals during the policy development leading towards the shift with regard to the law.

One of the two groups consists of doctors/ obstetricians and gynaecologists who were pro-abortion, and the other group comprises doctors who were anti-abortion. This caused a confusion pertaining to the Health Law, which in the end, could not be used to ensure the protection of women in accessing safe abortion. For example, the Law appears to include a contradiction when it states that:

"Certain medical procedures can be done in order to protect the mother's and/or the foetuses' lives" (Chapter 15), only to subsequently state that, "Abortion in all forms is prohibited. Any attempt to provide abortion services will not be left unpunished but one can be fined up to Rupiah 500.000.000 - (approximately. USD50.000), or the provider will be jailed for up to 15 years" (explanation of Chapter 15).

One effect of the confusing law has been the increased difficulty counsellors and doctors experience in writing up the reports involving the counselling sessions with clients and abortion procedures. This is because they must write the reports in such a way as to describe the client in terms which establish their (medical) need for an abortion. In contrast, and another consequence of

Box 10: Penal Code references to abortion

Chapter 346
"A woman who intentionally terminates her pregnancy, or asks other people to do so, will be sentenced with maximum 4 years in jail."

Chapter 347
"Whoever intentionally terminates a pregnancy of a woman without the woman's consent, will be sentenced with maximum 12 years in jail."

Chapter 348
"Whoever intentionally terminates a pregnancy of a woman, even with her consent, will be sentenced maximum 5 years and 6 months in jail."

the confusion, is that only a few doctors have been punished for terminating unwanted pregnancies with more than 20 weeks gestation.

v. Abortion and Islam

According to some famous Islamic scholars, it is possible to perform abortion in Indonesia. They prohibited the abortion after the heart-beat of foetus can be detected.

1. Abortion was permitted according to part of Hanafi, Maliqi and Hambali scholars.
2. Abortion was permitted if there is medical reasons according to a part of Syafei scholars.
3. According to Council of Indonesian Ulama (MUI), abortion is permitted as long as before 40 days of gestation.

vi. Looking forward: Efforts by the Women's Health Foundation since 2001

In 2000, an obstetrician-gynaecologist, helping women who experience unwanted pregnancy, was caught by police after he had just completed an abortion procedure.

After subsequent arrests and trials, the doctor was jailed, along with two midwives who assisted him, and three patients who had undergone abortion procedures. In response, a number of women's NGOs who had previously referred women with unwanted pregnancies to him, initiated a campaign of support by gathering signatures not only from Indonesia but also from several supporters around the world.

The doctor was released after 11 days in jail. This case encouraged women's health activist to begin a campaign aimed at amending the Law No. 23/1992 on Health that had so far failed to ensure women's access to safe abortion care.

A group of 12 activists from different professional backgrounds, including, obstetricians and gynaecologists, medical doctor, psychologists, lawyer and social scientists, decided to fight for Indonesian women's reproductive rights and established Yayasan Kesehatan Perempuan (Women's Health Foundation, WHF).

Guided by its mission, the Women's Health Foundation (WHF) has carried out several difficult tasks including: reviewing existing policies and laws that criminalise abortion, and conducting a large-scale study on 'Safe Termination of Unwanted Pregnancy' in nine large cities in Indonesia, in collaboration with several NGOs and the Indonesian Society of Obstetric and Gynaecologists. The findings gathered from "Safe Termination of Unwanted Pregnancy" were used to advocate for amendments to the Health Law number 23/1992. The struggle is still going on until today.

IV. CONCLUSION AND RECOMMENDATIONS

i. Conclusion

With the absence of humane policy and regulation, the incidence of unsafe abortion has not decreased in Indonesia.

However, even with a reformed policy environment, unsafe abortion would decrease only if the policies were complimented by a comprehensive sexual, reproductive health and rights education/information campaign. Until then, women will not stop their efforts in trying ways to terminate their unwanted pregnancy, no matter what the policy situation.

From the above findings it is clear that the demand for safe abortion is very high. In addition, we can see that with the policy of the clinic restricting its ability to provide abortion services for unmarried women and for married women with no more than 10-12 weeks gestation, and requiring each client pay a certain amount of money, means that the actual number of clients assisted was much lower than the actual demand for the services.

Referring to the characteristics of the clients studied, we can see that 60% sought abortion because they already had too many children or their youngest child was still very small, 21% wanted an abortion because of contributing psycho and social factors, 8% due to chronic illness, 10% because they considered themselves too old, and there was one rape case.

Significantly, though more than 85% of the clients surveyed were educated (50% finished high school, while 35% graduated from university or an academy, and two women had a Masters Degree), and 75% of women had husbands who were working in the private sector or ran their own business, it seems that the high level of education and economic status do not guarantee that a woman is knowledgeable about SRHR, especially the contraceptive methods for preventing unwanted pregnancy.

With the absence of a clear Health Law, there are no written regulations or policies and guidelines in this hospital or clinic. In fact, all policies were given verbally. Hence, any health care provider could have interpreted the policies differently.

Consequently, all aspects regarding abortion procedures and services could not be monitored and supervised, including the method and equipment used to guarantee safe abortion that a woman deserves as her right. This is significant, as the unclear status of abortion means that the opportunity exists for some gynaecologists to misuse their power, and so, monitoring and evaluation of service provision is vital.

Despite the fact that the right to perform abortion services is limited by providing training and clinic management to very few senior gynaecologists, no medical staff members has emerged to question the system nor start making changes to the policies and services in the clinic/hospital. All of these factors, when combined, potentially undermine the safety of the clinic's abortion services. Women in Jakarta, thus, are at risk and face dangerous options even in leading medical facilities.

ii. Recommendations

a. To the government

1. The New Health Law No. 36 of 2009 issued in October 2009, consists articles on reproductive health issues including abortion regulation. It is important for the government of Indonesia to speed up the drafting of health regulations concerning RH and abortion, so that the new Health Law (No. 36/2009) can be implemented.
2. The government should allocate adequate resources to implement the new health law, including the training of health care providers to perform abortion procedures safely.
3. Revise the criminal code in order to de-criminalise women who seek abortion as well as the health providers who perform the services.
4. Promote SRHR education/information for all, especially for young people, to prevent unwanted pregnancies.
5. Make available range of contraceptive methods and provide access to contraception without any stigma and discrimination especially for young people.
6. Client records of women seeking abortion in the health facilities should be comprehensive. These records should be used to inform government actions to improve the health and well-being of women seeking abortion services.
7. Abortion procedures should include the elements of counselling, which is non-judgmental. Counselling should inform women of various contraceptive methods and the respective side-effects of each method so that women are informed about the contraceptive choices.
8. To make available a range of contraceptive methods at the health facilities.

b. To the Medical Professional Association (The Indonesian Society of Obstetrician and Gynaecologists [POGI], Indonesian Medical Association [IDI] and Indonesian Midwives Association [IBI])

Medical professionals are daily confronted with the high demand for abortion services and, as professionals, they perfectly understand its causes and consequences.

It is thus expected that they will take an active role in supporting women's efforts to procure safe abortion including counselling and post-abortion care in a non judgemental safe environment. As qualified medical professionals, they have the power to influence the decision makers in the Ministry of Health, as well as the Parliament.

c. To the media

The media not only has the power to form public opinion, but also bear the responsibility to educate the community on SRHR. At present, most printed and electronic media promote negative messages about abortion. A greater number of media groups (printed and electronic) are required to be more open-minded and sensitive to the SRHR needs of women. Obviously, women need to be empowered with knowledge and accurate information on SRHR in order to be able to make correct decisions for their own lives. These women must be supported by legal laws that protect their rights, capable and well-resourced obgyn and medical staff, and public opinion in order to protect themselves from unwanted pregnancy. This is the only way to reduce unnecessary unsafe abortion, and subsequently, maternal morbidity and mortality.

At last, after a long battle, the government passed a New Health Law (No. 36/2009) in October 2009. According to the policy, the law needs to be completed with government regulations in one-year time. Although the WHF, as an advocate for women's rights, initiated the drafting process, up until today, the Ministry of Health has not completed and passed the regulations, which are important in the implementation of the new law as a set of guidelines.

d. To the civil society

The civil society needs to push for the speedy drafting of health regulations and the implementation of health law.

The civil society also needs to raise awareness about the new health law with its constituencies.

Endnotes

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CHAPTER 5

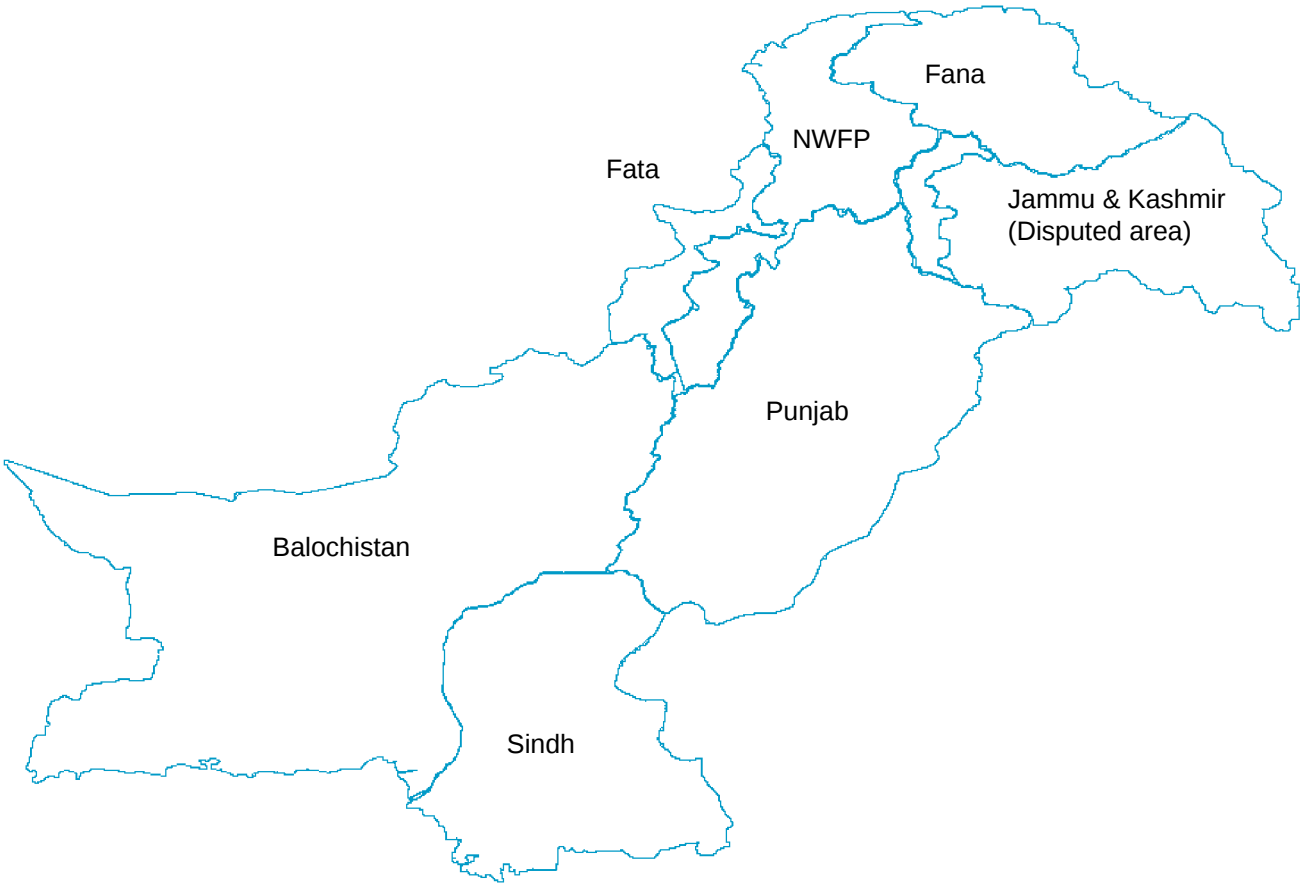
BARRIERS TO SAFE MOTHERHOOD IN PAKISTAN : A STUDY IN SELECTED SITES IN RURAL SINDH AND PUNJAB

By Hilda Saeed, Rahal Saeed and Dr. Saman Y Khan

I. INTRODUCTION

This review of the progress of the implementation of International Conference on Population and Development (ICPD) in Pakistan specifically stresses on contraception and abortion, with the cross-cutting themes of gender, social equality and equity; safe motherhood; sexual and reproductive health and rights; and HIV and AIDS and STIs. Shirkat Gah has opted to address the need for safe abortion services, including Post-Abortion Care (PAC), and the unmet need for contraception in view of poor maternal health indicators and a high incidence of induced abortion, including unsafe abortion within the country. Pakistan, situated in the South Asian subcontinent, is a large, complex country, divided into four provinces (Sindh, Baluchistan, Punjab and the NWFP) and into three other regions (Federally Administered Tribal Areas [FATA]; Federally Administered Northern Areas [FANA] and Azad Jammu and Kashmir [AJK] regions) (see Figure 10).

Figure 6: Map of Pakistan



NWFP: North West Frontier Province
FATA: Federally Administrative Tribal Area
FANA: Federally Administrative Northern Area
AJK: Azad Jammu & Kashmir

i. Country economic and social indicators

a. HDI, GDI and GEM

Fifteen years after ICPD, Pakistan's total population stands at an estimated 180 million with an average growth rate of 2.2% per annum, ranking it 6th in the list of most populous countries of the world.[1] It has receded from a record high growth rate of 3.7% per annum in the 1960s. According to the Pakistan Health and Demographic Survey 2006-07, 41% of the population is below 15 years of age, 55% are in the age group 15-64 and 4% are over 65. The overall sex ratio for all ages is 102 men per 100 women, which is considered implausibly high and attributed to a tendency to under-report women.[2]

Despite economic recession, militarisation, significant religious extremism and internal displacement of people, all of which have had a severe, adverse impact on Pakistan's development

Table 30: HDI, GDI and GEM trends in value and rank

	1995	2000	2005	2007
HDI Value	0.483	0.522	0.551	0.572
Rank	128	135	136	141
GDI Value	0.360	0.489	0.525	0.532
Rank	-	67	124	124
GEM Value	0.153	-	0.377	0.386
Rank	-	-	82	99

Source: Human Development Reports 1995, 2000, 2007-8, 2009. Available at: http://hdr.undp.org/en/reports/global/hdr2009/

sector, Pakistan's development status on the Human Development Index (HDI) has improved steadily; ranking 134th out of 177 countries in 2004, it now stands at 141 out of 182 countries, with a value of 0.572.[3]

Gender indicators have also gradually improved: the Gender-related Development Index (GDI) value is 0.532 with a ranking of 124 out of 155 countries and the Gender Empowerment Measure (GEM) value is 0.386 (99th rank out of 109 countries). Female life expectancy is now 66.5 years, whereas male is 65.9 years.[4] The adult literacy rate for females and males is 44% and 69%, respectively.[5] (See Table 34.)

Pakistani women have achieved some major milestones and significant amongst these is their political presence. At present, 24% of the National Assembly is composed of women (women on general seats are 15 and on reserved seats are 60, out of a total of 314 MNAs) and 17% of the Senate are women (total 99 Senators).[6] At the district level (*zila* level), there are 27,703 women councillors. Increasing literacy, the Protection of Women (Criminal Laws Amendment) Act 2006 and other related measures have aided women's progress with reduction in social exclusion, poverty alleviation and healthcare. At least four women's rights activists are now in the National Commission on the Status of Women (NCSW). Furthermore, the first female Speaker of the National Assembly of Pakistan was elected in 2008.

b. Human Poverty Index

Despite these improvements, poverty remains notable; the global economic recession, rapid devaluation of the rupee, escalating food and non-food inflation, compounded by lack of adequate governance and political stability, have retained significant levels of poverty in Pakistan.[7] Alarmingly, extreme poverty is leading to suicides.

The Human Poverty Index (HPI-1) value of 33.4% for Pakistan, ranks 101st among 135 countries for which the index has been calculated.[8] The country's Gross Domestic Product (GDP) for 2008 with regards to purchasing power parity was USD454.2 billion. As per official exchange rate, Pakistan GDP was USD160.9 billion with an expected 2.0% growth in 2008-09 as compared to 4.1% in 2007-08; the per capita GDP of Pakistan with regard to purchasing power parity was USD2,600 in 2008.

The poverty head count ratio has increased from 33.8% in 2007-08 to 36.1% in 2008-09, thus placing approximately 62 million people below the poverty line.[9] The poor in Pakistan are disproportionately rural and female. Fifty-two percent of Pakistani women suffer from poverty of opportunities, compared to 37% of men. The level of income inequality as defined by the GINI Index is 30.6. Socio-economic disparities are considerable: the poorest 10% survive on 3.9% of the national income, while the richest 10% have access to 26.5%.

c. Health sector

In 2006, government spending on health as a percentage of the GDP was 0.51%. Though health expenditures in absolute terms have shown a steady increase over the years, government spending on health as a percentage of GDP remains almost stagnant, standing at 0.57% in 2007-08.[10]

Under-5 mortality rate for girls is 94 per 1000, while for boys it is 85 per 1000 births.[11] The greater mortality rate for girls appears to be due to neglect in childhood and needs to be probed further. Disparities are high: under-5 mortality in the poorest 20% of the population is 121 per 1000, and in the richest 20%, is much less, at 60 per 1000.[12]

The ILO Maternity Protection Convention 2000 is applicable to, and enforced, for women employed in the government or corporate sector as registered workers; they are eligible for maternity benefits (cash, maternity leave, hospitalisation benefits), but it is not strongly enforced in other cases, e.g., agricultural workers or women in informal employment. So far, there is no legislation for

paternity leave. Since few government offices or private organisations have crèches at the workplace, women are unable to bring their infants to work.

d. Literacy

The national adult literacy rate (age 15 years and above) is 54.2%. Gender inequalities are clearly apparent in adult education with the female literacy rate at 39.6% and male literacy rate at 67.7%. Literacy remains higher in urban areas than in rural areas. The combined gross enrolment ratio in 2007 is 34.4% for girls and 43.9% for boys.[13]

Resistance to girls' education is decreasing; however, parental reluctance to send their daughters to school sometimes stems from safety factors, housework or discriminatory factors. At times, child marriages and other traditional norms are a hurdle to girls' education too.

e. Labour Force Participation and Employment Rates

Pakistan has a labour force of approximately 52 million people. The labour force participation rate for females is 19.6%, while male is 69.5%. The number of women under the category 'employed' indicates a declining trend: from 31.2% in 2003-04 it has come down to 22% in 2007-08. Seventy-five percent of females are employed in the agricultural sector, 12.6% in services and 12.2% in industry. The overall unemployment rate remains unchanged at 5%.[14]

f. International conferences, declarations, treaties and conventions signed by Pakistan

Pakistan ratified the Alma-Ata Declaration of 1978; it is a signatory to the International Conference on Population and Development (ICPD) Plan of Action, 1994, and to the Fourth World Conference on Women, 1995. It was also a signatory to the UN World Summit 2005, which was a follow-up to the UN Millennium Summit 2000 in New York.

Pakistan has signed and ratified the 1948 Universal Declaration on Human Rights and the Vienna Declaration and Programme of Action adopted at the World Conference on Human Rights in 1993. The 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), was ratified in 1996, but with a reservation on article 29(1), pertaining to disputes. A general reservation invoking the primacy and supremacy of the Constitution over and above the provisions of CEDAW was made. The government has submitted reports to the CEDAW Committee though all have not been shared publicly, and it has not yet signed the Optional Protocol.[15]

The 1966 International Covenant on Civil and Political Rights, and the 1966 International Covenant on Economic, Social and Cultural Rights were ratified by Pakistan in 2008. The 1989 Convention on the Rights of the Child was ratified in 1990. Pakistan is a signatory to the 2002 SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution, and to the 2000 ILO Convention No. 183 on Maternity Protection.

g. National level laws and policies on SRHR, women/gender equality; young people's SRHR; Violence against Women, rape, sexual harassment and trafficking

The draft National Youth Policy 2006 was circulated widely amongst NGOs and the civil society. It was also reviewed by the Pakistan Reproductive Health Network (PRHN) members to address sexual and reproductive health and rights (SRHR) issues. Suggestions included amendments to language to be proactive, gender sensitive, and rights-based; incorporate specific SRHR concerns, education, information, and access to safe and friendly youth services. These suggestions were forwarded to the Ministry of Youth Affairs. Unfortunately, the process has stalled and the draft policy remains pending. The promulgation of the Protection of Women (Criminal Laws Amendment) Act (WPA) 2006 provides protection to women in cases of violence and false accusations of *zina* (adultery). The promulgation of WPA 2006 was the result of concerted struggle for more than 25 years by women's and human rights activists and NGOs through research, advocacy and lobbying with policy makers, parliamentarians and linkages with the media.

A similar process has been followed for two more Bills: the Domestic Violence (Prevention and Protection) Bill and the Criminal Law (Amendment) Bill have both been passed by the National Assembly and tabled in the Senate in 2009. Both bills have been prepared with inputs from the women's movement, Human Rights Commission Pakistan and the legal fraternity. The Criminal Law (Amendment) Bill includes amendments to the Pakistan Penal Code and Criminal Procedure Code to enhance punishment for offences relating to harassment of women.

The National Plan of Action for Women 1998 and the National Policy for Development and Empowerment

of Women 2002 are indicative of government commitment to implement institutional gender reforms. The Ministry of Women's Development in collaboration with civil society organisations (CSOs) is revising the NPA in light of the developments of the past decade. Shirkat Gah is also deeply involved in this process. The revised NPA will draw upon the ICPD+15 and Beijing+15 review processes underway, and align Government's priorities with emerging concerns. The National Policy for Development and Empowerment of Women is also currently under review.

ii. Context of the country in terms of SRHR

Changes in the sexual and reproductive health and rights arena have been mixed in Pakistan. Women's and girls' increasing educational opportunities have contributed to their rising age at marriage; women's age at marriage before age 15 has declined from 15% in the oldest cohort to 7% among women aged 20-24; mean age at first marriage has increased from 21.7 in 1990-1991 to 23.1 in 2006-2007.[16]

However, to date, there is no policy on SRHR: the National Health Policy refers only to maternal and child health. The government has continually shied away from any discourse on sexuality, except for STIs and HIV and AIDS with resultant inadequate public awareness of SRHR. The maternal mortality currently stands at 276 per 100,000 live births, with relatively low Contraceptive Prevalence Rate (CPR) at 30% and Total Fertility Rate (TFR) at 4.1. Currently, skilled care at childbirth is available only in 39% cases.[17] Optimal SRHR is impeded by limited access to family planning (FP)/reproductive health (RH) services, including outreach particularly to rural areas: Lady Health Workers (LHWs) or community based health workers provide coverage in the rural areas. Contravention of women's SRHR is evident in some contraceptive practices, e.g., spousal permission is considered essential for female sterilisation, as a requirement of the Ministry of Population Welfare (MOPW). The converse, of spousal permission for vasectomy, is not required. This spells a clear violation of women's right to contraception (interview with Dr. Laila Shah, Marie Stopes Society, Karachi, Pakistan).

Information on the legal and religious aspects of abortion in Pakistan is quite abysmal. Due to insufficient publicity regarding permissibility of abortion under certain circumstances, no government hospital will admit to any abortion case till the situation regarding it is clarified as part of Government Health Policy. According to an interview with Kamal Shah, Chief Executive Officer, FPAP, provincial health and population secretaries admit to their confusion on this issue but state that this is in accordance with Government policy. A few NGOs working in the RH sector provide post-abortion care related services in accordance with the Pakistan Penal Code, e.g., the Family Planning Association of Pakistan (FPAP) will provide services for rape survivors, or in case of contraceptive failure.

iii. SRHR, STIs and HIV and AIDS

According to estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS), about 96,000 people were living with HIV in Pakistan at the end of 2007 (just over 0.1%). Despite the low prevalence, there is evidence of local concentrated epidemics among Injecting Drug Users (IDUs) in major cities across the country (between 10-50% in Quetta, Faisalabad, Hyderabad, Karachi and Sargodha).

Since majority of the IDUs are either married or sexually active,[18] this constitutes a major threat of the spread of the virus to the general population. Prevalence rate amongst antenatal women have not yet been estimated (interview with Dr. Sikander Sohani of Aahung, Karachi, Pakistan). However, PDHS 2006-7 reports that women between 15-49 years who have ever heard about AIDS were 44% and 51% of them knew at least one method of preventing it. Nevertheless, gender inequalities may contribute to the spread of HIV and AIDS in Pakistan; women's low socioeconomic status, lack of mobility, less decision-making power as compared to men and issues of access are significant concerns.[19]

iv. Progress associated with ICPD

A National ICPD Plan of Action was never prepared. In 2000, a draft National RH Policy was prepared based on the ICPD definition of RH. However, this was never formally approved by the Ministry of Health or Population Welfare. The National Health Policy 2001 reflected the ICPD philosophy by addressing issues of RH with the inclusion of rights through primary health care. The policy builds upon a national vision for the health sector based on a 'Health-For-All' approach as defined in WHO's Alma-Ata Declaration of 1978 and continues in the direction set by ICPD. The Pakistan Population Policy 2002 is a direct follow-up of the ICPD commitment.[20] Monitoring of progress regarding ICPD commitments is regularly carried out by the government, though government reports tend to focus on achievements, not gaps.[21]

According to one expert interviewed for this study (Dr. Laila Shah, Marie Stopes Society, Pakistan) there is now an increased collaboration between the MOH and MOPW at the field level which has led to improved Primary Health Care (PHC), contraceptive

facilities, safe abortion and Post-abortion Care (PAC). She further stated that the Pakistan Government plans to increase Lady Health Workers to 200,000 across the country.

v. Criticality of the issue

This study focuses specifically on contraception and abortion, since these two areas are crucially important for achieving progress not only in the population and development sector, but also for overall national progress.

As mentioned before, Pakistan has 41% of its population below 15 years of age; their future reproductive health needs promise to be significant. Also there exists an unmet need for contraception in the current population estimated at 36%[22] (unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception). Meeting the current and future RH demands of its population is going to be an important challenge for Pakistan.

In the wake of the large unmet need for contraception, the fate of many unwanted pregnancies in Pakistan is induced abortion. About 890,000 induced abortions, with 196,671 of them being unsafe abortions, are estimated to take place in Pakistan each year.[23]

Unsafe abortion is sought in times of critical need, largely due to insufficient awareness of the law and public orthodoxy (interview with Dr. Laila Shah, Marie Stopes Society, Karachi, Pakistan). In Pakistan, under certain circumstances, abortion has been considered permissible[24] since 1997, to save the woman's life or to provide 'necessary treatment.'[25] Islamic law also permits abortion up to the first 120 days of pregnancy, prior to 'ensoulment.'[26]

Keeping these factors in mind and the threat of contraceptive commodity insecurity looming large in the near future, highlighting and advocating for these issues becomes critical for the health of its population and progress of Pakistan.

II. OBJECTIVES AND METHODOLOGY

i. Conceptualising the research

Initial desk research and data analysis, with valuable contribution by key informants and stakeholders, provided the basis for the monitoring review, steered through the Pakistan Reproductive Health Network (PRHN). Media reports added topicality in Pakistan's fast-changing political and economic scenario. Research locations were selected from Shirkat Gah outreach areas.

Two components of the RH package were probed: Comprehensive Family Planning (FP) services for women and men; and maternal health care, including safe motherhood and post-abortion care (Contraception and Abortion). The finer facets studied were the availability of/and hindrances to contraception at the grassroots level; people's attitudes towards contraception; availability and accessibility to safe motherhood services; and post-abortion care.

Where requisite facilities were unavailable, the reasons were investigated, including the prevalent situation in case of emergencies, or alternatively, in case of unwanted pregnancies. The study also obtained understanding of women's daily health care needs, including difficulties encountered within the home (e.g., limited inter-spousal communication) and within Basic Health Units of the Government of Pakistan and other health facilities.

ii. Overarching research/monitoring questions

Pakistan's commitments at ICPD led to the introduction of the Pakistan Population Policy 2002. This was reviewed with an overarching question to ascertain the impact of Health and Population policies at the community level. For the focus-group discussions (FGD) and in-depth interviews (IDI) guides, different components of RH were probed:

- Maternal health care, including safe motherhood, pre and post-abortion care for complications
- Availability of RH/FP services/ facilities;
- People's decisions regarding RH/FP by women/ couples;
- Community awareness and support for RH/FP
- Availability of new services/facilities
- Source of provision: Government, NGO sector or individuals?
- Common complaints about services and facilities
- People's health-seeking habits
- Knowledge of the use of ultrasound examination (this question was asked to establish uptake of modern health facilities, i.e., awareness regarding it, accessibility and utilisation; furthermore it was asked to probe possible prevalence of female foeticide)
- Availability of quality health care for women during pregnancy and delivery
- Transport arrangements for emergencies

In-depth interviews:

- Women/couples' responses to unwanted pregnancies
- People's/women's feelings regarding abortion
- Availability of safe/unsafe abortion facilities
- Quality of availability (i.e., do facilities/services include doctors, nurses, LHWs and others)
- Generally observed post-abortion complications and service provision in such cases
- Reasons for termination of pregnancy and related questions like who takes the woman for abortion and others

iii. Methodology and location

Two villages, Village Piyaro Lund in Sindh and Haft Madar in Punjab were selected for collecting information on the areas of interest to the study. Shirkat Gah has had a long presence in these locations and has developed trust with the community through its community-based organisation (CBO) partners – a fact which enabled rapport with villagers and facilitated answers to the sensitive questions of the study.

III. FINDINGS AND DISCUSSION

i. Characteristics of the FGD and IDI participants

As mentioned earlier, the participants of the focus group discussions and the in-depth interviews were residents of the villages of Piyaro Lund in Sindh and Haft Madar in the Punjab. The FGDs of men in the Punjab were conducted on Christian (one FGD) and Muslim (two FGDs) communities, while in Sindh, all three FGDs were conducted with Muslim men. The FGDs and the IDIs of women were conducted only on Muslim women both in the Punjab and Sindh villages.

Of the three FGDs conducted with men in the Sindh village (SV), 47 men participated in total; 17 in the first one, 15 each in the second and the third group. One FGD consisted of men from the Nagore tribe who were mostly farmers; the second FGD was conducted on men from the Lund Baluch tribe who were farmers, shop keepers and students and the third was conducted on men from the Syed clan who were farmers, teachers and some students. Most of them were in the age group of 21-30 years (19) but their ages ranged from teenage to 70 years.

Of the three FGDs conducted with men in the Punjab village (PV), 35 men participated in all; 12 in the first one, 11 each in the second and the third group. One FGD consisted of Christian men who were mostly daily labourers; the second FGD consisted of Muslim men from the Gujjar clan who were farmers and the third consisted of Muslim men from the Rajput clan who were also mostly farmers. Most of them were in the age group of 31-40 years (12) but their ages ranged from 20 to 70 years.

Of the three FGDs conducted with women in PV, again a total of 47 participated. The ages ranged from teenage to 50 years but the average age group represented was that of 21-30 year (23) and 31-40 year (16). They were from the Gujjar and Rangher clans. Although these women had no specific profession, their daily work included household chores, working in the fields next to the village.
Of the three FGDs conducted with women in SV, a total of 59 women participated. Their ages ranged from teens to 70 years but the average age group represented was 21-30 year olds (17). There were 21 women in the first group, 20 in the second group and 18 in the third group. Their daily work was the same as that of the rural women in the Punjab.

A total of four female in-depth interviews were conducted in PV: one of a TBA who was a 60-year old with eight children (5 boys and 3 girls), second of a 40-year old housewife with seven children (3 boys and 4 girls), third of a 35-year old housewife with three children (two boys and one girl) and the fourth was of a 24-year old Lady Health Worker (LHW).

In the Punjab, an in-depth interview was conducted on a 55-year old man with 10 children (five boys and give girls) who was an electrician by profession.
A total of three IDIs were conducted of males in SV; all interviewees were residents of village Piyaro Lund, District Tando Allah Yar, Hyderabad, Sindh. They included a 30-year old shopkeeper who was educated up to eighth grade and belonged to a poor family (income is Rs.3000 or USD34.80 per month) and of the tribe Khaskheli. The second interview was of a 45-year old male, who had education until second grade and by profession was a trader belonging to the Mirbahar tribe. The third interviewee was a 40-year old male, educated till the eight grade, and also a trader by profession belonging to the Lund Baloch Tribe.

Of the three IDIs conducted of females in SV, one was of a trained birth attendant (TBA), another of a 38-year old housewife with five children (three boys and two girls) and third of a 35-year old house wife with six children (three boys and three girls).

If one looked at the number of offspring in the PV focus group, the older Muslim men and the Christian men had on average seven to nine and six to seven children respectively, whereas the younger Muslim men had two to five children.

ii. RH services and the RH needs of the population

The study showed that there was a universal dissatisfaction amongst the respondents regarding the availability of the RH services at the level of the village and/or the community. This was particularly true of respondents from SV, both men and women. Nonetheless, as regards improvement in the awareness regarding RH issues, women in SV and both men and women in PV reported an improvement in the last five years.

However, men in SV reported none or little improvement. According to them, there had been little or no change in the RH/FP knowledge amongst men. They further added that the newly created cadre of LHWs needs to talk to men too because lack of proper knowledge prevents Sindhi men from adopting new FP methods *(more on this in the FP section)*. According to them, the current cadre of LHWs are young and unmarried, and they are hesitant and shy in talking to men about RH/FP related issues. They suggested that the Pakistan government needs to recruit married LHWs who would be more confident in talking to men in the community. In contrast to this opinion, younger and educated respondents in both study areas reported a greater awareness and better FP practice amongst their group and peers.

The universal dissatisfaction extended to the government-run health care delivery system, particularly at the Basic Health Unit (BHU) level. A BHU was a First Level Health Care Facility (FLCF) established in the 1980s by the Government, for providing Primary Health Care (PHC) at the village level all over Pakistan. BHUs have been usually located only three to five kilometres from the villages they serve. However, the field findings in both the villages in Sindh and Punjab show that, except for the very poor, BHUs were generally avoided by the respondents. Different reasons were given for this including: 1) BHU being a government facility, shuts down at 2p.m.; 2) it was invariably ill-equipped; 3) it was under-staffed or the staff were absent; 4) it had a poor supply and quality of medicines; 5) the attitude of the staff was careless; 6) and the staff charged a fee where there should be little or none. Going to the BHU was thus considered a waste of time and avoided. In contrast to this, the poor and the indigent in the village, who had little choice, were reported to utilise BHUs more regularly for their needs. However, even in this, women in PV reported that the BHU staff provided facilities like medicine and others to the people whom they were acquainted with and neglected the others.

Another strong and pervasive fact that emerged from the field findings was that nearly all respondents, except the poorer ones, in both villages, reported utilising privately run health facilities, located in the nearest town (usually 10-15 km. from the village), for any/all of their RH needs. This was despite the fact that it entailed greater expense (usually out-of-pocket) and travelling a greater distance. Respondents reported a greater trust and satisfaction on the private sector health facilities. Unequivocally, the health service of choice for RH needs (and others too) of the respondents was the private health sector. In both villages, the husbands usually cooperated with their wives in seeking quality health care services from the nearest town. In some instances, the in-laws were supportive too.

Community support, in the form of money, or looking after the household when the woman was taken to the hospital or in providing timely transport, was reported to be usually present. However, occasionally, the local leaders were not very cooperative. Also husbands tended to have/save an emergency fund when the wife got pregnant which was utilised at the time of need. However, the quality of the transport was very doubtful as women in PV reported being transported in a tractor trolley and suffering severe injuries like placental tears and bleeding , and even delivering in the trolley because of the rough ride.

Respondents in PV reported a steady decline in the use of home remedies, saying it was now only 50% popular. However, in SV it was still a common and a popular practice, with a reported prevalence of 80%. In PV, if a home remedy failed, then the patient was taken to a hospital. However, in both the villages in S&P, home remedies were still practiced by the poor and some women in SV reported that it caused death in extreme cases. The practice of consulting traditional spiritual leaders, including the local *pir*, was still common and some men in PV went so far as to say that they had prevented pregnancy through a *taweez* (an amulet).

The health service providers involved in the delivery of the RH services in the villages were quite a few and included (in decreasing order of popularity) 1) the (private) doctor (or hospital /maternity home) in the nearby town (very popular); 2) the spiritual healer (particularly for the poor); 3) the *Dai* (TBA); 4) Village Dispenser; 5) the nurse; and 6) the *Hakeem* (traditional physician).

Amongst the minority group, i.e., Christians studied in PV, the situation seemed to be particularly bad. It seems that their only recourse to RH services were the private hospital/s in the nearby town of Bhai Pheru, as even the Muslim *Dai* of the village was not ready to attend to the Christian women. There was a strong stigma attached to the *Dai* visiting the Christian women and Muslim members of the community would taunt her with remarks like

"have you become Christian too" if she did so. The Christians tended to go to a nearby town (again different from the town frequented by the Muslim community members) because it was where their relatives resided and they could stay with them for free. Furthermore, the level of awareness regarding FP of the Christian group was very limited.

iii. Safe motherhood

Awareness and better practices regarding safe motherhood have greatly improved (as the Pakistan Demographic and Health Survey [PDHS] 2006-7 data has also demonstrated). Women in both villages (in Sindh and Punjab) reported regular antenatal check-ups (ANC), with tetanus toxoid immunisation. The ANC, performed generally three times during the entire pregnancy, was usually done on the advice of a doctor and an ultrasound was performed at each visit.

The ultrasound was definitely the 'new kid on the block' and very popular. Whilst in PV, men and women reported that the ultrasound was used to determine the health and the position of the foetus, in SV, it was invariably reported that it was also used for determining both the position and the sex of the foetus. If it was a female foetus, the woman usually kept quiet and became sad. There was no report of sex-selective foeticide. The urge to know the sex of the child emerged very strong in the respondents from Sindh, where women went to a private health facility that charged Rs.200 (USD2.30) per visit as compared to a government facility, where it cost only Rs.50 (USD0.58) (1/3rd of the private fees) because the private facility revealed the sex of the foetus whereas the government one did not.

The behaviour regarding delivery seems to have undergone change over time as institutional deliveries are more popular now as compared to home deliveries. Men and women in both villages reported a trend towards institutional delivery at a private health facility in the nearby town as compared to home delivery in the village. This was truer for the well-to-do in the village (as mentioned earlier). In both S&P villages, it was reported that the poor still use the services of the TBA (untrained *Dai*) for home-based delivery. The TBA was assisted by the village dispenser who administered any injection that the woman may need. However, an interesting change reported in the behaviour of the *Dai* was that in case of a suspected complication, she referred a woman quicker to the health care provider as compared to before.

There seemed to be a limited trend towards post-natal check up in both villages. Few women reported going for one. Again, this finding was in line with the findings of the PDHS 2006-7.

iv. Family planning

In PV, a significant finding was that FP awareness was poorest in the Christian community. The Christian men reported no knowledge of any form of modern contraception. On the other hand, Muslim men reported that as women breast fed their babies for 2-2.5 years, natural birth spacing took place. Also in PV, the religious leaders, generally considered to be against FP, were reported secretly practicing it. They kept it a secret because they did not want other people to think they were committing a sin. Most of the older Muslim men in PV also considered FP to be bad.

The LHWs were particularly prominent in the field and were associated strongly with polio campaigns and distribution of FP supplies, especially in SV. In SV, the FP supplies (pills and condoms), which were distributed for free by the LHWs, were reportedly discarded by the community. Some women even reported giving the condoms to their children to use as balloons. Women ascribed the discarding of FP supplies to the fact that they were distributed free of cost and people do not appreciate anything given for free. This was particularly ironic as the men in SV reported purchasing condoms from the local pharmacy for their use. The purchases of condom were not done openly but secretly as people were shy about it. In PV, six grocery shops out of 12 (50%) stocked condoms but also sold them secretly for fear of detection. In contrast, the LHW network had a patchy outreach in PV with very limited FP service provision.

The LHW in PV reported that she had recently been given the injection Depo-Provera for administering to the women in the village. However, she reported that the village women felt that it may cause excessive bleeding during the monthly periods and/or also cause infertility, so they did not use it and the injection was not popular. Women in PV preferred sterilisation at the time of delivery and usually after five to six or more children. However, in SV, the injection method was popular and frequently used. Women in SV reported feeling more secure from unwanted pregnancy for three months with an injection and there was no hassle of remembering to take something daily (as in the pill).

Women in both S&P villages reported frequent and disturbing side effects and failure of modern FP methods (e.g., IUDs caused infection, increased bleeding, loss of breath and even cancer leading to death; use of oral pills resulted in obesity, leucorrhoea and menstruation becoming irregular). The side effects produced a great deal of fear and discouraged FP uptake by women. It not only led to cessation of use of FP methods but also discouraged from using any other method and discouraged

others from taking one up. Many women in PV also reported frequent failure of FP methods and therefore preferred sterilisation as it was trustworthy. Some men in SV reported to have undergone a vasectomy but men in PV felt that this would cause impotence and therefore kept away from it. Male condom use was reported and disposal of condom was cited as a big problem; they had been disposed off in *masjid* bathrooms or local drains. In PV, Muslim men felt that FP was more a responsibility of the woman.

Except for men in SV, most people reported that the awareness about FP had increased manifold, and TV and CSOs were quoted as an important medium of information. Many people in the villages possessed TV in their homes.

One significant finding regarding FP in both S&P villages was that it was particularly popular amongst the younger age group and used more by them. The small family norm seemed to be the preferred reality of the younger and/or more educated generation. Regarding preference for FP method, each area had its own preference, as outlined in Table 35.

The concept of using FP method through mutual consent (Table 36) was evident throughout the two areas studied, although secret use (meaning without informing the husband) and opposition to the use (e.g., the husband asking why the wife wishes to use family planning when he is providing for the children) continues to persist. Additionally, in some areas, although rare, the idea that FP is a sin also persists. Usually if husband and wife were in agreement, then the influence of the in-laws, particularly the mother-in-law, was reportedly reduced; in some places, the in-laws were reported being supportive of FP use by the woman.

A very interesting finding was that some men in SV stated that women are free to decide about FP, pointing towards a possible emergence of women empowerment. One lady councillor in the Sindh village reported that using FP was her own decision and that she received complete cooperation from her husband. However, this was a minority opinion and still, by and large, women could practice FP only after getting permission from the husband.

As compared to older women (age group 40-50 years), the younger women (age group 21-30 years) in PV, expressed a strong desire for limiting their family size but could not access FP services. The younger women felt that two children were enough whereas the women of the older age group reported a desire for larger families. The inability to access FP services had different reasons, e.g. the BHU did not offer FP services or because the services were too costly.

Thus, despite a potent (unmet) need for FP, the strong (rather very strong) deterrents to FP use and continuation were reportedly cost of buying FP supplies regularly, the reported side effects and lack of money to treat side effects. Other factors like effectiveness (as opposed to failure to prevent a pregnancy), accessibility and availability to good quality and cheap services for treating the side effects, were quoted as important factors too.

v. Unwanted pregnancy/Abortion

In the absence of good quality FP services, women resort to induced abortion to limit family size. This trend seemed to come through far more so in PV. Interestingly, on first questioning, most people denied this practice but on further questioning or by questioning around it, it became clear that it was a common practice.

a) Men's attitudes towards induced abortion:

The constant response of men from the S&P villages, both for Muslim and Christian men, was that induced abortion (IA) was a sin (almost 100% response). In the SV men said that even amongst their Hindu friends, this was considered a sin and they insisted that it was not practiced in their area.

Table 31: Preference of FP method (in %)

Punjab *(for both males and females)*	***Condom***	***Pills***	***Female Ster.***	***Male Ster.***	***Injection***	***Copper-T***
	10	5	70	0	5	10
	Condom	***Pills***	***F &M sterilisation***		***Injection***	***Copper-T***
Females	2	9	12		73	4
Males	43	20	4		33	0

Table 32: FP - Mutual decision

	Yes	**No**
Punjab *(for both males and females)*	80	20
Females	85	15
Males	80	20

However, further probing (discussed below) proved otherwise.

b) Women's attitudes and induced abortion:

Induced abortion seemed to be a common practice for women for FP purposes especially in PV. Interestingly, as in the case of other RH findings, the richer women were able to get the services of a qualified medical doctor (even a qualified gynaecologist), usually at a private hospital in the town nearest to the village.

The poorer women used the services of the village *Dai* and had an abortion performed under very unsafe conditions, leading to severe complications and even death was reported.

Apart from the medical doctor (in case of the rich) and the local Dai (in case of the poor), others who could be consulted for an induced abortion were the nurse and the local LHV. In fact, all range of female paramedics could be consulted in case of need, however, the LHW in PV reported that she considered it a sin and would avoid the subject if any woman asked her advice. Also the LHW reported that the government had not given them any medicine for this.

c) Cost of an induced abortion:

An induced abortion was usually an expensive procedure and the cost was equivalent to the month of pregnancy. The fee that was charged was about Rs.1,000 (USD11.6) per month in case of a married woman or girl and much more expensive in case of an unmarried woman or girl.

d) Marital status of women seeking induced abortion:

Reportedly, pregnancies were not uncommon in unmarried girls and it was reported that they resorted to induced abortion to get rid of it, especially in SV.

A few cases of unmarried girls getting pregnant and seeking an abortion were mentioned by the Sindhi men. As regards the reaction to such an incident, men stated that no honour killing took place in such circumstances as it was the family's matter and *Karo Kari* (honour killing) was more common in upper Sindh and not here.

e) Side effects of induced abortion:

Secondary infertility following induced abortion in both married and unmarried girls was commonly reported in both villages. Another common complaint was continuous severe bleeding for three months and continuous severe pain. Death was also reported following an induced abortion in PV by women.

f) Reasons for IA and husband's involvement:

The reasons quoted for seeking an abortion were manifold and included: 1) too many children, 2) poverty, 3) child too young, 4) mother too weak, 5) girl too young at marriage, and 6) newly wedded women who do not want a child immediately.

If a woman felt that her husband would oppose induced abortion, she went to her parent's house and had it secretly done there. However, women reported that many times, the husband supported the wife in seeking termination of pregnancy and provided the finances for it too. Sometimes, pressure from in-laws stopped a woman from getting an abortion even when she wanted it herself.

g) Methods adopted for IA:

The methods adopted for induced abortion included the traditional ones, i.e., inserting something into the vagina which could be an herb or a piece of wood (which usually was quite effective but also dangerous and unhygienic) or ingesting some strong herbal remedy (which may or may not be effective). Modern methods used for abortion included invasive ones like D&C. The use of the MVA was not reported.

Box 14: Case Study: Feroza

Feroza is 38 years of age. Educated till primary level, she was married 22 years ago at 16 years of age. She has three daughters and two sons. Her husband is a government employee and she herself is a former village councillor.

She lives independently, separate from her in-laws. She said that they have no health facility in their village but a Lady Health Worker visits the village and distributes contraceptive pills, tablets for strength and sometimes cold and fever medicine for children. She claimed that the injectable hormone is good and if they ask a doctor, they administer it.

Feroza said that men voice strong opinions regarding family planning. The opinion of in-laws on FP is not important because if the couple agrees, then no one interferes. However, if a woman has an operation (contraceptive surgery or tubal ligation), some people in the street (Mohalla) may comment but now most women have started FP. The decision is mutual -- a woman is like a leaf in the wind, she cannot decide on her own.

The Dai is available for RH but now the LHW also visits the village. However, the Government has provided no services. As for access to health facilities, they call the local Dai (available in the village) for any (RH) ailment. It would be more satisfactory if there were health services available in the village and they would not need to go far for them.

In case of any emergency, her husband takes her to the doctor in the nearby District Hospital Tando Allahyar using hired transport. Feroza gave birth to her first two children at home. The third child was born in a hospital, and the fourth again at home. She had her last child at the hospital. As a home remedy, she asked the Dai to massage her. Fortunately, Feroza has never had any miscarriage.

She said that women go for an ultrasound when the doctor asks them to. The change in the last five years is that now men take their women for regular check-ups and follow the doctor's advice. Also, the town of Tando Allahyar now has a lady doctor.

She mentioned that she had been practicing FP, i.e., taking the pill and using hormonal contraception; but she conceived. She said that because she is an independent woman, she talked to her husband and said she did not want this child as she felt unable to raise a small child. Her husband agreed and she went to a Lady Health Visitor (LHV) and had a D&C. It hurt a great deal but she had no choice.

The LHV was untrained because after recovery she consulted a Lady Doctor who told her she had developed a wound in her uterus and that was why there was constant bleeding and fever. She treated her for three months and now she was better.

The LHV charged her Rs.2000 (USD23) for the abortion. Feroza says that her family did not adversely react to her getting an abortion as it was a mutual decision of the couple. The couple is now careful in their use of FP so as to avoid going through another painful episode like that.

** Ferosa (wife of Sagheer Hussain), Village PL, District Tando Allahyar, Hyderabad, Sindh*
Note: Names have been changed to maintain the privacy of the interviewees and the village's name has been changed.

h) Post-abortion care:

Regarding post-abortion care (PAC), when poorer women underwent a miscarriage, the local *Dai* administered methergin to the woman while the more well-to-do went to private facilities.

However, what was tragic was that women reported that after going through the trauma of induced (unsafe or safe) abortion, usually conducted in the third month (however, fourth month pregnancy termination and beyond were also reported), the woman was not put on any FP method or provided any counselling on prevention of pregnancy and was soon pregnant again.

IV. CONCLUSIONS AND RECOMMENDATIONS

i. Conclusions

Data from the field reinforced the entire cross-cutting differentials demonstrated by the PDHS 2006-7 that affect the use of RH/FP and other services. Thus education, age group, income level, all affected the uptake of reproductive health services and the use of family planning.

This study also highlighted some hitherto unknown facts and pointed out many significant and challenging aspects of RH in Pakistan. It seems that whereas at one end, people in the community feel that there has been an improvement in the knowledge, awareness and practice (utilisation) of RH/FP services, yet on the other hand, it is not the government but the private sector that seems to be fulfilling their RH needs and is more trusted by them. Men and women nowadays are going towards institutional delivery, antenatal check-ups, ultrasound examinations and there is more FP use amongst the young and/or educated.

However, the poorer and the marginalised, the ones who need good quality subsidised government sector services the most, continue to be denied that and depend on unskilled and unsafe health practitioners for fulfilling their requirements.

Media, particularly television, has played a significant role in raising awareness on RH issues and reinforcing desired behaviour. However, services continue to lag behind, whereas it should be the opposite, i.e., advocacy only after the services have been set up properly. What has changed little includes post-natal care and post-abortion care (PAC). These services still remain elusive, patchily available, unknown and/or unpopular.

Despite many private NGOs coming into the field of RH/FP service provision that provide good quality PAC, their outreach and impact is still limited. This could be due to the size of the country and it will take a long time for them to reach the villages of Pakistan.

Opposition to FP use, though less, is still found in the community especially amongst the older and more religious minded. Amongst the newer findings is the information on the needs of the unmarried youth and the ubiquitous (and iniquitous) use of the ultrasound.

Unmarried girls/women need FP counselling and reliable services to prevent (unsafe) induced abortion and subsequent sequelae of secondary infertility with all its concurrent severe social problems. Although the ultrasound is amongst the best tools for monitoring the health of the pregnancy, but its use as a sex identifying tool is a dangerous phenomenon that needs further investigation.

An important unmet need that emerged from men was for more reliable knowledge on RH/FP, especially in the Sindhi village. Whereas most LHWs are serving women of the communities where they are located, being young and unmarried and living in this conservative culture, they are embarrassed and reluctant to discuss issues related to sexual matters with men in the community.

Strong deterrents to FP use and continuation, despite strong (unmet) need that have emerged from the study were: 1) cost of buying FP supplies regularly; 2) the varied and frequent side effects, with many believing that IUDs caused infection and increased bleeding and that oral pills caused loss of breath, obesity and leucorrhoea and general FP use resulted in irregular menstruation, increased bleeding, obesity and infection; 3) lack of money to treat side effects, and 4) lack of effectiveness of FP, i.e., oft reported FP failure (therefore preferred sterilisation as being more reliable).

These side effects produced a great deal of fear and discouraged contraceptive use by women. Such opinions/experiences not only led to cessation of use of FP methods, but also discouraged women/couples from using other methods. Inter-spousal communication appeared to be better than expected from the literature review, in that in several cases, the use of contraception was by mutual decision. However, there were also several cases where the husband frowned upon use of contraception, nor was his wife independently able to use contraception without his permission.

Trends towards progressive change, with greater use of contraception, were particularly evident in younger community members. Communities, by and large, are well-knit and cooperative towards each other in emergencies, or in times of financial need.

However, most tend to remain within their own kind, and are reluctant to mix with people of a different community, as evidenced by the social isolation of the Christian community in the Punjab village.

Younger women appeared more attuned to inter-spousal communication (in that they reported greater use of contraception/fewer children). Some also reported independent decisions about contraceptive usage, though the majority still expected decisions by the husband. In the absence of adequate RH/FP facilities, women tend to use induced abortion as a method of contraception.

This appeared to be a common practice among women. In most cases, the husbands were cooperative and supportive, although there were cases when the wife was unable to share her decision with her husband, and had an induced abortion in secret.

An abortion law permitting abortion in specific cases is operative, but has not been sufficiently publicised. Under the circumstances, an anomalous situation prevails. Some NGOs (e.g., FPAP, MSS) provide safe post-abortion care (PAC) facilities with confidentiality, but neither MOH nor MOPW have made such facilities available to women, with the end result that a high proportion of unsafe abortions continue to occur.

ii. Recommendations

a. Recommendations for the government

The government is signatory to the ICPD Plan of Action (POA) and pledged in 1994 to provide accessible and affordable RH/FP services to all its citizens according to their need/s.

That pledge was reiterated in 2005 and enshrined in MDG 5. However, it is a pledge that remains to be fulfilled. In order to ensure that it fulfils its commitment, following are some recommendations for the government emerging from our study:

i) The government needs to focus on good quality and affordable RH/FP services at the community level by reiterating the focus of the Prime Minister's Initiative on Primary Health Care and Family Planning (PMIPHC and FP) or the Lady Health Worker (LHW) programme, as it is popularly known, towards this. The LHWs have become too involved in many other health initiatives of the government like polio eradication, malaria control etc. and their focus on RH/FP, for which this cadre was primarily created, has diminished with time.

ii) The public sector health delivery system at the First Level Health Care Facility (FLCF) level, i.e., the Basic Health Unit and Rural Health Centre, whilst physically omnipresent and ubiquitous in all Union Councils of Pakistan, needs considerable reform in order to address the RH/FP and PHC needs of the community, particularly the indigent. Public sector health delivery system reform has been tried in different guises by the government, i.e., the Public Private Partnership (PPP) model of the Punjab Rural Support Programme (PRSP); the tertiary care hospital adopting Government FLCFs like the Holy Family Hospital, Rawalpindi model and others. Successful models need to be studied and replicated or scaled up.

iii) Furthermore, the genuine need of the public/community to have a functioning public health delivery system needs basic changes in the current system too. These could be pertaining to greater resource allocation towards the public health sector in the national and provincial budgets and/or better career structures of the doctors posted in rural areas and/or on-the-job training on management, supplies and administration of the medics and paramedics posted at the FLCFs and/or a system in place of continuous medical education. Also, improvements in the service delivery can be ensured through standardisation of services, e.g., the separate system of selling of FP supplies by the LHWs and the Family Welfare Workers should be removed and a homogenous system created and/or enhanced EmOC facilities with 24-hour service provision in keeping with WHO guidelines. Last but not the least, tracking of financial disbursements at the health delivery level can ensure effective utilisation.

iv) The concept of a male health educator/FP counsellor at the FLCF level or community level needs to be seriously explored in order for FP practice and uptake to improve in Pakistan.

v) The current provisions in the Pakistan Penal Code regarding abortion law need to be highlighted and the health sector informed on it so as to provide safe abortion services within the existing legal parameters.

vi) Furthermore, the government needs to acknowledge the high incidence of induced and unsafe abortion and initiate a dialogue on it. Also, it needs to make widely available safe abortion facilities as permissible under the law.

vii) The young in the villages of Pakistan are keen to adopt new RH ways. This desire needs to be cashed in and the government needs to focus on their needs and desires. The draft National Health Policy 2009 and the draft National Youth Policy 2006 must develop a greater focus on SRHR for the male and female youth of the country so that their emerging desires are adequately addressed and the current demographic transition becomes the demographic dividend. Each province needs to develop a clear health policy on this too.

viii) The misconceptions regarding FP, whether religious or cultural, need to be continuously and aggressively addressed through organising dialogues with religious leaders and other stakeholders. The television has proved a popular medium for conveying public health messages, this should be optimally utilised in the future too.

ix) In some areas the minorities and marginalised people in the villages are being neglected. The LHWs can be trained to meet their needs too.

b. Recommendations for the donors:

Donors are effective partners in any development process in a country. However, the important point is that donors work according to evidence-based national priorities and facilitate the change process.

Some of the recommendations that emerged from this study which can be aimed at the donors include the following:

i) Initiate dialogues on public sector health delivery system reform, especially for SRHR.

ii) Provide technical support and encouragement to the government for integrated, holistic approach to health, maintaining focus on RH/FP.

c. Recommendations for the civil society organisations:

Civil society organisations or non-governmental organisations (NGOs) have continued to prove that they are important accountability mechanisms for the country. Not only that, they provide the evidence required to change and act as agents of change. Thus they play an important role in keeping the countries development process on course. Of particular importance in this are NGOs like Shirkat Gah working on women's issues and their resolution, as women continue to be denied their basic human rights. Some of the recommendations that emerged from this study which can be aimed at the NGOs include the following:

i) The NGOs need to remind the government of its obligations through a comprehensive advocacy plan. In this case, the NGOs need to advocate for the following:
   - Increased focus of LHW programme on RH/FP;
   - Introduction of male motivators at the community/facility level;
   - Meeting unmet need with special focus on emergency contraception and examining medical contraception; and
   - Challenge the limited outreach of RH/FP services, which have led to high rates of unwanted pregnancies, unsafe abortion, maternal morbidity and mortality, and chronically low CPR through advocating for provision of safe abortion services and improving post-abortion care and post-natal care.

ii) NGOs need to help achieve policy change, by pressurising the government to meet its commitments to the various United Nations conventions, protocols and conference documents that it has signed, ratified and endorsed. Included in this is the responsibility of NGOs to monitor government compliance on international commitments.

iii) Create awareness about SRHR and sexual and reproductive rights in the broader framework of women's empowerment among women's groups, NGOs, the media, political parties and especially women parliamentarians for greater and effective advocacy.

iv) Create awareness among communities they work with to develop their own agency and mobilise to claim their due rights. Engage with duty bearers to deliver on their mandates.

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CHAPTER 6

REPRODUCTIVE RIGHTS IN MALAYSIA: INCREASING ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES, SRHR EDUCATION FOR YOUTH AND LEGAL ABORTION

Edited by Rashidah Abdullah
Reproductive Rights Advocacy Alliance of Malaysia (RRAAM) and Federation of Reproductive Health Associations of Malaysia (FRHAM)

I. INTRODUCTION

i. ICPD 15 monitoring and advocacy

The Malaysian NGO Report for ICPD 15 is one of 12 country reports in a regional ICPD 15 monitoring and advocacy project on sexual and reproductive health and rights (SRHR) led by the Asian-Pacific Resource and Research Centre (ARROW). The project's goal is to contribute to an improved policy environment in the 12 countries and the realisation of comprehensive, affordable and gender-sensitive SRHR services, particularly for poor and marginalised women.

Fifteen years have passed since the historic International Conference on Population and Development (ICPD) 1994 was envisioned in Cairo and agreed to by governments, NGOs and UN agencies including the Government of Malaysia.

The document by the ICPD Programme of Action still inspires and guides NGOs. This is because it was based on a fresh paradigm of commitment to human rights; sustainable development; reproductive rights; safe sexuality; women's equality and empowerment; and strengthening government partnership with NGOs. There were clear insights on what needed to be achieved and why, and agreements on what action had to be taken.

The Federation of Reproductive Health Associations (FRHAM) and the Reproductive Advocacy Alliance Malaysia (RRAAM), which was newly established in 2007, are joint country partners in this third ARROW ICPD monitoring project. FRHAM was the ARROW partner for the ICPD 10 Regional Project and the NGO Focal point for ICPD 5.

Instead of monitoring a plethora of indicators as in past ICPD projects, ARROW partners are focusing on one SRHR ICPD issue which critically needs to be addressed. FRHAM and RRAAM chose the low and stagnated use of contraception for 20 years, as found by the Malaysian Population and Family Survey (MPFS) 2004. Related to this are the issues of increased reports of abandoned babies and a perceived increase in unwanted pregnancies of young people; a stalemate in the planned implementation of a revised sex education curriculum in secondary schools; and restricted access for women to legal abortion services despite a progressive law.

The report is structured according to these three issues. For each issue, findings are reported in relation to the ICPD agreements, discussed, and then specific actions needed to be taken are stated. A general discussion on policy and advocacy implications concludes the report. These specific issues are first examined within the overall context of Malaysia's progress in the ICPD SRHR agreements.

ii. Malaysia's progress in Sexual and Reproductive Health and Rights

a. Economic and social development

In 2008, 27.17 million[1] Malaysians in a modern nation state celebrated 50 years of independence from British colonial rule as well as successful socio-economic development.

When Malaysia was formed in 1963, it had a small rural-based population of 9 million people,[2] an agricultural economy, a high poverty level of around 50% and a high maternal mortality rate (MMR). By 2007, most people lived in urban areas, poverty was only 3.6%, maternal mortality a low 20 deaths per 100,000 live births, and both women and men were well-educated.[3]

b. Reproductive Health (RH)

Malaysia had a head start on the Cairo agenda in 1994, with already a low rate of maternal mortality of 59 deaths per 100,000 live births, a broad reproductive health programme, and a well-established and funded health system. Good economic growth rates between 5% and 7% allowed continued investment in public health, which by 2007, meant that 85% of people had access to free health services within five kilometres from their residence.[4]

There are no problems in accessing affordable maternal health services for married Malaysian citizens and Malaysia is a model for other countries in Asia. For women who are migrants (particularly those unregistered), foreign workers (especially domestic workers whose contracts do not allow them to be pregnant even when married), refugees and unmarried pregnant women, however, there are access problems connected to social stigma, cost and citizenship.

Women's access to contraceptive use, breast screening and cervical cancer screening services have lagged behind maternal care. Only 48% of married women are using contraception, only 50% of women had a pap smear in the three years prior to the 2004 MPFS survey and only 53% had ever had a breast examination in a clinic or hospital.[5] Although cervical cancer incidence has declined, breast cancer incidence has not and the incidence of HIV and AIDS continues to rise for women. Legal abortion according to the full extent of the law is difficult to access in government hospitals.

This data shows that aspects of RH which involve addressing the cultural sensitivities of the body, sexuality, gender, religion and morality have been harder to address than maternal health, which has fewer of these complexities.

c. HIV and AIDS

Malaysia has achieved all of the eight Millennium Development Goals (MDGs) except the sixth goal on HIV and AIDS, which is targeted to halt by 2015 followed by the start of the reversal of the spread of HIV and AIDS.[6] At the time of the ICPD, there were only 3,390 people with HIV and 105 people with AIDS in Malaysia.

The total number of people with the infection as at June 2008 has increased to 82,704, 14,133 people with AIDS and there have been 10,873 AIDS-related deaths since 1986.[7] Although male injecting drug users remain the dominant means of HIV transmission, by 2007, almost one-third of new HIV infections were due to heterosexual relations. New HIV infections for men have been declining since 2003, but the number of women infected has been steadily rising from 5.02% among total HIV cases in 1997 to 16.3% in 2007 or two additional women a day.[8]

HIV and AIDS has become a priority development and RH issue of the government, NGOs and UNDP. A government National Strategic Plan (2006-2010) and a Malaysian Aids Council Strategic Plan (2008 to 2015) has been developed, and RM500 million has been allocated under the 9th Malaysia Plan.[9] With the resources and strategy now in place, the issues of sexuality, sexual rights, women's rights, gender issues and condom use are the biggest challenges to reducing the epidemic.

d. Sexual health and sexual rights

UNICEF and the MOH emphasise that in order to have a more effective HIV prevention: "[i]nstitutional and social denial that sexual behaviour of young men and women actually takes place outside of marriage" and "sensitivities surrounding the introduction of sexual reproductive health education in schools" need to be addressed.[10] The key gender issues here are sexuality and sexual rights. Of specific importance within this, is women's ability to exercise their right to refuse sex if their partner has HIV and AIDS or is known to have multiple sexual partners and yet does not agree to use the condom for protection, and women's lack of power to negotiate with men to use the condom. For Muslim women, this debate is still in progress, as married Muslim women's right to refuse sex and demand safe and consensual sexual relations, has not been firmly established as a right.

Sexual health and sexuality needs and rights have begun to be more openly addressed in the last 10 years, due to the need to address sexuality in order to combat HIV and AIDS. However, there is a long way to go, including attitudinal, institutional and law reform. Sexual practices for example, like oral sex and anal sex, which are the reality for both heterosexual and homosexual relationships, are offences in the colonially inherited Penal Code punishable by imprisonment[11] and several prominent people have been charged since ICPD.

Singapore eliminated this clause from their Penal Code in 2007. Muslim transsexuals have also been charged for indecent dressing under the *Shariah* Offences Act in an increase of what NGOs call 'moral policing.'[12] Related to this, zealous Muslim religious department officials work hard to charge people with sexual offences like premarital sex, extra-marital sex and close proximity (*khalwat*).

There is need for acknowledging that sexual behaviour begins earlier now for young people, and that increasingly more people engage in sex before they are married, as well as perhaps after marriage with other partners.

Diverse sexual practices and sexualities also need to be accepted as the reality. Heterosexual sex is one form but there are also men who have sex with men, men or women who have sex with both men and women, women who have sex with women, as well as men who prefer to identify themselves as women (transsexuals). An understanding of social realities and sexual rights in a humanistic and professional way in a multicultural society rather than a judgemental and moralistic frame needs to be developed urgently.

e. Women's rights

Women's rights to gender equality and empowerment have been more understood and accepted than sexual and RH rights, due to strong advocacy from women's NGOs and the impact of the 1995 World Conference on Women in Beijing. There has been definite progress in legal equality since the ICPD. The Federal Constitution now includes the clause that there can be no discrimination on the basis of gender.

There have been improvements in laws to either eliminate discrimination or provide better protection such as the Domestic Violence Act (1994), the Sexual Harassment Code (1999) and amendments to the Guardianship of Infants Act (1999). Muslim women, however, whilst also benefiting from this civil legal reform, have experienced retrogressive amendments to the Muslim family law in the mid-1990s, including making polygamy easier for men.

Gender inequality attitudes and practices, which still prevail in the family and society, are key indicators on the continuous high incidence of violence against women despite the Domestic Violence Act of 1994, a strengthened rape law and the increased availability of gender sensitive police, hospital services and women's crisis services by the NGOs and government.

Evidence of this is that the incidence of violence against women (in all the forms of domestic violence, rape, incest, sexual molestation and sexual harassment), has not reduced and there is an increasing trend in rape.

For example, in 2004, there were 1,765 rapes reported to the police compared to 1,217 in 2000 and the majority were girls and young women under 18 years of age.[13] Such figures are globally estimated to represent only 10% of actual incidents, so it is likely that there are about 17,000 rape incidents per year.

Outcomes of coerced sex, rape and incest include unwanted pregnancies, unsafe abortion, STIs and HIV and psychological trauma, all of which are potentially very disempowering and limit life choices, especially for young women.

The education of girls and young women and men in sexual rights, gender equality, pregnancy, protection from unwanted pregnancy, and HIV and STIs is therefore urgent. However, sex education has been delayed in both the school curriculum and youth national service programme despite the fact that sex education modules have been prepared and are ready for implementation.

The SRHR aspects of the One-Stop Crisis Centres (OSCC) for gender-based violence survivors in the Accident and Emergency Departments of all General Hospitals, heralded as a model when first launched in the early 1990s, need urgent attention from women's NGOs and the MOH.

For many rape and incest survivors, emergency contraception is not routinely available, referral for abortion for unwanted pregnancies depends on the views of the Head of the O and G Department and there is little follow up to identify and treat HIV and other infections.[14] In addition, it seems that apart from the initial medical assessment, little is done to support the emotional wellbeing of these women. Women are, thus, not accessing their sexual and reproductive rights and health rights as planned through these services.

Malaysian women's annual deaths due to pregnancy, childbirth, unsafe abortion, reproductive cancers, unwanted pregnancies and gender based violence are comparatively lesser than AIDS-related deaths. However, the morbidity, mental suffering and restricted life choices of women (especially young women, poor women and marginalised women) due to unwanted pregnancies, having more children than they desire, and due to rape, is tremendous.

The tragedy is that this morbidity and suffering cannot be calculated as clearly as mortality. Women have the need and right for all their SRHR needs to be equally addressed through high quality gender-sensitive SRHR services as agreed in the UN Cairo and Beijing conferences as a critical component of their health, wellbeing and empowerment.

f. NGO participation in planning, monitoring and evaluation of SRHR policies and plans

NGOs have increasingly been invited to dialogues with the Ministry of Women and Family Development and the Ministry of Health since the Cairo and Beijing conferences. These ministries and the Ministry of Education have worked closely with NGOs on the development of curricula, including SRHR for students, as has the MOH in the development of a National Adolescent Plan of Action 2006-2020. The UNFPA continues to consult NGOs in the development of its country programme.

However, the NGO roles, overall, remain advisory rather than decision-making as agreed in ICPD. Furthermore, selected NGOs are invited to participate in some cases, rather than diverse and more critical NGOs.

The National Family Development and Population Board Act of 1966 requires no more than 10 members to be appointed by the Minister drawn from the fields of commerce, labour, education, social services and from various professions. The two NGOs on the Board in 2006 were FRHAM and the Older Persons Association, and the rest of the members listed under NGOs including the company, Focus On The Family, were individuals working in the government and the private sector.[15]

There are now a number of coalitions and alliances which need to be included in related SRHR structures, policy and programme decisions. Apart from FRHAM and NCWO, which were set up in the 1960s, these include the Malaysian Aids Council, Joint Action Group on Gender Equality (JAG), the Malaysian NGO Coordinating Committee on Reproductive Health (MNCCRH) and the Reproductive Rights Advocacy Alliance of Malaysia (RRAAM).

All are newly established in the last decade, and are very relevant for the government and the UN to better address SRHR issues.

II. OBJECTIVES

This country's study aimed to monitor the extent to which the specific ICPD agreements made by the Malaysian government have been achieved in the areas of:

- Reducing unwanted pregnancies, the unmet need for contraception, and the barriers to contraceptive use.
- Comprehensive and Rights-based sex education and more available SRHR services for young people.
- Increasing access to legal abortion, decreasing repeat abortions and improving provider training.

Research questions

- Has people's unmet need for contraception decreased since ICPD?
- Have the barriers to contraceptive use been identified and reduced?
- Why has the contraceptive prevalence rate not increased?
- What do women themselves and clients say about contraceptive use?
- Has the equal sharing of responsibility of men in using contraception and using the condom for protection from HIV and STIs increased?
- What do men themselves say about men's sexual practices and condom use?
- To what extent have reproductive rights been promoted and the quality of contraceptive services been improved?
- Have unwanted pregnancies amongst young people been reduced and are there stronger sex education and service efforts to prevent these?
- What do youth themselves say they want and need?
- Has accessibility of legal abortion services as part of reproductive health services increased?
- Has there been a decrease in repeat abortions and improvement in the quality of post-abortion counselling and as well as training of providers?
- What needs to be done, how, by whom and when, in order to better implement the ICPD agreements on sexual and reproductive health and rights?

III. METHODOLOGY

Evidence-gathering methods

- A consultation in October 2008 of 40 strategically chosen stakeholders from universities, NGOs, Parliamentarians, youth and government which focused on key monitoring questions and achievements of indicators in relation to ICPD agreements. Ten evidenced-based papers by the government, NGOs and academics were presented on the indicators and questions for each related ICPD agreement.[16]
- Interviews and discussion with the National Population and Family Planning Board (LPPKN), MOH Family Health Division, the Curriculum Development Centre of the Ministry of Education; the Academy of Family Physicians; the Academy of Islam, University of Malaya, and UNFPA.
- Document analysis of reports, policies and publications of LPPKN, the Malaysian NGO Coordinating Committee on Reproductive Health (MNCCRH), FRHAM, RRAAM, other related NGOs and academia.
- A questionnaire completed by 12 of the 13 Family Planning Associations.

IV. FINDINGS OF THE STUDY

i. Barriers to increasing contraceptive use and decreasing unmet need

ICPD agreements

Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50% by 2005, 75% by 2010 and 100% by 2015."[17] *UN General Assembly 1999 (ICPD+5*, para. 58).

As part of the effort to meet unmet need, seek to identify and remove all the major remaining barriers to the utilisation of family planning services (ICPD PoA 7.19).[18]

To increase the participation and sharing of responsibility of men in the actual practice of family planning [ICPD PoA 7.14 (e)].[19]

a. Unmet need

The ICPD+ 5 targets of reducing the gap between the individuals expressing a desire to limit the number of children and not using contraception has not been achieved. In fact, the unmet need for limiting births has substantially increased from 16% of married women in 1988 to a high level of 24% of women in the 2004 Malaysian Population and Family Survey (MPFS).[20] Stated simply, 24% of married women who said they did not want any more children were not using any kind of contraception in 2004. Now, women want fewer children but they have not

increased their use of contraceptives to achieve their desire. Women were not asked the question on their desire to space pregnancies and their actual contraceptive use, unlike in the 1988 survey.

Only married women were interviewed in the 2004 MPFS survey and unmarried women were excluded. Actual unmet need would, thus, have been higher as there is data that shows sexual activity and marriage age of young people are increasing.

b. Contraceptive use

The extent of unmet need is directly related to contraceptive use. The Contraceptive Prevalence Rate (CPR), which includes all methods, declined slightly since ICPD from 55% to 48% of married women of reproductive age using any contraceptive method, back to the 1988 level of 49%.[21] Contraceptive use has, therefore, stagnated for 20 years and is low for a country with Malaysia's level of socio-economic development and Human Development Index.

The CPR for modern methods has also not increased significantly which is of great concern. Only 32% of women used a modern method in 2004 compared to 30% in 1994 and 34% in 1998. Among the states in Malaysia, the use of modern methods in 2004 was lowest in Kelantan at only 16%, followed by Terengganu at 19% and the highest was Negri Sembilan at 63%.[22]

Malaysian married men's use of the condom in 2004 remained a low 6.9% and vasectomy a minute 0.1%, with male methods increasing only slightly since the ICPD. This data excludes condom use for single men, who were not interviewed. Many more women (6.1%) were undergoing sterilisation even though the vasectomy procedure is much quicker and easier for men.[23]

Women, thus, continue to take most responsibility for contraception and there is no progress towards the ICPD objective of men and women sharing the responsibility for contraception, equally.

A 2007 UNFPA-funded survey of students, workers, and sex workers found that of the 73% of sexually active men interviewed, only 40% had ever used the condom. The majority of men did not use a condom for their first sexual intercourse or with their primary partner.[24] All of the national family planning (FP) agencies reported initiatives aimed at increasing men's contraceptive responsibility since the ICPD, including employing male staff, and holding men's health clinics and seminars. However, they did not state if there were resulting outcomes in the increasing use of men's contraception at individual, clinic or state levels. Nationally, there has been no impact of these initiatives on men's contraceptive use.

c. Women's perspectives

The reasons women gave in 2004 for not using contraception are of great concern as "fear of side effects" is a high 26.9% and this reason has increased compared to 1994. When "medical and health reasons" are added, the total is 32.3%, which women gave for programme-related reasons. "Husband's objection" as a reason for not using contraception which is an indicator of gender power relations, has also increased from 8% in 1994 to 12.6% in 2004.[25] This is indirectly a programme-related reason, too, as the programme has been unsuccessful in influencing and educating men on contraceptive use and men's responsibility.

Women's "experience of side effects" has remained the highest single reason for discontinuing contraception, increasing in 2004 to 26.5% of the total reasons compared to 22.4% in 1994.[26] When combined with "discomfort caused by a method", "method failure", and "advised by a health professional," this makes a high total of 44.6% of discontinuation reasons related to dissatisfaction with contraceptive methods. This means that the client's confidence level in contraceptive methods is low; indicative of the quality of the information and service programme.

d. Perceptions of other stakeholders

The low key family planning policy was given as a major reason for the stagnated and low contraceptive use by LPPKN, MOH and FRHAM Consultation presenters, Consultation participants, interviewees and LPPKN publications. The FP service was said to be low-priority for time spent on client information and education by health providers compared to other RH services, and FP as a service is not regarded highly. Among the competing RH services of interest, family planning is the lowest.[27] (RRAAM Negeri Sembilan seminar; Consultation report; interview with MOH).

Information and education on contraception through wide community outreach stopped in the late 1970s and this is also attributed as a major reason by researchers[28] as well as LPPKN.[29]

References have been made in both government and NGO reports that beliefs about Islam and contraception are a factor in the lower use of contraception by Malays.[30] However, there are no up-to-date research findings on this aspect and there was no agreement of Consultation participants about this factor. Both LPPKN and the Academy of

Islam, University of Malaya stated that there is clear support from texts and *fatwas* for the permissibility of contraception for Muslims for spacing pregnancies. This was also the position of Sisters in Islam and the Kelantan Family Planning Association in their publication.

All national family planning agencies reported initiatives to continue to improve the quality of care of FP services, including obtaining client feedback. The improvement in the quality of care of FP programmes would be indicated by an increase in new clients, an increase in continuing clients (i.e., less discontinuance), greater use of effective methods, and an increase in client satisfaction. This data was not presented in the Consultation by any agency.

e. Structural barriers: The function of State Reproductive Health Committees

Each state has a Reproductive Health Committee led by LPPKN in which the MOH, FPA and LPPKN participate. This committee is the main mechanism for planning, monitoring and evaluating the national family planning programme. Eight of the 12 FPAs reported that this committee has not met at all in three years between 2006 and 2008, two FPAs reported one meeting and only one FPA reported two or three meetings.[31] This means that there is no coordinated planning and evaluation of implementing agencies at the state level in order to address barriers and improve performance. Particularly in states in which there is a very low use of any kind of contraception like Kelantan (24.3%) and Terengganu (29.9%), the non-functioning committees are missed opportunities as means of addressing programme barriers and contributing to making family planning a low priority, especially for LPPKN as the lead agency.

f. Reproductive Rights

ICPD agreements

The promotion of the responsible exercise of these rights (reproductive rights) should be the fundamental basis of government and community-supported policies and programmes in the area of reproductive health, including family planning.[32] (ICPD PoA, para 7.3).

Only FRHAM has included the concept of reproductive rights in the organisation's philosophy, in the objectives of family planning services and in the adoption of a rights-based approach in services. The actual components of a rights-based approach were not explained in the FRHAM Consultation presentation nor the extent that this approach has been successfully implemented. In the questionnaire to the FPAs, most responded to the question of *"whether they implement a rights-based approach in family planning services"* very generally.[33]

The MOH says its approach to contraception is a health approach rather than a rights approach with RH as the concept used. They have, however, begun some limited training in reproductive rights for about 25 doctors, annually, since 2006, following the publication of the WHO training manual on Gender and Rights in Reproductive and Maternal Health.

LPPKN did not mention the aspect of reproductive rights in their Consultation presentation. The National Family Planning Programme, which is coordinated by LPPKN, has objectives that do not mention reproductive rights. There is no operation in the concept of reproductive rights in the LPPKN reports examined and the term is included only once in a heading of the LPPKN report on "*Implementation of the ICPD PoA in Malaysia*" with no corresponding text.[34]

g. Discussion of findings

The underlying reason for the low priority of family planning services is the continued focus on population and development concerns as in pre-ICPD days rather than adopting the human rights, reproductive rights and women's rights framework of the ICPD PoA. The 1984 population policy expressed the economic need for more people as labourers and consumers. As the population size is still growing but at a slower pace than expected and fertility continues to decline, the government may not be worried about population size. In fact, it may be worrying that the decline of the fertility rate is too rapid and that labour will be a greater problem. Now Malaysia needs to recruit international workers and in 2003, foreign workers with permits accounted for 9.5% of the 10 million work force and non-Malaysians made up about 6% of the work force.[35]

The total fertility rate in Peninsular Malaysia had declined to 2.5 children per woman aged 15-49 in 2005, from 3.0 children in 2000 and 3.3 children in 1995. The decline had occurred within all communities. The Chinese and Indian fertility were below replacement fertility, at about 1.8 and 1.9 children per woman respectively, but the Malay fertility rate remained relatively high at 2.9.[36] The rising age for marriage and contraceptive use have contributed to the fertility declination. For example, women aged 30-34 who had never been married had gone up from 6% in 1970 to 14% in 2000.[37] It is expected that an increasing number of these women never marry. Women and men were also marrying later at an average age of 25 years for women and 27 for men in 2000. But these factors alone do not explain the whole picture.

Tey Nei Peng comments that the continued decline of fertility, despite a puzzling stagnation of contraceptive use for 20 years, may be due to abortion.[38] He contends that it is well known that in countries with a high Human Development Index (HDI), and low contraceptive use, such as Japan and Poland, abortion is the cause of low fertility.

WHO explains that abortion rates are highest globally in countries which have low CPR.[39] Abortion practice and incidence, thus, need much more research attention.

The complacency about low contraceptive use due to fertility decline, may be misplaced if a significant number of women are seeking abortions due to lack of confidence in modern contraceptive methods. As access to abortion is restricted, secretive and unaffordable in the private sector for low-income women (see section 4.3 in this report), they are the ones who would be most disadvantaged.

From a health perspective, the government may not also see any problems related to the low and stagnated contraceptive use, as maternal mortality continues to decline, women of high medical risk and high parity are being successfully targeted to use contraception, and family planning services are available in all MOH clinics. As LPPKN states in the publication, *Implementation of the ICPD-PoA*:

The government does not have a policy to bring about rapid decline in fertility. Instead, it has provided the necessary services for couples to decide on the number and timing of births based on informed decisions. As in other parts of the world, socio-economic development has set the impetus for fertility decline in Malaysia.[40]

Peoples' need and reproductive right to have accessible and effective contraceptive services in order to meet their desired family size according to their income, social, health and well-being needs as articulated at ICPD, apparently, have not been considered an important human right by the Malaysian government, yet.

There was only one reference to unmet need in the LPPKN ICPD 10 publication, as in the following recommendation:

Promote greater utilisation of reproductive health services including family planning, by stepping up IEC activities and making services more accessible and affordable that will result in greater use of modern and safe methods of contraception and reduce the unmet need for family planning.[41]

This recommendation is very pertinent and LPPKN can be asked to what extent were there successful efforts in implementing this in the last five years.

The total fertility rate is a demographic measure related to population growth and development, whereas unmet need indicates individuals' desire for children and is very relevant for human rights.

The serious omissions of unmet need questions in the 1994 MPFS and spacing births in the 2004 MPFS, are examples of neglect in terms of the importance of human rights and the ICPD agreements on unmet need.

h. What needs to be done, by whom and when

Develop an ICPD National Action Plan

This needs to be developed by the government in partnership with diverse NGOs including women's groups with time frames for specific objectives, for example:

1. Increasing the Contraceptive Prevalence Rates;
2. Decreasing unmet need; and
3. Immediately identifying priority research for overcoming barriers to contraceptive use identified in the 2004 MPFS.

A paradigm shift to a Rights Approach

LPPKN, MOWFD and MOH need to immediately adopt the ICPD human rights and reproductive rights concept in population, RH and family planning policies and programmes. This includes free access to information and contraceptive services as a basic right for everyone without exception (e.g. marital status, citizenship, ethnicity or religion).

Establish new indicators

The monitoring and evaluation of RH programmes by MOWFD, LPPKN and MOH need to go beyond mortality, morbidity and demography to include indicators of reproductive rights such as the unmet need for contraception, the extent of accessibility to SRHR information and services, and the extent of accessibility to legal abortion services.

Increase passion and commitment to contraceptive services

The loss of enthusiasm, passion and effectiveness which family planning programmes had in the 1970s, can only be regained through the effort of the government and FPAs in providing contraception and establishing SRHR educational programmes as a higher priority, giving it greater recognition and making more effort in conducting the programmes.

More qualitative programme research

Much more in-depth research needs to be done by all agencies and academics to understand and overcome programme weaknesses that cause lack of confidence in modern contraceptives and contraceptive drop-outs. Two important areas are on how to best educate men so as to reduce their objections and increase their use of male methods and what works best for empowering women to successfully negotiate their sexual rights.

Earlier discussion of MPFS findings

There needs to be discussion led by LPPKN between MOH, MOWFD, MOE, parliamentarians, researchers, and NGOs, nationally and at state levels, on the implications of the findings of the 2004 MPFS. LPPKN needs to provide more information and analysis of the 2004 MPFS findings.

For example, the specific reasons husbands do not agree with family planning and the specific reasons for stopping contraception were clustered under the large category of 'others.' Discussion and publication need to be carried out much earlier for future MPFS surveys and other researches so that findings can be quickly utilised to improve programmes.

A strategic planning state and needs approach

Up-to-date state data on CPR and unmet needs have to be available, analysed and discussed regularly by state and national level Reproductive Health Committees in order to strategically plan a state and needs approach aimed to increase contraceptive use.

ii. Unwanted pregnancies and access to contraceptive services and information for youth

ICPD agreements

To address adolescent sexual and reproductive health issues including unwanted pregnancies… (ICPD PoA 7.44).

To prevent unwanted pregnancies and to reduce the incidence of high risk pregnancies and morbidity and mortality (ICPD PoA 7.14 a).

To make quality family planning services affordable, acceptable and accessible to all who need and want them, while maintaining confidentiality (ICPD PoA 7.14 c).

Innovative programmes must be developed to make information, counselling and services for reproductive health available for adolescents and adult men (ICPD PoA 7.8).

a. Unwanted pregnancies

There appears to be an increasing number of unwanted pregnancies and abandoned babies reported in the media. These include heart-rending incidents of schoolgirls and factory workers giving birth in toilets, and married women abandoning new-born babies. One baby is abandoned every ten days in the Klang Valley. From 2001 to 2004, the Social Welfare Department recorded 315 cases of abandoned babies, while police statistics revealed 100 cases a year.[42] This data is expected to be under-reported and a higher incidence is more likely the case.

There is no available data to the public on the number of women with unwanted pregnancies seeking refuge in social welfare and NGO homes, annually. One centre for women and teenagers run by a Muslim couple in Kuala Lumpur was reported to have provided shelter for 80 to 100 unwed pregnant women and girls in a year, with about 40% of them being undergraduates.[43]

b. Sexuality and age of marriage

Young people are becoming increasingly sexually active before marriage but reliable up-to-date data is not available for the public. Data from a media survey by LPPKN between 1994 and 1996 quoted by MOH found that about 24% of 13 to 19 year olds had engaged in sexual intercourse and 18.4 % had their first intercourse between the ages of 15 to 18.[44]

There is also an increasing trend of later marriages and not marrying, which means a period of 10 or more years between some young people beginning their sexual activity and marriage. The average age of marriage in the year 2000 was 27 years of age for men and 25 for women. 14% of women aged 30 to 34 years had never married in the year 2000.[45] If contraception were not used during these years, there would have been a high risk of unwanted pregnancy.

c. Contraceptive use and services

There is no data on the extent of the use of contraception by young and unmarried people. This critical information needs to be made available in order to plan effective programmes. We do know from the 2004 MPFS that a little less than half of the young people aged 13 to 24 had heard of at least one contraceptive method. Despite the prominence of condoms in pharmacies and retail shops, only

one in four young people knew about the method. The rhythm method was mentioned by only 2% of the young people in the survey.[46] This shows a huge unmet need for information on contraception.

Very limited contraceptive services are discreetly provided for young and unmarried people in government and NGO reproductive health services; 'discreetly,' meaning this is not openly talked about.

The MOH clinics provide contraceptives to unmarried people on a case-by-case basis for 'high-risk young people,' who are sexually-active, drug users or HIV positive.[47] Nine of the 12 FPAs, who responded to the FPA questionnaire, also provide contraceptives discreetly. This is a definite progress for both government and NGOs as this shows they have begun to respond to the contraceptive needs of youth.

Most unmarried people are therefore thought to obtain contraceptives from private sector outlets, including pharmacies which can legally provide contraceptives irrespective of marital status and not on a restricted case by case basis, and retail shops that sell condoms. Even for married couples, 27% of current oral contraceptive users obtained the pill from pharmacies in 2004.[48]

d. Education efforts

The implementation of the revised Reproductive Health and Social Education curriculum for in-school secondary school students, which "is designed to provide accurate and up to date knowledge about human sexuality in its biological, psychological, socio-cultural and moral dimensions,"[49] has been delayed. The curriculum was developed with the assistance of NGOs, including FHRAM, AWAM and the Women's Centre for Change, over four years, endorsed by religious leaders of all faiths and approved by the cabinet in 2006 with a budget allocation of RM20 million. The curriculum is said to have been delayed due to changes in priority, commitment and political will related to top officials of the MOE.[50]

Implementation of the new component completed in 2008 on "Family and Healthy Lifestyle," for the compulsory National Service Education Programme for youths aged 18 years who have just completed school, has also been delayed and was not part of the 2009 programme. NGOs, such as FRHAM, WAO and AWAM, who worked with LPPKN on developing the component, assess that although the allocated hours and content are inadequate to address the actual sexuality components, it does provide a way of reaching adolescents on the importance of gender equality and empowerment and violence against women issues.[51]

However, the in-school and out-of-school government curricula promote sexual abstinence as the main method of preventing unwanted pregnancy, whereas the reality is that many young people are increasingly not abstaining from sexual activity. Contraception information is not included in either curriculum. Abstinence can be promoted but education on sexuality, pregnancy, contraception and especially condom use, needs to be included in order to prevent unwanted pregnancy, HIV and STDs.

e. Discussion of findings

The delayed implementation of the Reproductive Health and Social Education curriculum in secondary schools appears to be related to fears and concerns of top policy-makers. The specific concerns have not been revealed and need to be, especially as the key religious leaders of all faiths have given their approval for implementation as has the cabinet. It would be a tragedy and neglect of young people if concerns were political in nature, particularly related to issues pertaining to elections.

Meanwhile, young people remain critically in need of comprehensive and accurate education to protect themselves from pregnancy, HIV and AIDS, rape, incest and coerced sex. Access to such information is a reproductive and human right. In delaying the curricula implementation, this right is not being acknowledged and respected by top policy makers, due to perhaps self-interest.

Up-to-date and congruent research findings on young peoples' knowledge, attitudes and behaviour towards sexuality, unwanted pregnancies, abortion and contraception were not available for this study, and different agencies and academics gave different figures. Without accurate data for assessing young peoples' needs, and for planning education and service interventions, ad-hoc planning rather than strategic planning is more likely, resulting in less effective outcomes.

If reliable national studies have been done, the findings are not available to FRHAM and RRAAM, let alone to young people themselves and the public. For example, the findings of a study of youth sexuality by an academic published in the newspapers several years ago were vigorously disputed by the government as being inaccurate.

Difficulty in accepting social reality, which may be disturbing to one's religious views and is also politically sensitive, such as the increasing premarital sex and drug use among young people, have been a common denial in modernising Malaysia, more so apparently for top politicians than for parents and youth themselves. This reluctance to accept reality

is speculated to be one of the main reasons why HIV infections and high levels of drug use have not been effectively addressed.

f. What needs to be done, by whom and when

Urgent implementation of curricula

Top policy makers of the MOE, MOH, and MOWFD need to work closely together with a strong will to begin implementation of a high-quality Reproductive Health and Social Education curriculum for secondary students in 2009 and the National Service curriculum in 2010.

Recognise that sexual abstinence alone does not work

The MOE, MOWFD and MOH need to recognise that the concept of promoting sexual abstinence as the sole method of reducing sexual activity and preventing unwanted pregnancies among young people is not backed up by international studies. Abstinence can be promoted in the curricula but education on sexuality, pregnancy, contraception and especially condom use needs to be also included in order to prevent unwanted pregnancy, HIV and STIs.

Strengthen NGO advocacy, monitoring and evaluation

MNCCRH needs to strengthen advocacy efforts including developing policy brief with evidence and lessons learned on comprehensive sex education, including Scandinavia's sex education experience of reducing unwanted pregnancies without a corresponding increase in the sexual activity of young people.

The MNCCRH, with the support of other NGO allies, needs to promote through convincing policy briefs and dialogues, the need for a holistic, comprehensive, non-moralistic approach to sexuality and RH education for pre-school to out-of-school youth needs, including vulnerable youth in juvenile homes, places of refuge for unmarried pregnant women and drug users.

Implementation of the new curricula for youth needs the continued involvement of the MNCCRH, women NGOs and the Reproductive Health Committees to regularly monitor and evaluate it for ensuring the effectiveness of the new content on sexuality, VAW and gender equality.

Website strategic planning

Government and NGOs need to ensure that the youth educational websites they manage have all the SRHR information youth need and are the first sites that appear when the terms sex and pornography are searched by young people.[52]

iii. Women's accessibility to legal abortion services and improvement of post-abortion counselling and providers' training in abortion

ICPD agreements

…Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling…. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications from abortion. Post abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions. (ICPD PoA 8.25).

…the right of men and women to other methods of their choice for regulation of fertility which are not against the law… (ICPD PoA 7.2).

In circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health." (UN General Assembly ICPD+5, 1999)

*…..Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions (*ICPD PoA 8.25).

a. Restricted access to public health services

There is strong anecdotal evidence of very restricted accessibility of women to legal abortion in several public hospitals in Kuala Lumpur, Selangor and other states. Abortions, when provided in government hospitals, are usually for medical reasons only, including saving the life of the woman and not according to the full extent of the Penal Code, which includes physical and mental health reasons.

Some women who have been raped or survived incest and women with foetuses which have gross

brain deformity have been reported to have been refused abortion.[53] In one Kuala Lumpur hospital, extreme reluctance to perform any kind of legal abortion was reported in 2007. Women whose foetuses were known to be grossly deformed were referred to other government hospitals in which there were doctors who were comfortable executing abortions. In another Kuala Lumpur hospital, discussion of abortion among staff was not allowed, raped women who wanted an abortion could not get access and hospital social workers were not permitted to refer women to the private sector.[54]

Anecdotal evidence from the Women's Aid Organisation, reported from a focus group discussion, showed that some low income, young and disadvantaged women had been refused safe, legal and affordable abortion from government hospitals.[55] Eight of the FPAs reported that they do not refer women who requested for abortion to state General Hospital and five gave the reason that the Obstetric and Gynaecology (O&G) Department does not accept abortion referrals.[56]

The OSCC in general hospitals for survivors of rape and domestic violence do not routinely refer to the O&G Department when unwanted pregnancy is an outcome. Emergency contraception to prevent unwanted pregnancy is also not routinely provided although the drug is now available for hospital services. These centres were designed together with women's NGOs in the mid-1990s to be women-centred and gender-sensitive, but women until now have not been able to access their sexual and reproductive rights. Nine FPAs reported that they did not know if the state general hospital provides abortion for pregnant women who have been raped or experienced incest and only one reported the service is available.[57]

b. Costly and secretive private sector services

Abortion services are available in the private sector, especially in urban GP and specialist clinics, but services are costly, secretive, unregulated and their quality has not been assessed. Ten FPAs refer women who request abortion to private clinics, and report to between 1-5 doctors on their referral list. Two FPAs do not refer women, the reason of one FPA being that he/she did not know any private doctor who could provide the service.[58]

An agency for refugee women reported to RRAAM the difficulty in finding out, initially, which private sector doctors provide abortion services, and then, in actually obtaining the service.

The reported cost of an abortion can reach RM2,000 (USD675), making the service inaccessible to poor, low-income and young women. An average fee for an early abortion could be around RM300 (USD100),[59] which shows that some doctors are exploiting the confusion on the legality of abortion.

It is not known if accessibility to abortion services in the private sector has increased since the ICPD as RRAAM only began monitoring the services in 2007.

The limited accessibility of abortion services contributes to the increasing numbers of reports of abandoned babies in the media, discussed earlier under point 3.2. The reported circumstances of the many women who had unwanted pregnancies show desperate, isolated and mentally distressed women without social support.

Abortion accessibility also affects the life choices and well being of women. It was reported to RRAAM by a research worker working in shelter homes that some unmarried women told her of their mental distress. The unmarried women would have preferred to have an abortion than go through with the pregnancy but they did not know where to go.[60]

In government hospitals and many private doctor services, the main abortion method is still the traditional dilation and curettage, which requires anaesthesia and hospitalisation, is more costly and carries more risks than the manual vacuum aspiration (MVA) method. MVA is a short outpatient service available globally for 35 years.

Medical abortion using Mifepristone (or Methotrxate) and Cytotec has been available globally for over 15 years. Research shows this is the preferred method of women in developed countries. However, but in Malaysia, it is rarely available in private clinics and is not available in government hospitals. Mifepristone is presently manufactured by WHO but is not registered in Malaysia. Abortion methods which are cheaper, more convenient, safer, and in which women have more control as they are less 'medicalised', are important to increasing accessibility.[61]

c. Barriers restricting access to legal abortion

Legal barriers

The main barrier is misconceptions of doctors, nurses, the media and the public that abortion is not legal. A RRAAM survey found that of 120 doctors and nurses from both the public and private sectors involved in RH services, 43% responded incorrectly about the law.[62]

Women themselves are similarly not well informed. A survey of RH clients who had had a legal abortion

in a private clinic, found that 41% did not know the correct legalities on abortion.[63] Even the LPPKN has inaccurately described the law in the LPPKN publication titled, *Implementation of the ICPD PoA in Malaysia*, reviewed for this report. It incorrectly states that *"abortion is allowed only on medical grounds."*[64] Until 2007, key NGOs had similar inaccuracies in their website or in media statements made until they were informed correctly.

The language of the Penal Code on abortion is also confusing as it begins with possible offences in the section titled 'miscarriages' and then qualifies these offences with exceptions.[65]

Although no doctors have been convicted of abortion offences since the 1989 Penal Code Amendments, which extended permissibility of abortion from saving a woman's life only when physical and mental health reasons are deemed injurious, there have been a few doctors charged with contravening some aspects.

As these cases have had wide media publicity, some doctors are, thus, afraid of convictions as well as confused about the law. The Malaysian Medical Council Code of Ethics is not up-to-date on the legal status of abortion. This adds to the confusion and uncertainty of doctors about the law.

There have been no initiatives after the progressive amendments to the Penal Code in 1989, until 2007, to educate health providers, women, the media and the public on the up-to-date legal status of abortion.

Service barriers

There is evidence that there are unsympathetic and judgemental attitudes of many doctors and nurses on unwanted pregnancies and abortion. When asked the survey question: "What do you think women who are pregnant due to rape should consider doing?", 38% of the 120 doctors and nurses responded that such women should continue the pregnancy and either look after the baby themselves or give it up for adoption rather than consider having an abortion.[66]

There is no MOH policy on provision of abortion services and availability of abortion services was reported to vary according to the views of the Head of the O&G Department in the various hospitals. The hospital requirements of more than one doctor's decision before an abortion is done (even though only one doctor's decision is required by the Penal Code), and the consent of the husband for the procedure are also service barriers.[67]

The ethical issue of the personal religious or other moral beliefs of doctors on abortion influencing their provision of services and referral has been reported to RRAAM as a common barrier within government hospitals, which explains the different practices in the O&G Departments of government general hospitals.

The continued media sensationalising of abortion as a moral rather than a health and rights issue, lack of empathy for women needing and entitled to abortion, as well as on-going media statements that abortion is illegal, keep the public and service providers incorrectly informed. Fifteen percent of doctors and nurses responded in a survey that the media was the main source of information for them on the legality of abortion.[68]

d. Decreasing repeat abortions and improving post-abortion counselling and provider training

No national data on repeat abortions is available. Neither is there reliable data on abortion incidence, and the number and ages of women dying from unsafe abortion. As abortion services are part of the package of RH services, such up-to-date data is essential. In addition, the probable effect of abortion practice on fertility levels, discussed earlier, requires data to be available.

There are no known Malaysian studies assessing the availability and quality of post abortion counselling.

Medical education curricula for undergraduates in the three public universities – HUKM, USM, and UM, are not up-to-date on the legality of abortion. In the first university, the abortion law is being incorrectly taught. In the second university, postgraduate students were reported to be confused about the law. In the third university, the law is understood as allowing abortion for health reasons only, such as when the foetus is deformed.

Practical training on abortion is not available for undergraduates due to the very few numbers of abortions carried out in government hospitals. More content on abortion is in the post-graduate medical curriculum and more practical experience is available in the provision of abortion services. The situation in the many other private universities is not known but needs to be assessed.[69]

e. Discussion of findings

Neglecting and disrespecting women's needs and reproductive right to access a legal abortion in government health services when their physical and mental health are at risk, is again evidence that the human rights of individuals and the reproductive rights of women are not yet a priority of the government. Although there is definitely a widespread of the ignorance and confusion about

the legal status of abortion, the fact that the law has been amended 20 years ago but is not known to most people, shows insufficient concern for women's needs and rights, especially among organisations which advocated for these legal reforms.

In fact, there is a case to make on the violation of Malaysian women's reproductive rights to legal abortion services in government hospitals. This violation can be addressed to the CEDAW committee in the 2009 NGO report on Malaysia as well as to the Malaysian Human Rights Commission.[70]

There are many accessibility issues to address in O& G, and OSCC hospital services as well as in referrals from MOH clinics. However, once the legal status of abortion is widely understood and with the current open attitude of the Family Health Division of MOH and champions among the Heads of O and G Departments, improving service accessibility is possible.

For the first time on SRHR issues, women's NGOs and reproductive health NGOs have teamed up under RRAAM with committed medical specialists, lawyers, feminist women's health researchers, the FPAs, the MOH and the MMA to undertake doctors' education in abortion and reproductive rights in all the states in Malaysia.

It is critical that medical education curricula and lecturers are correctly informed about the law, the latest abortion methods and the needs and reproductive rights of women.

The media also need to be informed urgently as well as the public and women themselves. Unless this is done at the same time as state education seminars, doctors who are misinformed and incorrect in their understanding about the legality of abortion, and do have the competency to provide quality services, will be produced, continually.

e. What needs to be done, by whom and when

Comprehensive review and update of medical education curriculum

Contraception, abortion and SRHR issues need to have a higher priority in the medical curriculum at all levels for public and private universities. A comprehensive curricula review and revision needs to be undertaken by MOH and MOE to:

1. Address the low CPR and barriers to family planning access;
2. Introduce a reproductive rights and gender framework;
3. Explain the legality of abortion accurately;
4. Teach all abortion methods and ensure training practice; and
5. Include empathy training, socio cultural issues and professional ethics.

Expansion of MOH abortion services

The MOH needs to have a clear policy and practice on the provision of legal abortion services as a core RH service in the O&G Department including referrals from the OSCC, MOH clinics and other agencies, which is in full compliance with the Penal Code and in accordance to women's reproductive rights. Rape and incest survivors, and poor, vulnerable and disadvantaged women, should be prioritised when it comes to abortion services.

Malaysian Medical Code of Ethics

MNCCRH, FRHAM, RRAAM and other NGO allies need to work with the MMA and the O&G Society to ensure that the Malaysian Medical Council Code of Ethics is accurate and clear on the legal status of abortion.

Education for doctors and nurses

Doctors and nurses need education provided by MOH, LPPKN, the MMA, the O&G Society, independently, and also in collaboration with RRAAM, MNCCRCH, and FRHAM on:

1. The legality of abortion and ICPD reproductive rights agreements;
2. The range of abortion methods including manual vacuum aspiration and medical abortion;
3. Managing professional ethics with personal views; and
4. How to be more empathetic and non-judgemental about pregnant rape/incest survivors and all women with unwanted pregnancies.

Doctors' training in gender and rights

The MOH needs to accelerate the very good initiative begun in 1996 to train doctors in gender and rights as per the WHO Reproductive Health module.

Media campaign and policy makers and public perception

A strong sustaining information and education campaign of service providers needs to be planned by NGOs, MOH and the MOWFD to correctly inform the public, the media, and policy makers on the legality of abortion and to create more empathy and

understanding for women in need of and eligible for a legal abortion.

V. CONCLUSION AND RECOMMENDATION

i. General policy and advocacy implications

a. Reproductive rights and national action plans

Overall, the very little progress in the ICPD area of reproductive rights extending from policies, programmes, and curricula for medical students and secondary students, reveals that there was a critical need for an implementation plan post-ICPD in the area of reproductive health and reproductive rights, spelling out specifically what needed to be done, by whom, and how, in this complex human rights issue. Government, NGOs and academics need to work closely together on a definite plan of action. For this to happen, the government, especially the MOWFD and LPPKN, need to believe that the implementation of the reproductive rights approach is what women want, need and have a right to and that this will significantly improve women's health, empowerment and gender equality.

b. NGO-GO partnership and NGO advocacy

The MOWFD, and LPPKN need to believe that diverse NGOs like the MNCCRH, women's NGOs, RRAAM and MAC, in addition to FRHAM, are genuine ICPD stakeholders who need to be involved in policy and programme planning, monitoring and evaluation of decisions as stakeholders not only as advisors, and that this participation will result in better policies and programmes which will benefit more people.

It is often assumed that FRHAM represents all NGOs but this is not the case. Each NGO is autonomous and has its own position and experience to share. NGOs also come together as networks, committees or alliances based on common objectives, such as MNCCRH, NCWO, JAG and RRAAM.

As for the advocacy of NGOs, the fact that RH and reproductive rights were not on the advocacy agenda of women's NGOs until 2007 has been a big barrier, even though the first National Action Plan on Women in 1996 included reproductive rights in the women's health objective. The concept of reproductive rights, thus, needs to be revisited, including both the principles and the concrete operations in population, RH, family planning, and youth policies and programmes.

ii. What needs to be done, by whom, and when?

a. Include more NGOs in the National Population Board

The National Population Board which has 10 places for NGOs, the public and civil society, needs to consider including more NGO representatives, including women's NGO representatives rather than individuals, as NGOs can effectively represent civil society concerns on SRHR issues.

b. Adopt the ICPD framework of reproductive rights

The ICPD framework of reproductive rights needs to be explained and promoted by NGOs for adoption by the government as the basic paradigm of family planning and SRHR programmes in the ICPD era.

c. Economic development and human rights

NGOs, in particular FRHAM and MNCCRH, need to make an evidence-based case to the government on the health and socio-economic needs and rights of poor, vulnerable, disadvantaged, and marginalised individuals (including youth) and families to prevent unwanted pregnancies through accessibility to high-quality contraceptive information and services. This right has to be a higher priority than the development needs of the country for expanding the population of consumers and the work force.

d. Reproductive rights violations

Any reproductive rights violation, especially if concerning the government's responsibility to ensure access to contraceptive information and services and legal abortion services, needs to be reported by NGOs to the Malaysian Human Rights Commission and included in the NGO alternative CEDAW Report.

e. Strengthen MNCCRH membership and advocacy

The MNCCRH needs to be strengthened in its advocacy capacity including:

1. Increasing the membership of women and youth

groups which are active in sex education for youth and SRHR, as well as including committed SRHR policy oriented researchers; and

2. Developing a strategic advocacy plan on SRHR.

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CHAPTER 7

CONTRACEPTIVE USE OF YOUNG PEOPLE IN THE PHILIPPINES: A STUDY IN SELECTED URBAN POOR COMMUNITIES IN METRO MANILA

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I. INTRODUCTION

The Philippines is the 13th most populated country in the world with 97,976,603 people.[1] Manila, the country's capital, has a population of 11,553,427[2] in an area of only 636 square kilometres. However, the greater urban area of Metro Manila, which includes Manila, puts the population at around 20,075,000[3] people.

Population is growing rapidly at three births per minute. Half of the Philippine population is below the age of 21, thus the country has what is referred to as a 'youth bulge' that will continue into the year 2025 because of our weak family planning programmes. Consider as well that on average, 23% of the youth have premarital sex[4] and almost half of all pregnancies in the country or almost 800,000 births annually are unplanned.

Given that 85% of the population is nominally Catholic,[5] its strong and influential Catholic clergy has been a major hindrance in the passage of laws and policies that recognise and protect the reproductive health rights of Filipinos. This has translated into inadequate, and in some areas, totally non-existent reproductive health information, services and supplies.

II. RESEARCH PROBLEM/ OBJECTIVES

Poor contraceptive use among young people stems from situational factors, such as social proscriptions against young people engaging in sex, the sporadic, unplanned nature of sexual encounters among them (especially teenagers), lack of knowledge during the first sexual encounter, and limited mobility and access to contraception.

These can be explained partially by significant national and local policies that reflect the Catholic teachings of confining sex within marriage and regarding procreation as the sole reason for engaging in sexual intercourse. Thus, the right of young people to sexual and reproductive health is barely acknowledged and has given rise to problems of availability and accessibility to information and services relating to traditional and modern contraception.

This study looks into the reasons for the low level of contraceptive use among sexually active youth in selected urban poor communities in Metro Manila, with a focus on the accessibility of young people to family planning information, services and supplies and their knowledge about contraception.

The second part of the study seeks to present the policy and legal situation vis-à-vis raising awareness about young people's sexual and reproductive health and rights. It aims to describe how these rights have been expressed in national health and population policies. The study seeks to establish that lack of effective access to FP information and services among Filipinos in general and young people in particular are due mainly to the absence of a government policy to provide the full range of safe and legally acceptable family planning methods.

III. PARTICIPANTS IN THE STUDY

Young people are the target of the study although it is a group which has no categorical designation in any Philippine law. PD 603 (otherwise called the Child and Youth Welfare Code[6]) and EO 209 (known as The Family Code[7]) both use the term 'child' and define it as a person below the age of majority.[8] The word is used interchangeably with terms 'minor' and 'youth.'

On the other hand, the Anti-Child Abuse Law[9] is broader in scope as it includes those over 18 years of age but are unable to fully take care of themselves or protect themselves from abuse, neglect exploitation, cruelty or discrimination, while RA 8044, Act Creating the National Youth Commission extends the category 'youth' to persons from 15-30 years old.

In contrast, the United Nations uses the term 'adolescent' to refer to persons between 10-19 years of age and 'youth' to those between 15-24 years old. Although there is no legal definition of 'young people, it has been empirically described as males and females from 10-24 years of age and thus, covers both adolescents and youth.[10]

According to the World Health Organisation (WHO), this age group comprises a little over 30% (or roughly 26 million) of the Philippine population.[11] The participants in our study ranged from ages 12-21 who therefore fall under the class of 'young people.'

IV. METHODOLOGY

Data were gathered through a survey administered to more than 308 young people (134 males and 170 females, and 4 who did not specify their gender)

with an average age of 18 years and additionally, through focus group discussions (FGDs) conducted among 45 respondents from the same Metro Manila communities.

i. Primary data analysis

a. Survey

Survey questions were developed to elicit the information necessary to prove the hypothesis of the study. These survey questions were distributed to key, urban poor areas in Metro Manila through health workers or NGO workers we had previously worked with in the selected communities.

In some areas, the questionnaires were left in the *barangay* (community) health centre which is one of the key areas frequented by young people with reproductive health care concerns.

b. Focus Group Discussions

As some of the questions did not limit the responses to a pre-identified selection of answers and instead required the respondents to answer them individually, several focus group discussions were held to follow up on the concerns that were raised in the surveys.

In some instances, the original respondents of the survey could not be tracked, or were no longer available since most of the communities covered a big area and were densely populated. Some were run by notorious youth gangs, which made it particularly difficult to organise meetings in areas not considered 'neutral.'

The FGD aided the researchers in observing the body language and emotions of the participants, as well as providing the participants an occasion to sort out their thoughts about sexual and reproductive health.

The tabulations that are mentioned in this study only refer to results of the survey. Unless otherwise specified, 'the number of respondents' refers to the number of individuals who took the survey. Although the FGD results were also tabulated as far as practicable, the inherent differences in the two methods did not permit considering the two results as one.

ii. The research areas

The views of the young people involved in the study are better understood when placed in the context of their community surroundings. The first challenge we met in identifying our research areas was the sensitivity of the topic. Since the intrusive nature of the questions would affect the readiness and openness of respondents to give honest answers, we chose communities considered urban poor according to official government classification in which we already had youth partners. What follows is a short description of the selected urban communities or *barangays* in Metro Manila based on a Women's Health Care Foundation (WHCF) Baseline Study conducted in 2000.[12]

a. Barangay 176, Caloocan City

Barangay Bagong Silang (also known as Barangay 176) is classified as a less developed area of Caloocan City. From February 1982 to November 1983, a series of resolutions were passed to develop the area and formalise ownership of lots for the relocated squatter families coming from nearby areas in Metro Manila.

Bagong Silang's estimated total population of 500,000 composed of 83,000 households (as of 2000) made it the most populated *barangay* throughout the country.

b. Barangay 178, Camarin, Caloocan City

Barangay 178, now called Caloocan City North, is also located in Caloocan City. Some portions of Camarin are now occupied by migrant dwellers from Metro Manila.

Barangay 178, which is both a residential area and a small business community, is about 549.12 hectares. Its total population (based on the 2000 National Statistics Census) is 64,148 with 13,369 households or families. Some families operate convenience stores commonly managed by women in the family, while repair shops are managed by male family members.

c. Barangay 649, Baseco, Manila City

Most houses in Baseco (or Barangay 649, Zone 68, District V) are built on stilts, commonly about two metres above seawater. The makeshift houses are within the premises of the port.

A recent survey conducted by the Office of the Barangay Chairwoman shows a total population of 45,017 with a total number of households at 3,499. Barangay Profile 2001 lists common occupations such as labourer, carpenter, stevedore, fishermen, land and water transport worker, retailer/vendor, blue-collared employee or working professional.

The *barangay* has a history of gang riots between

migrant Moslem groups and Christian groups. Barangay Chairman Generoso Hispano Jr., elected in 1997, was able to keep peace among warring groups but he was killed in an ambush in 2000.

d. Barangay 144, Pasay City

Barangay 144 has a total land area of 4.2 hectares where settlements made of semi-concrete (30%) and wood makeshifts (70%) are closely constructed. On the average, residential structures are occupied by three households.

Barangay 144 had a total population of about 3,404 with a total of 345 households back in 2000. It is estimated that about 50% of the population is transient such that there is some difficulty in establishing the community profile in some aspects. Residents of Barangay 144 eke out a living through vending.

e. Barangay Gulod, Novaliches, Quezon City

Barangay Gulod was established in 1962. Gulod is about 98.61 hectares. There are four depressed areas that form part of this *barangay* and there are frequently flooded areas as well. The latest available data is a 1997 report showing that the total population of Barangay Gulod was about 140,000 and the total number of households had reached 22,000.[13]

V. FINDINGS AND DISCUSSION

i. Sexual activity of respondents

a. Sexual initiation

Sexual initiation occurred between the ages of 16-18 years for 70% of 308 respondents followed by 13-15 years for 26% of the respondents. The age of first sexual intercourse for 2% of the respondents was 12 and below. For 1% of the respondents, it was 19 years and above. As for the number of "sexual partners since first sexual experience" for 308 respondents, 66% of 132 male respondents have had only one partner, 5% have had two and 29% have had three or more ("*marami na*"). Among 129 female respondents, 83% have had only one partner, 5% have had two partners, and 12% have had three or more.

b. Non-use of contraceptives

A significant number of the youth, constituting 73% of respondents (48% of which are males and 51% of which are females), do not use contraceptives. Among 167 non-users, 47% are single, 26% are married and 23% are in a domestic partnership (living in with a permanent partner but not legally married). Only 137 non-users indicated whether or not they had children or how many. Forty-nine percent have no children, 9% are pregnant, 36% have one child, 4% have two children and 1.3% have three children.

c. Reasons for non-use of contraceptives

The respondents were allowed to check more than one reason for non-use. Lack of information about contraception was indicated by 32% of the 291 responses to this question as the reason they were not using contraceptives. Concern about contraceptive side effects was a primary reason for 19% of the responses. Considering that the study was conducted in urban poor communities, 13% of the responses attributed the cost of contraceptives (or having no money to buy contraceptives) as the reason behind their non-use, while distance to one or more sources of contraceptives/family planning (FP) information and services (for example, distance of health centres or clinics) was the main reason for 6% of the responses.

Non-use was motivated by wanting to have children (8%) and an equal number cited partners'/spouses' disapproval of contraceptives (8%) as a reason. Three percent said using contraceptives would make sex "less thrilling." Only 2% of the respondents point to religion as a basis for non-use. Three male FGD participants gave other reasons for not using contraceptives among which was that he plans to undergo a vasectomy, one limited himself to having 'quickie' sex, which he believed would not result in pregnancy, while the last did not want to "waste his sperm."

d. Reasons for unplanned first pregnancy

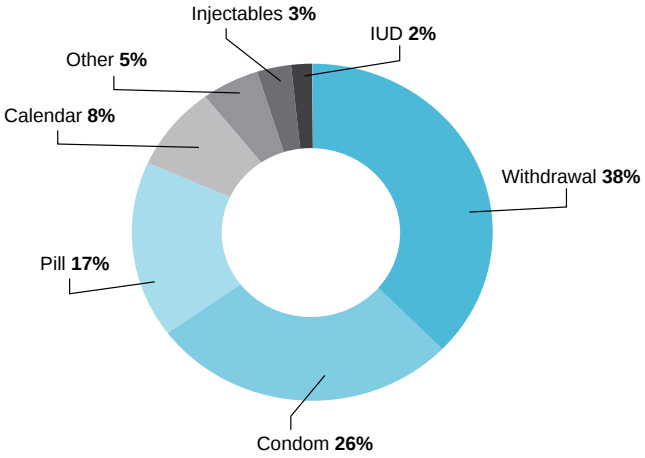
One hundred thirty respondents said that their first pregnancy was unplanned. 65% of them attribute their non-use of contraceptives as the reason for their unplanned first pregnancy while 7% cited ineffective use of contraceptives (chosen contraceptive failed). Other reasons cited by 11 respondents included lack of experience, drunkenness and premature ejaculation.

e. Contraceptive use

Only 74 out of 308 respondents (24%) reported that they were using contraceptives at the time of the

study. Most young people using contraception were women (70%) who had gone to (or had completed) high school and are married with a child. Out of the contraceptive users, 42% are married, 30% are in a domestic partnership and 26% are single. Sixty percent have reached high school, 30% have been to college, 4% have taken vocational courses, and 6% have gone to the elementary level.

Figure 7: Contraceptive methods used

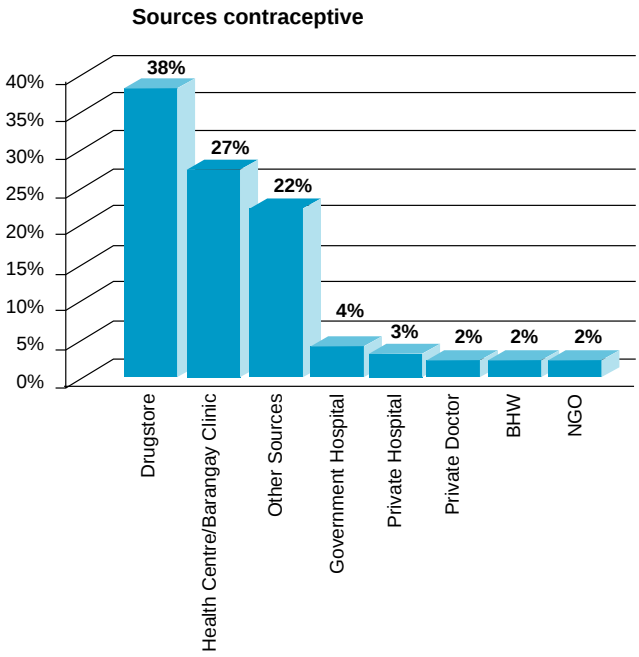


As to what contraceptives they used, the respondents were allowed to indicate more than one method. Out of the 174 responses that were generated, the withdrawal method was indicated by 65 responses (38%), followed by the condom (27%) and the pill (17%). Thirteen responses pointed to the calendar method (8%), six responses specified the use of injectables (3%), and three responses (2%) cited the IUD. Other methods such as breastfeeding and ingesting a soft drink mixed with Cortal (a paracetamol tablet) were indicated by eight responses (5%).

f. Sources of contraceptives

Respondents were allowed to check more than one source of contraceptives. Out of 117 survey responses, the most common source of contraceptives is the drugstore as indicated by 44 responses (38%). The community health centre/ clinic was indicated by 32 responses (27%), while 26 responses (22%) pointed to other sources such as peers/*barkada*, stores (like 7-11, SM and Divisoria), and a club. Only five responses cited government hospital (4%), while less than five responses each pointed to the following sources: private hospital (3%), *barangay* health workers (2%), private doctor (2% and NGOs (2%).

Figure 8: Sources of contraceptives



g. Sources of information on contraceptives

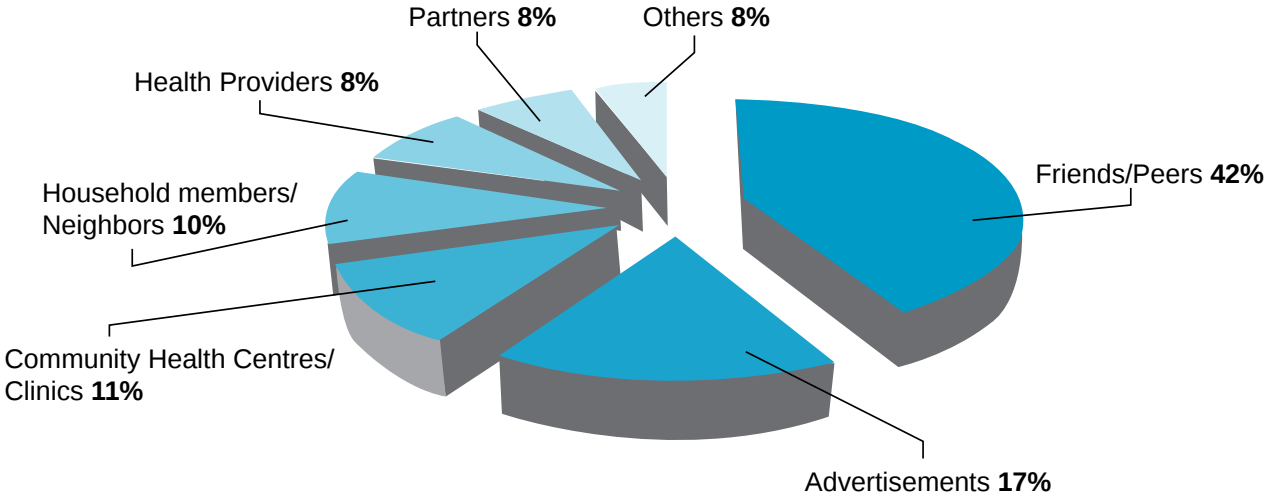
Respondents were allowed to check more than one source of contraceptives. Out of 346 survey responses, friends/peers ranked highest as the most common source of information about contraceptives as indicated by 147 responses (42%). This was followed by advertisements (17%), *barangay*/ community health clinics (11%), relatives or household members (10%), health providers such as *barangay* health workers, nurse/midwife, private doctor (8%), and partners (7%). Other sources that were indicated by 16 responses (5%) include school, youth organisations and NGOs. Six FGD respondents said they had no source.

h. Frequency of contraceptive use and preferred contraceptive

When asked how often they use contraceptives, 36 respondents revealed that they use contraceptives such as the condom (15), injectables and the pill (each of which was cited by six respondents), withdrawal (4), and the calendar method (2) on a monthly basis. Thirty-three respondents said they use contraceptives (mostly condoms) before intercourse.

The respondents were allowed to indicate more than one option as regards their preferred contraceptive. Out of 333 responses, 114 responses cited condoms as the most preferred contraceptive (34%) followed by the pill (31%), injectables (10%), withdrawal

Figure 9: Sources of information on contraceptives



(10%), the calendar method (7%) and IUD (5%). Their preferred method starkly differs from the contraceptive method actually used by respondents.

i. Need for contraceptive use

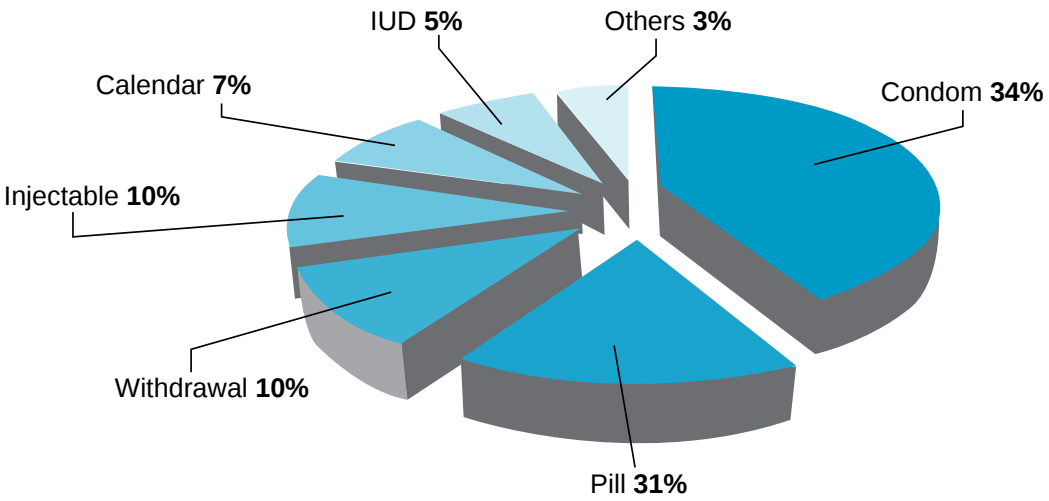
Sixty-two percent of all survey respondents thought they needed to use contraceptives, while 38% felt they did not need contraceptives. Among 170 respondents with a perceived need for contraceptives, 64% were female and 36% were male. Among 105 respondents without a perceived need for contraceptives, men significantly outnumbered the women (79% to 21%).

Among the 32 FGD respondents, eight males said that they did not need contraceptives, three males simply did not want to use contraceptives, another three said they could control themselves anyway, and one said he did not know anything about contraceptives. The rest (17 females and six males) deemed it important to use contraceptives mainly because of economic considerations, specifically since having many children is costly or not desirable during hard times especially when one is unemployed. Other reasons mentioned are the importance of having a planned pregnancy and limiting family size, having no desire for another pregnancy after four children and lack of preparedness to build a family, especially at a young age.

j. Desired changes

As for the "changes desired" relative to the "purchase and procurement of contraceptives" as indicated by 464 responses, 137 survey responses (30%) cited more affordable contraceptives while 76

Figure 10: Preferred contraceptives



responses (16%) pointed to guidance by health care providers as an area that had to be improved. Sixty-two responses (13%) believed contraceptives should be made accessible (available in different places). Fifty-eight responses (13%) verbalised the need for more information on family planning methods, while 52 (11%) expressed their hope that there would no longer be any stigma attached to the purchase or procurement of contraceptives.

FGD participants recommended that health centre workers should have better knowledge of SRHR and improved accessibility to contraceptives. In addition, they specified that SRHR services should be accessible and given out for free for those who are unable to afford them, that family planning should be promoted through house-to-house visits, service providers should not scold or moralise the youth (for example, with regard to their being sexually active or promiscuous at a young age), and reading materials on FP should be written in Tagalog.

The FGD participants stressed that parental guidance on FP should be encouraged. They articulated that the government should be serious with their responsibility to provide these kinds of services. Interestingly, the participants opined that since life is hard, contraceptives should be made legal so more people can use them.

ii. Discussion

This study recognises that the rights of young people are important in as much as many participants belong to two significant sectors of Philippine society which the Constitution vows to protect: women[14] and youth.[15]

In general, young people lack sufficient knowledge to protect themselves from the consequences of sexual behaviour. The lack of effective access to FP information (contraceptives) and services are due mainly to the absence of a government policy to provide a sound family planning programme to young people who are sexually active. In the State of the Philippine Population Report 2000, family planning is defined as the "fundamental right of couples and individuals to choose the number and spacing of their children, taking into account their responsibilities to their communities and the country." We submit that reproductive and sexual health is part of the state's duty "to promote the right to health of the people and instil health consciousness among them."[16]

Our study shows that for 70% of the participants, sexual initiation occurred between the ages of 16-18 years. The 2002 Young Adult Fertility Survey (YAFS3) national survey established this pattern, too, and revealed no significant differential in the probability that sex was initiated based on the economic status of the survey respondents. A possible explanation to this is the biological or physiological changes that all persons undergo at this stage of life that remains constant despite their economic station in life.

Our study likewise demonstrates that engaging in non-marital sex is not evidence of promiscuity given that 66% of male respondents and 83% of female respondents reported having had only one partner since they became sexually active.

Seventy-three percent of the respondents did not use contraception. Our study reveals that "lack of information about contraception" is the overwhelming reason given for non-use of contraceptives among young people in poor Metro Manila communities. Compared, however, to the findings of the YAFS3, this reason is only a distant second to "didn't expect to have sex," the reason most cited by the poorest 20% of the YAFS' nationwide Filipino youth sample.

"Didn't expect to have sex" was not among the multiple-choice items under the question nor did it come out as "other reasons." The question we posed in the survey questionnaire that was administered to the respondents was: "If you are not using contraceptives, what do you think is/are the reason/s for this?" "Lack of information about contraception" can, however, be seen as a precursor to a "didn't expect to have sex" attitude since lack of information about contraception can and does affect or shape attitudes towards sex, pregnancy and contraception, and attitudes towards contraception have a potentially strong impact on contraceptive use.

Another variable regarding young people's non-use of contraceptives on which this study and the YAFS3 have contrary findings is the role played by religion in the decision-making process of young people.

While this study shows that religion is not a significant factor (only 2% of the respondents cite religion as the reason for non-use of contraceptives), it was a common reason cited by participants in the YAFS3 for non-use of contraceptives. This contradiction could lie in the size and definition of this study's sample.

Nonetheless, the ReproCen study is consistent with nation-wide reports that "85 million Catholics have endorsed the Reproductive Health Bill[17] as a means of family planning", giving rise to the conclusion that there is no Catholic vote.[18] The bill's principal author further said that the "Pulse Asia survey in 2007 indicated that 93% of Catholics considered it important to have the ability to control their fertility and plan their families."

Many of our youth get little or no information from

government services or schools. Participants pointed out that in the event that SRHR is discussed in guidance counselling, it is oftentimes founded on moralistic perceptions. This may be a reaction to the concern of some adults (especially parents) that discussing sex is taboo. Thus, they perceived that sex education classes and counselling are likely to encourage young Filipinos to engage in sex and would promote promiscuity. However, the results of a study analysing 23 school-based condom availability programmes in the US[19] indicate that such programmes do not hasten the onset of intercourse among students or increase its frequency.

Likewise, in the Philippines, public school children who were interviewed after the Department of Education Sex Education Modules[20] were tested said that they were discouraged rather than encouraged to engage in early sexual activity. Nevertheless, the government pulled out the modules due to opposition from the Catholic Bishop Conference of the Philippines. A crucial argument for this opposition is that sex education is a right reserved for parents. However, Professor Corazon Raymundo, former director of the University of the Philippines' Population Institute (UPPI), counters that "sex education in schools is necessary because it is not in the nation's culture for parents to discuss sex with their children."[21]

Considering this, a national Adolescent Sexual and Reproductive Health and Rights (ASRHR) programme is necessary, where services are not limited to information, education and communications (IEC) but likewise teach both 'resistance skills' to delay the onset of sexual activity as well as contraceptive skills to prevent teenage pregnancy. Limiting instructions to young people with slogans such as "chastity in singleness" and "just say no" is to abdicate our moral responsibility to them.

We reiterate that teaching sex education in schools (or counselling by health workers), and sex education by parents are not mutually exclusive. The young people who participated in the study articulated their preference for parental guidance on family planning among the changes they hoped to see. The reality though is that at present out of 346 survey responses, friends/peers ranked highest as the most common source of information about contraceptives as indicated by 147 responses (42%), while relatives or household members was merely the fourth source and accounted for only 10%. Likewise, the YAFS3 study showed that among the poorest 20% and wealthiest 20% of their respondents, the drugstore ranked first, friends second and community health centre third as the source of information on contraceptives. Since parents are in fact not active in educating their children on sexual matters, the absence of well-designed sexuality education programmes taught by responsible adults would leave our young people at the mercy of friends. Peers are usually equally unprepared as they derive most of their knowledge about sex from media and the internet, channels over which parents have little control.

The Reproductive Health Bill[22] now pending in Congress squarely addresses this issue. It provides that RH education shall be taught in an 'age-appropriate manner' by trained teachers. Furthermore, it explicitly recognises the "natural and primary right of parents in the rearing of the youth" and thus, mandates the Population Commission to "provide concerned parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching reproductive health education to their children."

When asked what changes the research participants wanted to see, our survey showed that 16.4% of the young people wanted more guidance by health care providers, 12.5% verbalised the need for more information on family planning methods, while 11.2% stated that the stigma attached to obtaining contraceptives should be eliminated. In the focus group discussions, the main suggestion made by participants to improve access to contraceptive/FP information and services was for health centre workers to have adequate knowledge and provide complete and accurate information on all FP methods. These point to the pivotal role played by health providers and calls for them to not only brush up on their knowledge of young people's SRHR but to learn new counselling and communication skills.

The Convention on the Rights of the Child[23] is an important document which lays the basis for the right of young people to reproductive and sexual health care in light of the child's 'evolving capacities.' States who signed the convention are committed to "take appropriate measures to develop preventive health care, guidance for parents and family planning education and services."

The interest of young people (including minors) when it comes to access to contraceptives, like the interest of adults, is significant given the high incidence of sexual activity, unplanned pregnancy and sexually transmitted diseases. Although it has been argued that the government intention in barring access by minors to contraceptives is in the child's best interest, it is not clear how denying information and services on the other hand furthers the child's interests. Another justification given is the state's concern to foster a particular moral climate. It has not been established, however, that depriving minors of contraceptives has served as a deterrent to them engaging in sexual activity or altered their sexual attitudes.

The Reproductive Health Bill[24] addresses these

issues by compelling community-based volunteer workers to undergo additional and updated training on the delivery of reproductive health care services. Furthermore, section 21 thereof penalises any public or private health care service provider who "knowingly withholds information or impedes the dissemination thereof, and/or intentionally provides incorrect information regarding programmes and services on reproductive health including the right to informed choice and access to a full range of legal, medically-safe and effective family planning methods."

Since advertisements are a significant source of information, we see the role that a more involved private sector can play through media and other less formal communications (including TV commercials) to raise awareness and acceptance of SRHR. The various forms of mass media are powerful instruments in disseminating knowledge and awareness. There have been positive changes brought about by the initiatives and advocacies of women NGOs working in media. However, the institutions can do much more. The Philippine NGO Beijing +10 Report on Women and Media pointed out that women are still "portrayed in very limited, sexist and stereotyped roles" suggesting passivity and domestication.

Out of 105 respondents, there were more men than women who did not perceive a need for contraceptives (79% to 21%). Some male participants in the study responded that since the use of condom decreases their enjoyment of sex, it is their partner's responsibility to use contraceptives to prevent pregnancy.

Here, we see the importance of drawing the connection between traditional gender roles and harmful sexual health practices. The narrow definition of masculinity gives rise to the question of whether it is any single person's sole burden to say "no" and take responsibility to protect against pregnancy or sexually transmissible diseases. Counselling should, thus, include lessons that will bolster the decision-making capacity of young women which is crucial to the exercise of SRHR.

A prevalent belief that avoiding pregnancy is a woman's responsibility reflects little knowledge of sexual health and safe sexual practices as well as absence of respect for the female partner. Moreover, Philippine laws that continue to give priority to decisions made by males impose an unfair double burden on women (the disparate impact of pregnancy on women and the responsibility to avoid it).

In her 2008 State of the Nation Address, President Arroyo categorically announced that she is not supportive of reproductive rights. The lack of government action to provide the full range of contraceptive methods is more apparent in poor communities. Respondents confirmed that only 18% had received RH information from community health clinics and health professionals, while 41% got information from friends and peers. Furthermore, only less than 15% identified government hospitals, *barangay* health workers, private doctors or NGOs as sources of contraceptive supplies.

An apt illustration is the City of Manila which passed EO 003 in 2000 that has not been repealed until today. It has caused the cessation of contraceptive supply in city health centres and public hospitals. Under its former mayor, even medical missions that offered these services and clinics supported by private and NGO sectors were shut down, and their health care workers who provided access to family planning information were harassed. It is not enough that now under Mayor Alfredo Lim, NGOs are allowed to provide these services considering that the State itself is obligated to follow the law and comply with its domestic and international law obligations.

A restrictive and oppressive law effectively banning contraceptive information, services and supplies contravenes the individual's right to liberty[25] to decide matters that are private and intimate in nature.[26] The Constitution, under Article XV Section 3(1), likewise affords spouses the right "to found a family in accordance with their religious convictions and the demands of responsible parenthood."[27]

The contraceptive ban violates international human rights instruments which the Philippines has signed. The key human rights document is the Universal Declaration of Human Rights (UDHR).[28] It is not a legally binding document but it represents the shared aspirations of governments about what rights are and why they should exist for all people everywhere. The two covenants, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) further clarify the rights set out in the UDHR. Unlike the UDHR, these are legally binding documents.

Equality of rights for women is a basic principle of the United Nations. The preamble to the Charter of the United Nations sets as one of its central goals the reaffirmation of "faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women." By its terms, all members of the United Nations are legally bound to strive towards the full realisation of all human rights and fundamental freedoms.

The Philippines is also a state party to the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), which obligates states to "ensure access to specific

educational information to help to ensure the health and well being of families, including information and advice on family planning." The Millennium Development Goals (MDGs) stemmed from the Millennium Declaration that seeks to advance "a shared vision of a much improved world by 2015." This Declaration was signed by 189 Member States in September 2000, ensuring their commitment to "promote gender equality and the empowerment of women as effective ways to combat global poverty, hunger and disease and to stimulate development that is truly sustainable."[29] As a signatory to this international declaration, the Philippines is committed to pursue these goals, one of which is the promotion of gender equality and empowerment of women, within the 1990-2015 time frame.

The MDG recognises the equality and empowerment of women and girls as among the most effective ways of fighting poverty and disease while generating progress that is sustainable. The State must undertake all measures to remove manifestations of gender inequality. This includes lack of access to information and services on the full range of legally allowed and scientifically safe family planning methods which fosters gender inequality given that only females get pregnant. Thus, if women do not have the information and means to control their own fertility, it is highly unrealistic that they will have a way to chart their own destinies.

VI. RECOMMENDATIONS

The rights of young people to health, information and education are enhanced through access to sexual and reproductive health information and services, which should be increased through the use of multiple entry points (education, work, sports or other social activities) and settings (home, community, workplace, school, clinic/health centre) in order to address the knowledge gap on family planning and contraception. Here, the Government must monitor and ensure that mass media follows gender-neutral policies and sends out the right message to young people whose values are shaped partly by mass media.

Continued support should be given to the comprehensive Reproductive Health and Population Development bill now pending in Congress that establish an unequivocal national policy respecting and protecting the right to reproductive and sexual health of all (including youth) and disregarding marital status as a requirement for receiving reproductive health services. In the absence of a national law, local legislative councils should pass ordinances explicitly making available information on the full range of family planning methods.

Interestingly, only 2% of the respondents cite religion as a reason for not using contraceptives. Given that religion does not hold sway in making decisions on family planning, then legislators who advance reproductive rights should be convinced that doing so would not jeopardise their 'inability.'

Pending the passage of an RH law, we also recommend that FP and sex education classes and seminars be conducted in communities through NGO-led activities but in partnership with government entities. Parental involvement should be encouraged but refusal of parents to participate should not hinder these seminars. An aggressive information drive will be more successful with the development of accurate, age-appropriate and user-friendly informative brochures about SRHR and life skills.

Furthermore, government-supported training of health workers on the substantive aspects of both modern and traditional family planning, as well as counselling and communication skills, is crucial. Government must provide accurate and evidence-based information relayed in a manner understandable to young people in order to correct misconceptions about contraceptive side effects among others and help them develop the ability to make informed and intelligent choices and practice healthy sexual behaviours.

Endnotes

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2 *National Statistics Office. (2007). Population and Annual Growth Rates by Region, Province and City/Municipality: 1995, 2000, 20007. Retrieved 5 October 2009 from the National Statistics Office Website: http://www.census.gov.ph/data/sectordata/2007/municipality.pdf*

3 *Demographia World Urban Areas and Population Projections. (2009). Demographia. Retrieved 5 October 2009 from the Demographia Website: http://demographia.com/db-worldua.pdf*

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6 *Article 2 of Presidential. Decree No. 603 was enacted on 10 December 1974.*

7 *Executive Order 209 took effect on 3 August 1988.*

8 *Republic Act No. 6809 was passed on 13 December 1989. It lowered the age of majority from 21 to 18 years of age.*

9 *Republic. Act No. 7610 was passed on 17 June 1992.*

10 *United Nations Population Fund (UNPF). (2007). Supporting Adolescents and Youth. Retrieved 5 October 2009 from the United Nations Population Fund (UNFPA) Website: http://www.unfpa.org/adolescents/*

11 *Department of Health. (2009). Adolescent and Youth Health and Development Program (AYHDP). Retrieved 9 December 2009 from the Department of Health Website: http://www.doh.gov.ph/programs/adolescent_health/ayhdp*

12 *Women's Health Care Foundation (WHCF). (2001). Baseline Study for the Project Addressing the Unmet Reproductive Health Needs of Adolescents and Women in Metro Manila. Manila, Philippines: WHCF.*

13 *There are also four major subdivisions within the barangay: the Forest Hills Subdivision, Villaflor Village, Sta. Monica Village and Menrey Subdivision, where the affluent families reside.*

14 *1987 Constitution, Article 2, Section 14 (Philippines) provides that: "The State recognises the role of women in nation-building, and shall ensure the fundamental equality before the law of women and men."*

15 *1987 Constitution, Article 2, Section 13 (Philippines) provides that: "The State recognises the vital role of the youth in nation-building and shall promote and protect their physical, moral, spiritual, intellectual, and social well-being. It shall inculcate in the youth patriotism and nationalism, and encourage their involvement in public and civic affairs."*

16 *1987 Constitution, Article 2, Section 15 (Philippines).*

17 *House Bill 5043 entitled An Act Providing for a National Policy on Reproductive Health, Responsible Parenthood and Population Development, and for Other Purposes.*

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22 *The full title of House Bill No.5043 is "An Act Providing for a National Policy on Reproductive Health, Responsible Parenthood and Population Development, and for Other Purposes".*

23 *United Nations General Resolution. (1989). Convention on the Rights of the Child. Retrieved 9 December 2009 from the United Nations Website: http://www.un.org/documents/ga/res/44/a44r025.htm*

24 *Section 15 of House Bill 5043.*

25 *1987 Constitution, Article 3, Section 1 (Philippines) provides that: "No person shall be deprived of life, liberty, or property without due process of law, nor shall any person be denied the equal protection of the laws." Constitution. Article III section 1.*

26 *1987 Constitution, Article 2, Section 11 (Philippines) provides that: "The State values the dignity of every human person and guarantees full respect for human rights."*

27 *1987 Constitution, Article 15, Section 3(1) (Philippines) provides that: "The State shall defend (t)he right of spouses to found a family in accordance with their religious convictions and the demands of responsible parenthood."*

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ARROW is committed to promoting and protecting women's health rights and needs, particularly in the area of women's sexuality and reproductive health.

We believe that good health and well-being and access to comprehensive and affordable gender-sensitive health services are fundamental human rights.

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