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UNDERSTANDING THE CRITICAL LINKAGES BETWEEN GENDER-BASED VIOLENCE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: FULFILLING COMMITMENTS TOWARDS MDG+15

INTRODUCTION

The Asia-Pacific region is home to more than 60% of the world's population and is a culturally, economically and politically diverse region. Gender disparities persist in access to health, access to sexual and reproductive health and services, education, employment and income, political participation and within the family. The outcomes are significantly worse for women and girls who are politically, socially and spatially excluded due to a variety of intersecting factors, including age, disability, caste, citizenship status, economic status, education, ethnicity, location, gender identity and sexual orientation, and situations of conflict, disasters and other emergencies. Moreover, gender-based violence remains a pernicious reality in the region: rates of violence continue to be high and the forms of violence continue to be manifold.

This advocacy brief aims to inform policy-makers and decision-makers on the critical linkages between eliminating gender-based violence (GBV) and achieving the Millennium Development Goals (MDGs), particularly goal 5 on improving maternal health and providing universal access to reproductive health.

Although this brief concentrates mainly on the above linkages, it is now well-recognised that ensuring that women are free from violence will have a positive impact on achieving all goals, including on addressing poverty, gender equality, children's health and HIV/AIDs.

INTERNATIONAL COMMITMENTS ON ADDRESSING GENDER EQUALITY, GENDER-BASED VIOLENCE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

As per international frameworks, governments have recognised and endorsed the rights of women and girls to equality, security, liberty, integrity and dignity, and to lead a life free from violence. Governments have signed onto, endorsed and ratified these fundamental principles which are enshrined in the UN Convention on Elimination of All Forms of Discrimination of Women (CEDAW, 1979), the UN General Assembly Declaration on the Elimination of Violence Against Women (1993) and the Vienna Declaration on Human Rights (1993).

The International Conference on Population and Development Programme of Action (ICPD POA, 1994)[1] highlighted comprehensively the elimination of all forms of gender-based violence, including domestic violence and sexual violence, and called for the protection, promotion and fulfilment of the rights of women to live a life free from violence. The Beijing Platform for Action (BPFA, 1995) also identified gender-based violence as a critical area of concern.[2,3]

Table 1: 13 Countries in Asia-Pacific and the international documents and treaties related to SRHR they have signed onto/ratified/acceded

	CEDAW*	ICESR**	ICCPR***	ICERD****	CRC*****	ICPD PoA•	Beijing Platform of Action••	Milennium Declaration 2000
Bangladesh	Acceded	Acceded	Acceded	Acceded	Signed & Ratified	Signatory	Signatory	Signatory
Cambodia	Signed & Acceded	Signed & Acceded	Signed & Acceded	Signed & Ratified	Acceded	Signatory	Signatory	Signatory
China	-	Signed & Acceded	-	-	-	Signatory	Signatory	Signatory
Fiji	Signed & Acceded	-	-	Signed	Signed & Ratified	Signatory	Signatory	Signatory
India	Signed & Acceded	Acceded	Acceded	Signed & Ratified	Acceded	Signatory	Signatory	Signatory
Indonesia	Signed & Acceded	Acceded	Acceded	Acceded	Signed & Ratified	Signatory	Signatory	Signatory
Laos PDR	Signed & Ratified	Signed & Acceded	Signed & Acceded	Acceded	Acceded	Signatory	Signatory	Signatory
Malaysia	Acceded	-	-	-	Acceded	Signatory	Signatory	Signatory
Nepal	Signed & Ratified	Acceded	Acceded	Acceded	Signed & Ratified	Signatory	Signatory	Signatory
Pakistan	Acceded	Signed & Acceded	Signed & Acceded	Signed & Ratified	Signed & Ratified	Signatory	Signatory	Signatory
Philippines	Signed & Acceded	Signed & Acceded	Signed & Acceded	Signed & Ratified	Signed & Ratified	Signatory	Signatory	Signatory
Thailand	Acceded	Acceded	Acceded	Acceded	Acceded	Signatory	Signatory	Signatory
Vietnam	Signed & Ratified	Acceded	Acceded	Acceded	Signed & Ratified	Signatory	Signatory	Signatory

*CEDAW1** *Convention on the Elimination of All Forms of Discrimination against Women : Article 16 (SRHR); Articles 2 and 11 (GBV)*
*CESR*** *International Covenant on Economic, Social and Cultural Rights: Articles 10, 12 and General Comment 14 (SRHR); Article 3 (GBV)*
*CCPR**** *International Covenant on Civil and Political Rights: Articles 3, 6(1) and 23 (3) (SRHR); Articles 3 and 7 (GBV)*
*CERD***** *International Convention on the Elimination of All Forms of Racial Discrimination: Article 5 (SRHR)*
*CRC****** *Convention on the Rights of the Child: Articles 24 and 34 (SRHR); Article 34 (GBV)*
CPD PoA• *The InternationalConference on Population & Development Programme of Action: Chapters 7 and 8 (SRHR); Chapters 4 and 7 (GBV also including 5.10, 11.16, and 12.13)*
BPfA••• *Beijing Platform for Action: Paragraphs 74, 83, 92, 93, 04, 95, 96, 97, 100, 106, 017, 108, 109, 110, 147, 165, 178, 206 and 217 (SRHR) and Paragraphs 8, 12, 17, 24, 39, 44 and 46 (GBV)*

The Millennium Declaration,[4] endorsed by governments across the world in 2000, is grounded on the principle of equality: that "the equal rights and opportunities of women and men must be assured." The Declaration identified the promotion of gender equality and the empowerment of women as an effective way to combat poverty, hunger and disease and to stimulate sustainable development. It also resolved to "combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women."[5] In the recent MDG+10 Summit, governments across the world also committed themselves to take "action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education and gender inequality, and paying particular attention to *eliminating all forms of violence against women and girls*," in order to achieve the MDGs, particularly goal 5.[6]

Table 1 on the left lists which Asian-Pacific governments have signed on to these various international agreements and treaties.

These international frameworks have been reaffirmed at the regional and sub-regional levels, including in the following:
- the 2004 Social Charter of the South Asian Association for Regional Cooperation (SAARC);
- the 2004 Declaration on the Elimination of Violence Against Women in the Association of South East Asian Nations (ASEAN);
- the 1994 and 2004 Pacific Platform for Action; and
- the 2009 Cairns Communique.

The MDGs can only be achieved if states understand and accept their ultimate and onerous responsibility to fulfil obligations to international treaties and agreements and must perform them in good faiths. State obligation entails compliance by government units across different sectors.[7]

Eliminating gender-based violence requires the obligation of states on the principles to:
- i Respect rights of women;
- ii Protect rights of women;
- iii Promote rights of women;
- iv Fulfil rights of women; and
- v Obligations of means and results.

How prevalent is gender-based violence?

Globally, the figures for gender-based violence are staggering:[8]
- between 10% and 69% of women report that an intimate partner has physically abused them at least once in their lifetime;
- between 6% and 59% of women report attempted or completed forced sex by an intimate partner in their lifetime;
- between 1% and 28% of women report they have been physically abused during pregnancy by an intimate partner;
- between 7% and 48% of adolescent girls and between 0.2% and 32% of adolescent boys report that their first experience of sexual intercourse was forced;
- approximately 20% of women and 5%–10% of men report having been sexually abused as children;
- between 0.3% and 12% of women report sexual violence by a non-partner; and
- it is estimated that 2.5 million people are trafficked every year, the majority of them women and children.

Gender-based violence is prevalent in the region as is shown by Demographic Health Surveys in countries where this data is available (see Table 2).

Worldwide, gender-based violence is "a serious cause of death and incapacity among reproductive age women as is cancer, and it is a more common cause of ill-health among women than traffic accidents and malaria combined."[9] Moreover, according to the World Bank, rape and intimate partner violence accounted 5% of the healthy lives lost to women aged 15-44 years in developing countries. Globally, 9.5 million disability-adjusted life years (DALYs) were estimated to be lost by women in the reproductive age group, comparable to DALYs lost from tuberculosis, HIV and sepsis during childbirth.[10]

Table 2. Percentage of women who ever experienced physical or sexual violence and experienced violence in the last 12 months

Country	Experience of physical or sexual violence since age 15	Experience of physical or sexual violence in the last 12 months
Bangladesh	53% (one in two)	25% (one in four)
Cambodia	20% (one in five)	10% (one in 10)
China	34% (one in three)	
Fiji	80.2% (have seen someone in their house being abused)	
India	35% (one in three) 40% (if it includes emotional violence)	56% (one in two) 72% (if it includes emotional violence)
Nepal	Not available	Not available
Pakistan	One in three	
Philippines	24% (one in four)	7%
Thailand	30% (one in three)	
Vietnam	31% (one in three)	

Sources: Bangladesh Demographic Health Survey (DHS) 2007; Cambodia DHS 2005; India NFHS 3 2005-6; The Philippines NDHS 2008; Not all countries which have the DHS methodology commission the domestic violence data (for example, Indonesia and Nepal). For China, Thailand and Vietnam: UNFPA. For Fiji, FWCC study quoted in the ADB report. For Pakistan, Fikree, Journal of International Gynaecology and Obstetrics.

Definitions

Gender-based Violence (GBV)

Gender-based violence is "any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."[11] In Asia-Pacific, gender-based violence takes many forms, including intimate partner violence and marital rape, sexual violence, dowry-related violence, son preference and female infanticide, sexual abuse of female children, female genital mutilation/ cutting, and other negative customary practices harmful to women, early marriage, forced marriage, non-spousal violence, violence perpetrated against domestic workers and other forms of exploitation and trafficking.[12] Gender-based violence is born of and perpetuated by unequal power relations and gender relations.

Reproductive Health (RH)

Reproductive health is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity"; it "addresses the reproductive processes, functions and system at all stages of life." It "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 right of men and women [as well as gender non-conforming people] to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access 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."[13]

Reproductive Rights (RR)

Reproductive rights "recognise that the sexual and reproductive health of both women and men [as well as gender non-conforming people] requires more than scientific knowledge or biomedical intervention." Rather, they require "recognition and respect for the inherent dignity of the individual." They "refer to the composite of human rights that protect against the causes of ill health and promote sexual and reproductive wellbeing."[14] They "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."[15] RR include the right to safe, legal and accessible abortion services.

Sexual Health

"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[16] The purpose of sexual health care should be "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[17] "For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[18]

Sexual Rights

"Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. They 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 related to sexuality; sexuality education; respect for bodily integrity; choose their 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."[19]Sexual rights also include the "right to personhood (the right to make one's own choices), equality (between and among men, women and transgender people), and respect for diversity (in the context of culture, provided the first three principles are not violated)."[20] Moreover, "a human rights approach to sexuality and sexual policy implies the principle of indivisibility—meaning that sexual rights are inextricable from economic, social, cultural and political rights. Freedom to express one's sexual or gender orientation or to be who one is as a sexual person, to experience erotic justice, is interdependent with a whole series of other rights, including health care, decent housing, food security, freedom from violence and intimidation, and to be in public space without shame."[21]

Sexual Violence

Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[22] Sexual violence can take place in different circumstances and settings. These include coerced sex in marriage and dating relationships, rape by strangers, systematic rape during armed conflict, sexual harassment, sexual abuse of children, sexual abuse of people with mental and physical disabilities, forced prostitution and sexual trafficking, child marriage, denial of the right to use contraception, forced abortion and violent acts against the sexual integrity of women, including female genital cutting and obligatory inspections for virginity.[23]

MDG 5: HOW GENDER-BASED VIOLENCE IMPACTS ACHIEVEMENTS IN MDG 5

The women's health and rights movement and global gender analysis clearly indicated has always analysed gender and other power relations as crucial determinants of sexual and reproductive health (SRH) outcomes. Gender inequalities within the family and society, including gender-based violence, affect women's sexual and reproductive health. Whether women are able to choose when to have children or able to protect themselves from sexually transmitted infections and HIV, whether they survive a pregnancy, and whether they give birth at home or in the hospital, are all affected by these factors. It is thus important for us to analyse the slow progress in the region within a rights framework and a gender and social equality-lens with regards the reduction of maternal mortality.

Goal 5: Improve maternal health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5.B: Achieve, by 2015, universal access to reproductive health

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage (at least one visit and at least four visits)
- 5.6 Unmet need for family planning

Both MDG 5A and 5B are intimately intertwined: maternal health is a component of reproductive health, and policies, programmes and interventions in one will impact the other.

MDG 5A TARGET: REDUCING MATERNAL MORTALITY BY THREE QUARTERS BY 2015

Based on the recent 2008 WHO/UNICEF/UNFPA and World Bank estimates, eight of the 13 Asian-Pacific countries covered in this brief are said to be "making progress," while Vietnam and China are "on track" towards achieving the reduction of maternal deaths by three quarters by 2015. Fiji, Malaysia and Thailand have not been categorised in this grading as these countries had an MMR of less than 100 in 1990. One-third of all maternal deaths in the world occur in South Asia.

Despite this progress in the region, maternal mortality estimates continue to be remain high particularly in South Asia—Nepal (380 deaths per 100,000 live births), Bangladesh (340), Pakistan (260) and India (230)— and in South East Asia—Lao PDR (580), Indonesia (240) and Cambodia (290). However, it is important to consider that the ICPD target of lowering the MMR to below 100 has only been achieved in 6 out of 12 countries.

The well-recognised factors contributing to a reduction of maternal deaths in the region include availability of and ocean to skilled birth attendants (SBA), emergency obstetric care (EmOC), post-partum care and these need continued priority investments.

Can gender based violence exacerbate/contribute to maternal deaths?

However, a crucial factor that is paid less attention as a contributing factor to maternal deaths and morbidities is gender-based violence.[24]

Gender-based violence, domestic violence and intimate partner violence have already been identified as a definite cause of maternal deaths in the region. Studies from South Asia, for example demonstrate that maternal deaths are attributable to gender-based violence. In Western India, a study found that almost 16% of maternal deaths were associated with intimate partners violence or violence by a family member.[25] In Matlab, Bangladesh, a study found that 9% of maternal deaths were caused by injuries and violence,[26] while the WHO study found that "14% of the maternal deaths are considered to be due to violence.

The contribution of violence to maternal deaths equals that of abortion and is only surpassed by haemorrhages. The relatively large contribution of violence towards the maternal mortality is possibly due to high rates of fatal forms of violence such as acid throwing, burning and murder of women. Therefore it is understandable that the health sector is attempting to address gender-based violence by linking it to the reduction of maternal mortality."[27]

Violence during pregnancy

Violence during pregnancy may be more common than previously thought of and the prevalence rate is estimated at approximately 4% to 32% in developing countries.[28] A study in Pakistan found that 15% of women reported being physically abused during pregnancy, with one third of them reporting a subsequent miscarriage.[29]

Violence during pregnancy has been documented to be "associated with a variety of obstetrical risks, including late entry into prenatal care, increased smoking and substance abuse, a history of STIs, unintended pregnancy (mistimed or unwanted), vaginal and cervical infections, kidney infections, miscarriages/abortions, premature labour, foetal distress, bleeding in pregnancy, and inadequate weight gain" as well as low-birth weight, a leading cause of infant deaths in developing countries.[30] All of these reflect that gender-based violence can be an underlying factor for maternal and infant mortality and maternal morbidity.

Gender-based violence also contributes to maternal deaths indirectly: a) through causing unwanted pregnancies; b) through limiting ability to use contraception; c) through dissuading ante-natal check-ups and other health-seeking behaviour and d) through causing poor pregnancy outcome, which will push the woman to another immediate pregnancy, and hence increase the risk of poor outcome once again.

MDG 5B TARGET: ACHIEVING UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

MDG 5B is centred on creating universal access to reproductive health. The reproductive health consequences of gender-based violence have been well-documented. Survivors of violence report more induced abortions, miscarriages, stillbirths, low-birth weight babies, and are at greater risk for having had attempts made on their lives than non-childbearing women. They have fewer ante-natal care visits and post-natal care follow-ups; have delayed entry into ante-natal care; and some sexually transmitted infections (STI) and HIV-risk behaviour. Other studies also indicate high parity is a consequence, rather than a risk factor, for violence; and that there can be an increased risk of unintended pregnancy among abused women. Men who are violent towards their partners are also more likely to have multiple sex partners, which may increase risk for STIs and HIV.[31,32]

This has also been corroborated by evidence from the *2004 WHO Profiling Domestic Violence: A Multi-Country Study* which elaborated the following health consequences of domestic violence comparing findings for women who experienced domestic violence to women who have never experienced domestic violence.[33] These are enumerated below.

The reproductive health consequences for women who experienced domestic violence were:
- A higher mean number of births in most age groups and countries.
- Less likely to say that their birth was wanted when child was conceived, in all but one of the countries.
- Consistently higher likelihood of having a birth that is not wanted at all, in all but one of the countries.

With regards to contraceptive use and contraceptive needs, women who experienced violence:
- Were more likely to have tried contraception, but also more likely to have discontinued it.
- Tended to have a higher total need for family planning.
- Had higher total unmet need, in seven countries in the study.
- Had higher unmet need for limiting births, in all countries.

According to the study, other health consequences were:
- More likely to have a non-live birth (due to miscarriage, abortion, or stillbirth).
- Self-reported prevalence of STIs is at least twice that among women who have never experienced violence.
- Experience of violence is associated with a delay in accessing ANC.

In addition, a higher prevalence of HIV among women who experienced violence than non-abused women has also been documented.[34]

In this section, we will examine more closely the linkages between gender-based violence and three MDG 5B indicators: contraceptive prevalence rates, unmet need for family planning and adolescent birth rates.

Contraceptive prevalence rates and unmet need for family planning.

Increases in contraceptive prevalence rates over the past 10 years has been greater than ten percentage points in countries such as Cambodia, Nepal, India and Pakistan; between 5-9% in Bangladesh and Thailand; and less than 4% in all other countries. This is demonstrated in Table 3 in the section on Reference Tables. It further indicates that CPRs appear to taper off and remain in the middle range for a long period of time in countries such as Indonesia, Malaysia and the Philippines. Hence in some countries, it may be necessary and useful to look at other factors which may affect contraceptive behaviour.

Table 4 (in the section on Reference Tables) shows that declines in unmet need have also been modest over the ten-year period.

Access to modern methods of contraception continue to be a challenge in a high-CPR country like Vietnam, a middle-level CPR country like Malaysia and the Philippines, and a low-CPR country like Lao PDR.

It is critical to understand the reasons behind the CPR, which may vary from lack of choice of contraceptive methods, religious constraints and cost and availability of contraceptives and accessibility of contraception due to socio-cultural factors.

Women must have control of their reproductive health choices

The most common reasons given by women with unmet need for family planning are concerns about the side effects, health consequences and inconvenience of methods. The prevalence of these concerns is particularly high in South and Southeast Asia.[35] It is also important to look at and address reasons for non-use of contraception which include spousal opposition and religious opposition to use of contraception by women. Contraception is the first step in women gaining control over their own fertility, and being able to decide the number, spacing and timing of their pregnancies.

In all countries surveyed, the data shows a positive relationship between use of contraception and participation in household decision-making[36]; and that unmet need is highest among women who do not participate in any household decisions[37] and among women who believe wife-beating is justified.[38,39] Hence it is also critical to look at gender-based violence and its linkages with

improving contraceptive behaviour, in addition to providing a range of contraceptive methods and counselling.

Studies in India have shown the links between abuse and unplanned pregnancies,[40] the positive relationship between experiencing physical domestic violence and lower likelihood of contraceptive adoption,[41],[42] and covert use of contraceptives (due to women wanting fertility choices different from husbands) and domestic violence.[43]

Adolescent birth rates

Early marriage : adolescent birth

There is a strong correlation between an early age of marriage and the occurrence of gender-based violence. This impacts contraceptive behaviour, reproductive behaviour, health seeking behaviour, and maternal mortality and morbidities, such as fistula and uterine prolapsed.

Globally, it is estimated that 17 million young women are married before the age of 20. Between 25% to 50% of all young women give birth before they turn 18 in low-income countries.

The adolescent birth rate has been declining steadily in the past ten years in the region, but continues to be highest in Nepal and Bangladesh. Adolescent birth rates are also high in India, Cambodia, Indonesia, the Philippines and Thailand. Only China and Malaysia have the lowest adolescent birth rates. Table 5 (Reference Tables) shows these trends.

Adolescent birth rates also seem to be higher in countries that do not strictly enforce the legal age of marriage. In fact, data shows that in Bangladesh, India and Nepal, the median age of marriage is lower than the legal age of marriage.[44]

Early marriage: less autonomy

Younger married women are more at risk for violence. A recent 10 country study[45] demonstrates that age at first marriage is a major factor related to experiences of violence: women who were younger than 20 years old when they first married or started living with their current husband or partner were more likely to report physical or sexual violence than those who reported being 20 years or older when they first married. Data from the WHO multi-country study shows that 20–36 % of women ages 15–19 years old in 10 of 15 study sites reported being subject to at least one act of physical violence in the previous year and the rates of current physical violence are higher in the 15–19 year age group, compared with older women ages 20–49 years old.[46]

Recent research shows that young women in particular tend to report that first sex was physically forced or obtained through threats, trickery, or deception and early marriages, especially in settings where arranged marriage is common, are frequently characterized by forced early marital sex.[47]

Younger girls who marry at an early age often have negligible sexual experience, lesser information, no autonomy and little negotiating power within the relationships - an Indian study showed only one in seven married girls aged 15-19 (13.8%)could go to market without her husband's permission and only one in ten (10.2%)could visit friends without permission. Twice as many older married women had the freedom to do these things.[48]

Their partners often are older, for example, in Bangladesh the mean age difference between a married girl aged 15-19 and her husband is 9.8 years,[49] and more sexually active. This puts younger women at greater risk of contracting reproductive and sexually transmitted infections, including HIV.[50]

Early marriage is also associated with lower educational attainment for girls, limiting their employment opportunities, economic security and productive value to society. All these factors contribute to low levels of decision making in the family, increased vulnerability to violence, and limited access to social and economic resources.[51] There are cases that a combination of these factors also leads to death. For example, a study in Matlab, Bangladesh, for the period 1976-1993, found that pregnant adolescents had a greater risk of suicide death than non-pregnant adolescents.[52] Early marriage often leads to early pregnancy and early childbearing, which are linked to higher risks of maternal mortality and morbidity.[53]

RECOMMENDATIONS

- **Build a strong evidence base** in order to better support policy and programmatic interventions for lowering maternal mortality and improving universal access to reproductive health, taking into consideration its inter-linkages with gender-based violence.

  These can be done through the following:
  a. ensuring that censuses are gender-sensitive;
  b. commissioning the full Domestic Violence components in countries that have the DHS modality, as India and the Philippines have done;
  c. disaggregating data by age, income, education, sex, location and ethnicity, as in the case of Nepal; and
  d. including gender-based violence and sexual and reproductive health outcomes in the analysis of data.

- **Enact and implement progressive laws and policies that promote, protect and fulfil gender equality, including anti-domestic violence and anti-gender-based violence policies.** In Nepal, recently, there have been many progressive policies that enable an inter-sectoral approach and response to gender-based violence. These include the constitutional amendment 11 and the new national plan on gender-based violence, which includes male accountability.

  Policy directives that adopt a holistic and integrated strategy in order to eliminate gender-based violence need to be issued by the most relevant policy-making bodies within the country context. For an inter-sectoral approach, this is particularly

critical; similar policy directives need to be issued by different main line ministries.

- **Promote and adopt an inter-sectoral response to addressing gender-based violence.** A comprehensive inter-sectoral approach involves not just the women's and family ministries, but also the following:

  a. *education, media and communication sectors:* they are necessary to transform societal attitudes and spark mindset change on attitudes towards gender-based violence. Within the education sector, it is essential to have a curriculum which promotes equality and refrains from sex stereotypes, as well as imparts negotiation skills to prevent transmission of inter-generational violence.
  b. *government youth ministries:* they need to take on the issues of adolescent and young women and their vulnerability to gender-based violence, and create policies and programmes which are able to help prevent and eliminate gender-based violence for adolescent and young women.
  c. *law enforcement, judicial and social protection agencies:* police officers, lawyers, judges, social workers and counsellors and others need to be gender-sensitised to understand gender-based violence. Different stakeholders should come together to offer the necessary support services for survivors such as free legal aid and counselling for rehabilitation.
  d. *non-government organisations that work on women's rights, sexual and reproductive health and rights and addressing gender-based violence:* they are key players in tackling gender-based violence, as many provide women's shelters, run sexual and reproductive health and rights services, provide capacity building and training, advocate for and monitor policies and programmes that address gender-based violence.
  e. *faith-based groups:* they need to promote progressive views and interpretations on partnership, familial and societal relationships and roles.
  f. *men and boys:* for long-term social transformation and effective interventions, particularly the prevention of inter-general violence, men and boys must be involved and transformed into advocates for gender equality and addressing gender-based violence. The inter-linkages of gender-based violence, sexual and reproductive health and gender inequality must be examined.

- **Incorporate a health sector response within the inter-sectoral response to gender-based violence.** A health sector response that is comprehensive and based on women's rights is an essential and strategic delivery point to respond to gender-based violence.

  This would:
  a. enable early screening and detection of gender-based violence and quicker intervention;
  b. provide treatment and care for victim-survivors who are at the crisis point; and
  c. reduce maternal deaths and the burden of disease caused by gender-based violence.

Health sector responses to gender-based violence can be systemic within health facilities as demonstrated in Malaysia and Thailand. It can be implemented with completely sensitised health personnel as in Dilaasha, Mumbai, where every staff undergoes regular and consistent gender-sensitisation and understands the issue of gender-based violence.

It is better science to screen for violence early and to ensure the health sector is responsive to this issue in every aspect to enable better health outcomes for women. Good reproductive, sexual and maternal health outcomes reduce the burden of mortality and disease and enable countries to achieve the MDGs.

Components and qualities of a comprehensive health sector response

- places equal emphasis on screening and treatment of gender-based violence, including care and management of cases
- has first-order responses and advanced responses at the community level, as well as the primary and tertiary levels – and is linked across the informal and formal sectors
- has entry points throughout the health system to enable access to screening and treatment, including services such as home visits during pregnancy and postnatal period to provide support to mothers and detect cases of abuse
- is inter-linked with referrals within the health sector (especially mental health, which is often over-looked)
- is inter-linked with referrals to different sectors - to shelters, legal aid, financial aid and skills development programmes for at-risk cases
- includes access to facilities such as separate examination rooms, medical instruments and tests, and necessary medicines. Facilities should maintain privacy and confidentiality and provide immediate attention for survivors including rights-based counselling support services.
- includes institutionalised periodic gender-sensitisation for all health staff which includes training, monitoring and evaluation
- is supported by community resources and inter-linked with women's organisations for continuous gender-sensitisation of the health sector
- addresses the impact of gender-based violence within the curriculums of medical and nursing schools. Curriculums and health personnel should promote progressive religious interpretations on spousal roles & relationships and screening, treatment, care and case management and emphasise the rights of the survivors.
- offers a confidential complaints/feedback mechanism for survivors who have interacted with the health system.

REFERENCE TABLES

Table 3: Contraceptive Prevalence Rates (Any Method) (1995-2008)

Country	1995	2000	Latest Available
Bangladesh	49.2 (1997)	53.8	55.8(2007)
Cambodia		23.0	40.4 (2005:CDHS)
China	83.8 (1997)		90.2(2004)
Fiji (2003-2008)			35(2003-2008)
India	40.7 (1993)	48.2(1999)	56.3(2006)
Indonesia	57.4(1994)	60.3(2003)	61.4 (2007)
Lao PDR		32.2(2000)	
Malaysia	54.5 (1994)		
Nepal	28.5(1996)	39.3(2001)	48.0 (2006)
Pakistan	11.8 (1991)		29.6 (2006PDHS)
Philippines	47.8 (1998)	48.9 (2003)	50.7 (2008)
Thailand	72.2(1997)	71.5 (2005-2006)	81.1 (2006)
Vietnam		78.5(2002)	79.0 (2007)

Source: Bangladesh DHS 1996-1997,1999-2000,2007; Cambodia DHS 2000 and 2005; India National Family Health Survey (1992-93, 1998-99,2005-06); Indonesia DHS(1994, 2003,2007); Nepal DHS (1996,2001, 2006); Pakistan DHS (1991,2006); Philippines DHS (1998, 2003, 2008); Fiji, Lao PDR, Malaysia, Thailand and Vietnam (data from World Contraceptive Use 2003, 2007,2009)

Table 4: Unmet need for family planning (1995 -2008)

Country	1995	2000	Latest available
Bangladesh	19.4	15.3	17.1(2007)
Cambodia		32.6	25.1(2005)
China			
Fiji			
India		15.8	12.8
Indonesia	9.2		9.1(2007)
Lao PDR			27.3(LRHS 2005)
Malaysia			
Nepal	31.4	27.8	24.6(2006)
Pakistan	28.0		24.9(2006-07)
Philippines	19.8		22.3 (2008)
Thailand			
Vietnam			4.8(DHS 2002)

Source : Bangladesh DHS 1996-1997,1999-2000,2007; Cambodia DHS 2000 and 2005; India National Family Health Survey (1992-93, 1998-99,2005-06); Indonesia DHS(1994, 2003,2007); Nepal DHS (1996,2001, 2006); Pakistan DHS (1991,2006); Philippines DHS (1998, 2008); Vietnam DHS 2002; Lao Reproductive Health Survey 2005.

Table 5: Adolescent Birth Rates in 13 countries

Country	2000-2007*	2010**
Bangladesh	127	72
Cambodia	52	39
China	5	10
Fiji	30	32
India	45	68
Indonesia	51	40
Lao PDR	110	37
Malaysia	13	13
Nepal	106	101
Pakistan	20	46
Philippines	55	45
Thailand	46	37
Vietnam	35	17

Sources:
** WHO, World Health Statistics 2010*
*** UNFPA APRO, Young People in the Asia-Pacific Region*

ENDNOTES

1 Relevant sections include the following: "Principles"; "Gender Equality, Equity and Empowerment of Women";" "The Family, Its Roles, Rights, Composition and Structure"; "Reproductive Rights and Reproductive Health"; "Population, Development and Education"; and "Technology, Research and Development." *See* United Nations (UN). (1994). *International Conference on Population and Development Programme of Action*. United Nations Population Fund (UNFPA). (1994). Principles. In *Programme of Action* (p. 8-12). New York, USA: UNFPA. Retrieved November 10, 2010, from United Nations Web site: http://www.un.org/popin/icpd/conference/offeng/poa.html

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