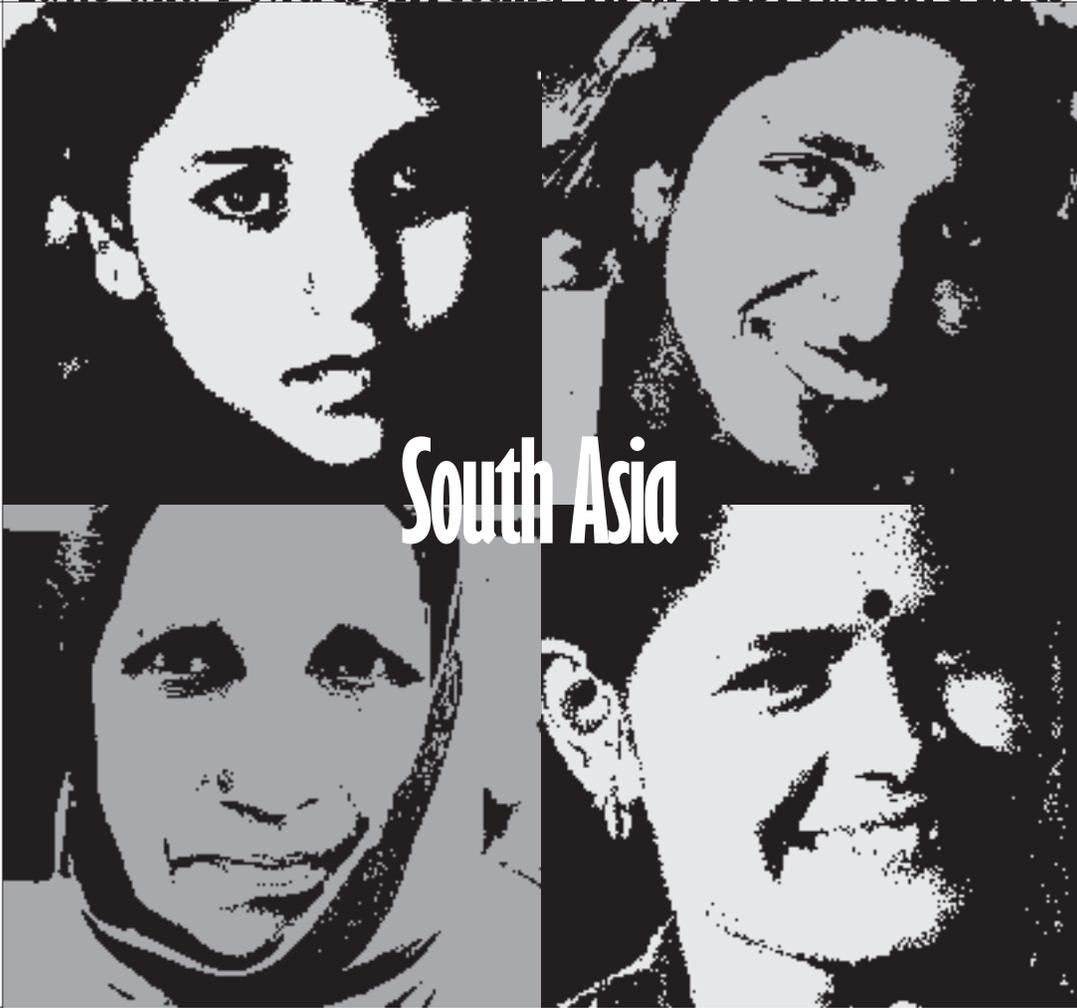


Women of the World:

Laws and Policies Affecting Their Reproductive Lives



Edited by The Center for Reproductive Rights

**WOMEN OF THE WORLD: LAWS AND POLICIES
AFFECTING THEIR REPRODUCTIVE LIVES**

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Foreword

Imagine a world in which the laws and policies of every country enabled women to fully enjoy their reproductive rights. While this is still a distant goal, a confluence of factors has enabled women's health and rights advocates to bring this goal into focus. The 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW) were groundbreaking for so many reasons. One of those is that governments agreed that everyone has reproductive rights, and that such rights are an inalienable part of established international human rights. This recognition that the "traditional" human rights framework applies to women's unique human condition, including their reproductive and sexual lives, was overdue, yet inspiring to women around the world.

The ICPD and the FWCW also recognized that an enabling legal and policy environment that ensures women's equality is necessary to ensure positive reproductive and sexual health outcomes. But to reach the goal of a changed legal and policy environment, advocates and policymakers need more information to support their efforts.

This series of reports, *Women of the World: Laws and Policies Affecting their Reproductive Lives*, is intended to give advocates and policymakers a fuller view of the laws and policies governing women's lives to better enable legal and policy reform and the implementation of laws that will improve women's health and lives. Initiated soon after the ICPD and the FWCW, the series to date has included reports covering Anglophone Africa, East Central Europe, Francophone Africa, and Latin America and the Caribbean. The Center for Reproductive Rights and our collaborating organizations have raised awareness in each of the 30 countries covered by the series to date, and in many cases have contributed to improvements in laws, policies and their implementation.

We are very pleased to introduce the newest report in our series, *Women of the World: Laws and Policies Affecting their Reproductive Lives—South Asia*, covering Bangladesh, India, Nepal, Pakistan, and Sri Lanka. This report was a collaborative effort with non-governmental organizations in the region. The product of three years of work, the release of this report coincides with the ten-year anniversary of the ICPD. South Asia is illustrative of the situation in many regions: Despite some gains, the principles agreed to at the ICPD and the FWCW have not translated into adequate legislation and policy so as to begin to transform the lives of the vast majority of women.

We at the Center for Reproductive Rights want the law to work for women, ensuring their ability to exercise their reproductive rights and to enjoy full equality, no matter their country or community of origin. We hope our *Women of the World* publication will become a useful tool for transforming women's reproductive lives in the South Asia region through legal advocacy and reform.

Katherine Hall-Martinez, Director, International Legal Program
Melissa Upreti, Legal Adviser for Asia, International Legal Program
Center for Reproductive Rights
March, 2004

Overview*

Gender-based discrimination constitutes one of the greatest threats to women's health and lives worldwide. The threat is particularly great in South Asia, where formal laws discriminate against women more than in other regions.¹ Consequently, according to most indicators of human development, women in South Asia—specifically Bangladesh, India, Nepal, Pakistan, and some parts of Sri Lanka—are among the worst off in the world.² A closer look at the state of women's reproductive health in the region tells the story clearly. South Asia has some of the world's highest rates of unplanned pregnancies, maternal deaths, unsafe abortions, child marriages, and sexual trafficking and violence; furthermore, current rates of HIV infection among South Asian women are soaring. Although governments have tried to address these problems by establishing reproductive health-care services, such attempts have been undermined by a lack of coordinated efforts to promote women's reproductive autonomy. Clearly, there is a pressing need for a fresh, human rights-based approach to women's reproductive health.

I. Introduction**

A reproductive rights framework offers a powerful tool for advancing women's reproductive health and empowering women to address the social conditions that jeopardize their health and lives. Reproductive rights are founded on principles of human dignity and well-being. They encompass a broad range of internationally and nationally recognized political, economic, social, and cultural rights. Broadly speaking, they include two key principles: that all persons have the right to reproductive health care, and the right to make their own decisions about their reproductive lives.

To local and international advocates, the reproductive rights framework offers significant benefits. Governmental commitments—at major international conferences such as the Fourth World Conference on Women (Beijing, 1995), the International Conference on Population and Development (ICPD), Cairo, 1994) and the World Conference on Human Rights (Vienna, 1993)—have set the stage for transforming declarations of reproductive rights into a reality for women. More recently, with the adoption of the Millennium Development Goals (2000), governments have agreed that addressing women's reproductive health is key to promoting gender equality and the right to development.

This wave of commitment to women's reproductive

health and rights marks a distinct shift from the development trends of the 1970s and 1980s, which were dominated by population concerns and structural adjustment programs that led to drastic cuts in government spending on health and education. Women's health and rights are now clearly etched on the international political agenda. What remains is for governments to transform these commitments into meaningful change by introducing gender-sensitive laws and policies that respect, protect and fulfill women's reproductive rights. It is crucial that advocates hold governments to their commitments and seek accountability for violations of reproductive rights.

Violations of reproductive rights may be expressed in a number of different outcomes: unplanned and forced pregnancies, coercive family planning measures, deaths during pregnancy and childbirth, deaths or complications due to unsafe abortions, early marriages, and forced, unsafe sex. These experiences are widely tolerated and accepted as either natural and inevitable (maternal mortality), or customary and necessary (child marriage). A reproductive rights analysis, however, identifies each of these experiences as fundamental violations of human rights for which governments are legally accountable.

*The Overview reflects the Center for Reproductive Rights' institutional views, not those of the partners.

**Unless otherwise noted, statistical information and references to legislation and policies are more fully referenced in the relevant country chapter.

In South Asia, the perpetuation of these violations is rooted in the following barriers to women's reproductive freedom:

Social barriers

Discrimination against women is widespread in South Asia. Social and religious norms largely essentialize women as inferior to men. The most glaring manifestation of this discrimination is the distinct preference for sons among all segments of society, regardless of class, caste and ethnicity. This cultural undervaluing of women's fundamental existence translates into inadequate respect for women's inherent dignity and freedom in all aspects of their lives. Family members routinely make the most important decisions relating to women's health, education, access to property and marriageability. Women are arbitrarily deprived of the right to make their own choices on the most fundamental aspects of their lives simply because of their sex, resulting in a denial of their personhood and autonomy, especially in the private sphere.

Legal barriers

Social discrimination against women is also reflected in laws and policies throughout the region. Regional agreements protect fundamental rights to life, equality and nondiscrimination for all. However, religion-based personal laws governing marriage, divorce and inheritance institutionalize inequality within marriage and undermine women's ability to exercise their constitutional rights to equality. Personal laws legitimize discriminatory and often violent practices within the home by giving such practices an aura of sanctity and exempting them from public scrutiny. In addition, most personal laws do not grant women equal rights to property or guardianship. And in the public sphere, few laws in the region protect women from sexual violence or discrimination in the workplace.

Political barriers

Participation in public life is key to influencing the political agenda and the allocation of public resources. Quotas for women in local and sometimes national governing bodies represent positive, concrete steps that have increased women's political involvement in parts of the region such as India and

Nepal. However, the results are mixed. Women's access to power and state resources remains extremely limited in South Asia. As a result, women's reproductive health problems continue to be ignored throughout the region.

The remainder of this overview discusses issues of concern and offers a series of recommendations for governments and advocates in the following five key reproductive rights areas: fertility, including family planning and population policies; pregnancy and childbirth, including maternal death and morbidity and unsafe abortion; sexual violence, including rape and sex trafficking; the emerging concerns of HIV/AIDS and essential aspects of health care; and the especially vulnerable groups of adolescents and refugees.

REPRODUCTIVE RIGHTS INCLUDE

- The Right to Life, Liberty and Security
- The Right to Health, Reproductive Health and Family Planning
- The Right to Decide the Number and Spacing of Children
- The Right to Consent to Marriage and to Equality in Marriage
- The Right to Privacy
- The Right to be Free From Discrimination on Specified Grounds
- The Right to be Free From Practices that Harm Women and Girls
- The Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment
- The Right to be Free from Sexual Violence
- The Right to Enjoy Scientific Progress and to Consent to Experimentation

II. Reproductive Rights in South Asia: Critical Issues and Possible Interventions

The following sections describe some of the key issues of concern for women in the five countries surveyed in the region.

A. FERTILITY

In South Asia, fertility rates have fallen significantly over the last few decades as access to modern forms of contraception has grown.³ However, the ability of women to make independent decisions about their own fertility remains severely constrained by discriminatory social practices and restrictive population policies. An influx of family planning funds to the region has increased the availability of contraceptives, but most women lack the agency to use them as they see fit. Social expectations regarding childbearing often trump women's personal desires. Similarly, population policies dictate women's reproductive choices by imposing state-mandated, small-family norms. In a culture that values sons over daughters, women are likely to find themselves caught

between family pressure to bear male children and government pressure to bear no more than two children; women caught at the intersection of these agendas are essentially forced to abort female fetuses until they achieve the birth of a male child.

1. Family Planning

Background and key facts

Governments in South Asia have enjoyed considerable domestic and international support for family planning programs. As a result, the region has adopted a liberal approach to the legalization and importation of contraceptives, and countries have made significant advances in promoting access to contraception, particularly among married women. In Bangladesh, the contraceptive prevalence rate for use of any method has risen from 7.7% in 1954 to 54.3% in 2000.⁴ In Sri Lanka, where efforts to increase access to family planning have been combined with steps to educate women and increase the age at marriage, the current overall contraceptive prevalence rate is 70% and at par with the average level of use in more developed regions.⁵ The Sri Lankan case illustrates how women's right to control their fertility cannot be realized without addressing a range of barriers to women's equality. Although Sri Lanka's level of contraceptive use is the highest in the region (and its level of fertility is the lowest), other South Asian countries have some of the lowest rates of contraceptive use in the world. In Pakistan, for example, only 28% of married women practice contraception, and the proportion using a modern method is even lower—20%. Overall, less than half of all married women in the region are using a modern form of contraception. Studies suggest that more than 30% of married women in Nepal and Pakistan have an unmet need for family planning; this measure does not take into account the needs of unmarried women of all ages and marginalized groups, such as adolescents and refugees.

Areas of Concern

Lack of autonomy in reproductive decision-making

The family planning-related policies of most of the five countries covered in this report have embraced the key principles enshrined in the Programme of Action adopted by the Cairo Conference ("ICPD Programme of Action") which includes the right of individuals to decide freely and responsibly the number and spacing of their children, and to have the information and means to do so. However, these commitments are not supported by robust strategies that focus on promoting women's empowerment and reproductive self-determination. As a result, women succumb to social pressure to bear children. In many families, this means pressure on women to bear many children, preferably sons, and little control over the timing and spacing of children, with

no concern for women's health. Women in such situations are forced to silently endure the trauma of forced pregnancies that endanger their health, and to forgo opportunities such as education or employment. Denial of autonomy has particularly problematic consequences in South Asia, where son preference is prevalent and leads women to often coercively undergo sex-based abortions even in the face of legislation prohibiting the procedure.

Discriminatory laws

Discriminatory provisions relating to marriage and inheritance in the customary and personal laws of different ethnic and religious groups throughout the region, as well as in the secular laws of some countries, create inequality within marriage and deprive women of the ability to negotiate sex and childbearing on their own terms. Many of these laws permit marriage at a younger age for women than for men, and allow the marriage of minors with a guardian's consent in lieu of individual consent. Most personal laws across the region fail to grant women equal rights to property, thereby increasing their economic dependency on male family members who assume a greater say in all aspects—including reproduction—of their lives. Labor and employment laws also influence fertility decisions. Although current labor laws generally provide for limited maternity leave, such laws only benefit women employed in the formal sector. The majority of working women in South Asia are employed in the informal sector where protections are virtually nonexistent. In Bangladesh, women are allowed a maximum of two three-month periods of maternity leave. In an environment where access to family planning is still not universal and the option of legal abortion for unplanned pregnancies is unavailable, these stringent limitations on maternity leave are unfairly restrictive.

Limited focus of current policies and programs

Current family planning-related policies largely ignore the needs of unmarried adult and adolescent women. Although some reproductive health policies of the countries surveyed in this report state that they aim to provide services based on women's "life-cycle" needs, none of the policies specifically address the unique barriers unmarried women face in accessing family planning services and information. In all five countries surveyed, existing national-level data on women's knowledge, use and unmet need for family planning focuses solely on married women. This reveals the lack of adequate information on the family planning needs of unmarried women. Refugees, internally displaced populations, migrant workers, victims of sexual violence, and commercial sex workers represent other extremely vulnerable groups that are often left out of family planning-related policies, or whose needs are marginally addressed. India, Bangladesh and Sri

Lanka include some provisions in their policies relating to reproductive health and family planning services for displaced, migrant or “high-risk” populations. Women from these communities experience aggravated forms of discrimination or abuse and are most likely to experience unplanned and unwanted pregnancies. The failure to provide access to health care to these women is discriminatory.⁶

Lack of emphasis on female-controlled temporary methods of contraception

The ability of women to control their fertility and to protect themselves from sexually transmissible infections (STIs) depends upon their ability to access and use contraceptives that offer dual protection, such as male and female condoms. Male condoms are widely available in the region, but women have little control over their use. On the other hand, modern female-controlled temporary methods, such as the female condom and emergency contraception, are still not easily accessible, although emergency contraception has been approved in all countries surveyed in this report except Nepal. With the exception of India and Sri Lanka, countries surveyed in the region do not have official statistics about the incidence of STIs. This is troubling, considering that STIs are the second leading cause after maternity-related conditions of morbidity among women aged 15–44 in low-income countries, according to a study by the World Health Organization.⁷ Most countries surveyed in the report have laws that criminalize the intentional spread of STIs as well as policies to prevent and treat them, but surveillance systems are generally poor and routine screening and treatment is still not widely available.

Lack of access to infertility treatments

In a cultural setting where marriage and procreation are fundamentally tied to one’s identity and social standing, infertility can have devastating consequences, especially for women. In Nepal and certain religious communities in Bangladesh, a wife’s sterility is a legally recognized ground for bigamy. The current array of modern reproductive technologies can be used for a variety of purposes. In South Asia, however, the debate has focused almost entirely on the use of technologies such as the sonogram to determine the sex of a fetus. There has been relatively little focus on the advantages that reproductive technologies confer to infertile women seeking to overcome the discrimination and stigma that result from infertility. Among the countries under study, not one has a comprehensive law that provides for the use of reproductive technologies to treat infertility.

Recommendations for Action

The right of individuals and couples to determine freely and responsibly the number, timing and spacing of their

children and to have the information and means to do so is a basic human right.⁸ This principle has been affirmed in numerous international consensus documents and has been given legal force in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).⁹ This right gives rise to a governmental duty to ensure that men and women have equal access to a full range of contraceptive choices and reproductive health services and information. This right constitutes the core of reproductive rights, which also include the right to make decisions regarding reproduction free of discrimination, coercion and violence.¹⁰ In order to promote this right, governments in the region must take the following steps:

1. Formally recognize the right of couples and individuals to control their fertility as a fundamental human right.
2. Establish commissions to review laws that discriminate against women in marriage and employment, and introduce reforms that protect women from coercion, discrimination and violence in reproductive decision-making.
3. Expand current family planning programs to meet the needs of diverse populations, including unmarried adult women, unmarried adolescents, refugees, commercial sex workers, and victims of violence.
4. Expand the range of contraceptive choices for women and introduce methods that offer dual protection from unplanned pregnancy and STIs in all public health clinics. Female condoms, emergency contraception and, once they are deemed safe and effective, microbicides should be made available nationwide.
5. Introduce treatment for infertile couples in public health clinics.

2. Population Policies

Background and key facts

South Asia accounts for a significant proportion of the world’s population. Governments in the region have expressed their commitment to upholding the consensus reached at the ICPD Programme of Action that recognizes gender equality and women’s ability to control their own fertility as cornerstones of population and development programs. However, all governments in the region continue to use population policies primarily as instruments for controlling population growth and establishing a small-family or two-child norm without creating adequate protections for women’s reproductive rights. Bangladesh, India and Pakistan have so far relied heavily on sterilization programs to meet their demographic goals.

Areas of Concern

Imposition of a small family or two-child norm

The countries surveyed in this report have population policies that articulate a holistic approach to addressing population issues; they include objectives and strategies that not only address various aspects of reproductive health and services, but aim to promote gender equality and women's empowerment. However, all of these policies also have a heavy emphasis on curbing population growth and establishing a small family or a two-child norm. Through this emphasis, governments in the region are trying to determine and limit the number of children individuals can have. The international community has agreed that targets seeking to impose ceilings on birth rates without ensuring individuals the right to make their own decisions about the number, spacing and timing of their children violate their human rights. At their core, reproductive rights are founded upon this right. In the absence of a specific legal guarantee of this right and without the establishment of mechanisms to protect it from undue interference by state officials and private parties, the official goal of establishing a small family norm constitutes a genuine threat to women's reproductive freedom.

Influence of related laws

The goals of population policies are often in conflict with existing laws; this tension is perhaps most clearly manifested in the areas of marriage and abortion. For example, the population policies of both India and Pakistan have the objective of promoting delayed marriage or childbearing, but religious-based personal laws, which generally govern marriage, sanction the marriage of minors with parental consent. The population policies of Bangladesh and Sri Lanka aim to reduce maternal mortality, but abortion is illegal in both countries, which reduces the availability of safe abortion services and leads to maternal deaths from unsafe abortion. Unsafe abortion is a leading cause of maternal mortality in Sri Lanka, and is noted as the single most important reproductive health problem in the country.

Impact of social norms such as son preference

Population policies that seek to establish a small-family norm tend to have a negative impact on women's reproductive rights. Owing to strong son preference in the region, women are under enormous pressure to bear male children. Yet with growing political pressure to have fewer children, more women find themselves caught between these two agendas. The move toward enforcing a two-child norm has not been accompanied by a change in the underlying social and economic pressures to have sons.¹¹ Consequently, more women are pressured to use sex-selective abortion to meet their reproductive goals. Women's right to reproductive self-

determination is thus compromised when social and political norms limit their ability to exercise individual choice. This trend is most visible in India.

Emphasis on sterilization and evidence of unethical practices

Bangladesh, India and Pakistan have relied heavily on sterilization to meet their demographic goals.¹² Female sterilization is the most common method of modern contraception adopted by women in South Asia. This is consistent with global trends. Rates of male sterilization, however, remain extremely low throughout the region. The provision of female sterilization in the South Asian context raises important human rights concerns. South Asian women tend to lack access to a wide range of choices and they tend to undergo the procedure at a young age (i.e., the median age at sterilization in Bangladesh is 27). Furthermore, studies in India indicate relatively high death and failure rates from the procedure; moreover, there are disturbing reports from India about failures to follow governmental guidelines in the provision of sterilization services.¹³ Lapses in fulfilling patients' rights to free decision-making are of particular concern, since such failures may result in coercive and forced sterilization practices.

Introduction of disincentives

Several Indian states have formally introduced disincentives that deprive individuals with more than two children of various state benefits and other entitlements. These measures, which have proven to be ineffective at modifying fertility habits, directly contradict the country's National Population Policy. Even more disturbing, however, is the Indian Supreme Court's support for such measures on the pretext that they are necessary for meeting India's development goals and are in the global interest.¹⁴ This approach sets a dangerous precedent in the region, where almost every country is struggling to contain population growth rates to ensure economic development. The imposition of a two-child norm through disincentives conflicts with two important overarching goals of enhancing women's political participation and addressing the declining number of females to males. Studies have revealed that disqualifying individuals with more than two children from running in local elections has had a negative impact on women's political participation in five Indian states.¹⁵ Studies by non-governmental organizations (NGOs) have revealed a high incidence of sex-selective abortion among current or aspiring leaders in local government.¹⁶

Recommendations for Action

At the ICPD held in Cairo, the international community agreed in one of the consensus documents main principles that "advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of vio-

lence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes."¹⁷ The ICPD Programme of Action encourages governments to meet their population goals through education and voluntary measures instead of incentives and disincentives.¹⁸ In accordance with the formal commitments made in Cairo, governments in the region must take the following steps:

1. Formally recognize the advancement of women's reproductive health and autonomy as a central goal of official population policies.
2. Appoint commissions to review how population policies that strive to establish a small family or two-child norm interact with existing laws, such as matrimonial and employment laws, as well as customary practices, such as son preference; introduce reforms that promote reproductive self-determination.
3. Rigorously regulate and monitor the quality of contraceptive services and products being delivered in government clinics and in the private sector, and implement safeguards for efficacy, safety and the widest possible range of method choice.
4. Create mechanisms for lodging complaints about coercion or violence in public health facilities and private clinics.
5. Abandon the use of disincentives for enforcing a small-family norm.

B. PREGNANCY AND CHILDBIRTH

In South Asia, more women of reproductive age die of complications from pregnancy and childbirth than from any other cause.¹⁹ The high maternal death rates across most of the region are attributable to a range of social, economic and legal factors. These include the practice of early marriage and childbearing, lack of access to health care and family planning, inequality within marriage, and gender-based violence. The death toll has been fueled by the illegality of abortion in most countries surveyed in the region and the general lack of access to services, even in the limited circumstances in which abortion is legal.

1. Maternal Death and Morbidity

Background and key facts

It is estimated that India accounts for the highest absolute number of maternal deaths in the world.²⁰ India, Bangladesh and Pakistan rank among the dozen countries that account for 65% of all maternal deaths.²¹ Nepal also has a high maternal mortality ratio. One government study revealed a total of 4,478 maternal deaths per year, or one death every two hours.²² National government surveys in India reveal no sig-

nificant declines in maternal mortality and no major change in its causes over the last decade.²³ Many women throughout the region, especially those living in rural areas, lack access to pre- and postnatal care and trained assistance at delivery, which can contribute to maternal morbidity and mortality. In Bangladesh, for example, most women do not receive prenatal care and only 12% of births are assisted by trained personnel. The maternal mortality ratio is much lower in Sri Lanka than in the other countries in the region, although that ratio is three times higher in the conflict areas of Sri Lanka than in the country as a whole.

Actions taken by different governments in the region to address maternal mortality include the following:

- creation and expansion of pre- and postnatal services and emergency obstetric care, including the establishment of women-friendly hospitals;
- recruitment of female voluntary health workers and training of local midwives and birth attendants to deliver maternal and other related reproductive health services and information to women's doorsteps;
- introduction of a compensation scheme under which pregnant women are reimbursed for the cost of their trip to a health center;
- establishment of women's health groups in villages as a forum for discussion of health concerns and issues;
- adoption of policies to enhance the nutritional status of pregnant women; and
- expansion of immunization programs to cover women of reproductive age.

Areas of Concern

The impact of discriminatory laws and practices

The ability of women to survive pregnancy and childbirth is greatly determined by their social and legal status. Many instances of discrimination occur over a woman's life cycle to contribute to an increased risk for poor maternal health. Girls who experience discrimination in nutrition and health care during childhood are physically less able as adults to withstand the stress and exertion of pregnancy. In Bangladesh, the prevalence of malnutrition among women of reproductive age is reported to be the highest in the world,²⁴ and in India, malnutrition has been characterized as "a silent emergency."²⁵ Both countries have made the positive step of introducing national policies on nutrition. In addition, early marriage exposes young women to the risk of early pregnancy and limits their ability to complete their education, work and make independent decisions about their own health. Separately, many women are forced to carry pregnancies to term because of criminal abortion laws. The risk is greatest for women on the lowest socioeconomic rung of society.

The government of Nepal took a positive step to address the negative impact of discriminatory laws on maternal health by making advocacy for legal reforms to reduce the incidence of maternal deaths from early marriage and unsafe abortion an objective of its Safe Motherhood Program. This commitment is consistent with human rights principles.

Lack of accountability for failure to meet official targets

National development plans and health policies adopted by governments throughout the region clearly recognize that the high rate of maternal deaths is a major health issue. Certain governments have even introduced official targets for addressing maternal mortality. India has established a target of reducing the maternal mortality ratio to 100 maternal deaths per 100,000 live births by 2010; Nepal aims to reduce its maternal mortality ratio to 400 per 100,000 by 2008. Bangladesh aims to increase the rate of receipt of prenatal care among pregnant women to 60% by 2006, and to increase the percentage of deliveries attended by skilled attendants to 35% by that year. Although these goals are noteworthy, there is no system for monitoring progress toward these targets and, more importantly, for establishing accountability for failing to meet them.

Violence and pregnancy

Current maternal health policies fail to address pregnancy in the context of violence. Many unplanned and unwanted pregnancies occur as a result of acts of sexual violence, including marital rape and incest. The “culture of silence” that enables sexual violence against women overshadows the health risks created by pregnancies resulting from rape. Such pregnancies are most likely to be mismanaged and lead to maternal death or harm. The stigma often associated with these pregnancies deters women from seeking pre- and post-natal care.

A significant number of women also experience violence because of pregnancy. A growing body of research reveals that pregnancy makes women more vulnerable to violence and that women subjected to violence during pregnancy are more likely to miscarry. One study in Bangladesh has revealed that women aged 15–19 who were either pregnant or had recently given birth were three times more likely to die from violence inflicted by others than women who were not pregnant.²⁶ Health-care systems are generally not equipped to detect and address violence during pregnancy. Furthermore, the pregnancy-related needs of women in conflict situations and those of refugees fleeing war have been largely neglected, which leads to even higher risks of death and complications during pregnancy among these vulnerable populations.²⁷

Recommendations for Action

The right to survive pregnancy and childbirth is a human right.²⁸ At the 1994 ICPD and later at the 1995 Beijing Conference, the international community agreed that “all countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care ... The underlying causes of maternal morbidity and mortality should be identified and attention should be given to the development of strategies to overcome them.”²⁹ Recognizing the injustice of maternal deaths, traditional civil and political human rights bodies have characterized maternal mortality as a violation of the right to life.³⁰

In 2000, United Nations (UN) member states adopted the Millennium Development Goals toward eradicating poverty and promoting the right to development; improving maternal health was designated as one of the eight Millennium goals.³¹ In order to fulfill their obligations, governments in the region must take the following steps:

1. Formally assess the impact of discriminatory laws and practices on women’s ability to survive pregnancy and childbirth, and introduce legal reforms to eliminate those discriminatory practices against women that raise the risk of death during pregnancy and childbirth.
2. Increase access to maternal health services and support public education programs to increase awareness about the risks of pregnancy and the negative impact of discriminatory practices on pregnancy.
3. Set up systems for establishing accountability for the failure to meet maternal health–related targets.
4. Expand current safe motherhood programs to address the medical and social aspects of violence during pregnancy by training providers to detect symptoms of such violence and provide appropriate counseling and referrals.

2. Unsafe Abortion

Background and key facts

Unsafe abortion is a leading cause of death among women in South Asia. The region accounts for one-third of the world’s unsafe abortions³² and the largest annual number of abortion-related deaths worldwide.³³ An estimated 29,000 women die every year in the region from unsafe abortion.³⁴ This translates into approximately three deaths per hour.³⁵ Official estimates of abortion-related deaths in countries with laws that criminalize abortion are generally not available. In Nepal, where abortion was illegal until September 2002, it is estimated that close to half of all maternal deaths were caused by unsafe abortion.³⁶ In Bangladesh, where abortion is illegal on most grounds, the annual number of hospitalizations for

abortion complications is an estimated 71,800, which is equivalent to an average of almost 200 cases per day.

Areas of Concern

Criminal abortion laws

Bangladesh, Pakistan and Sri Lanka have not reformed their restrictive abortion laws. This lack of reform is inconsistent with recent global liberalizing trends that recognize the right to abortion as a basic human right and a public health imperative.³⁷ Evidence from around the world shows that rather than lessen the incidence of abortion, prohibitive and restrictive abortion laws pressure women to resort to clandestine, unsafe providers or to perform risky, self-induced abortions.³⁸ Criminal abortion laws pose the greatest danger to low-income women, who are more likely to experience unplanned pregnancies because they lack access to family planning services and information. In Nepal, women arrested and prosecuted under the now defunct abortion ban were almost without exception low-income, rural women.³⁹

Lack of accessible abortion services

Abortion has been legal in India for more than 30 years, yet women still die from unsafe abortions in huge numbers. Bangladesh, Pakistan and Sri Lanka have restrictive laws, but abortion services are generally unavailable on the few grounds on which it is legal. Nepal legalized abortion in September 2002, but the government waited more than one year to establish the parameters of service provision. The failure of governments to make abortion widely available, accessible and affordable reflects a lack of understanding of the health risks posed by unsafe abortions and amounts to a serious breach of duty to protect women from a leading cause of death.

Lifesaving services, such as postabortion care, are generally neglected in government policies. The governments of India and Bangladesh have recognized the need for postabortion care services. However, no specific policies on postabortion care exist in Pakistan, even though NGOs provide such services there. The Sri Lankan government has not made any provisions for postabortion care, despite having officially recognized abortion as a “crucial emerging reproductive health issue” and a matter to be addressed with “increasing vigor.”

Sex-selective abortion

A unique and troubling aspect of the abortion debate in the region is the issue of sex-selective abortion. A strong social, cultural and religious preference for sons combined with access to modern technology has led to the proliferation of sex-selective abortion, particularly in India. Regardless of the government’s attempt to curb the practice by outlawing prenatal testing for the purpose of sex determination in 1994, the sex ratio among children aged 0–6

ACTIVISM IN THE REGION BUILDS FOR BROADER RECOGNITION OF SEXUAL CRIMES

Various aspects of domestic violence and sexual harassment are criminalized by penal laws in the region. However, these provisions are limited in scope and fail to capture the diverse and insidious nature of many common crimes that occur in the private and public spheres. Certain criminal acts are permitted in the name of custom. For example, in Nepal, incest is generally considered illegal, but it is allowed within marriage if permitted by customary practice. In recent years, NGOs in the region have successfully advocated for the adoption of laws that address domestic violence and sexual harassment. In some cases, these legal gains have been supported by judicial activism. In India in 2003, for example, the government introduced the Sexual Harassment of Women at their Work Place (Prevention) Bill subsequent to a decision by the supreme court that recognized sexual harassment as a violation of the rights to life, dignity and the freedom to practice any profession. In Sri Lanka, although there is no separate law that addresses sexual harassment in the workplace, the Prohibition of Ragging and other Forms of Violence in Educational Institutions Act of 1998 recognizes sexual harassment in educational institutions and provides remedies for victims of such acts. NGOs are currently advocating for the introduction of specific domestic violence legislation in India, Nepal and Sri Lanka. In Bangladesh and Pakistan, the respective National Commissions for Women have recommended the introduction of domestic violence legislation. Governments in the region should enact laws that recognize sexual harassment and various acts of domestic violence, including crimes specific to women’s reproductive health, such as denial of the use of contraceptives, forced pregnancy in order to have a male child and forced sex-selective abortion. Such laws should be comprehensive and prescribe appropriate punishments and remedies, and create mechanisms for redress.

declined steadily over the past decade, from 945 girls per 1,000 boys in 1991 to 927 girls per 1,000 boys in 2001.⁴⁰ The practice of sex-selective abortion cannot be eliminated through criminalization alone. Bans on the practice must be accompanied by a sustained campaign to undo the cultural preference for sons. Attempts to restrict access to abortion without directly addressing and discouraging son preference

are only likely to result in more deaths from unsafe abortion and a higher incidence of forced pregnancies.

Recommendations for Action

The right to safe and legal abortion finds support in every major human rights treaty.⁴¹ Legal prohibitions on abortion have been recognized as a violation of women's right to life.⁴² The Programme of Action adopted at the ICPD called upon governments to consider the consequences of unsafe abortion on women's health.⁴³ It states that governments should "deal with the health impact of unsafe abortion as a major public health concern."⁴⁴ This consensus was reiterated at the 1995 Fourth World Conference on Women, where the international community urged governments worldwide to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions."⁴⁵ In addition, the international community has urged governments to undertake research "to understand and better address the determinants and consequences of unsafe abortion."⁴⁶ Governments in the South Asian region are obligated to protect and promote women's right to safe and legal abortion by taking the following steps:

1. Abolish criminal abortion laws where they exist and enact laws that permit abortion on broad grounds.
2. Create universal access to safe and affordable abortion services by expanding abortion services to the level of primary health care. Ensure that safe, affordable and high-quality abortion services are available widely on the grounds currently recognized under the law.
3. Introduce options to surgical abortion, such as the use of mifepristone, in government programs.
4. Provide for the humane treatment and counseling of women who have undergone abortion procedures, whether legal or illegal. Post abortion treatment, counseling and family planning services should be offered promptly and without bias.
5. Introduce comprehensive policies to address the underlying causes of sex-selective abortion, in addition to enacting laws that prohibit the practice.

C. SEXUAL VIOLENCE

Sexual violence represents one of the greatest threats to women's health and security in South Asia.⁴⁷ Studies reveal alarmingly high rates of sexual crimes against women, such as rape, sexual harassment, incest, sexual abuse, and sex trafficking. Formal laws criminalize a range of sexually motivated crimes. Yet their implementation is weakened by commonly accepted stereotypes about female sexuality and the patriarchal mind-set of perpetrators of violence, which is often

shared by law enforcement agents and, to some extent, is institutionalized by formal laws. The trauma of those who experience violence is further compounded by a general lack of access to emergency health care for the survivors of violence. Formal health systems are generally not equipped to address the medical and social impact of sexual crimes.

1. Rape

Background and key facts

Rape is one of the most common forms of sexual violence against women and is criminalized by penal codes across the region. However, in all instances, the legal definition of rape is limited to sexual intercourse involving penetration and is generally not recognized among married couples. The enforcement of existing remedies remains weak and the high level of underreporting of rape crimes testifies to that fact. A study on female victims of violence in Bangladesh revealed that 68% of the women never told anyone about their experience and thus failed to initiate criminal proceedings.⁴⁸ Burdensome evidentiary requirements are particularly harmful, as they protect perpetrators of violence by validating stereotypical notions of female sexuality and adversely influencing the outcomes of rape cases.

Areas of Concern

The legitimization of rape within marriage

The legal approach to marital rape in the region mirrors social perceptions of marriage and female sexuality, and ranges from complete nonrecognition in the law, such as in Nepal and Pakistan, to partial recognition when the woman is below a certain age or under other limited conditions. For example, in Sri Lanka, Bangladesh and India, the wife must be under the age of 12, 13 or 15, respectively, for an act of nonconsensual sex in a marital relationship to be considered rape. In Sri Lanka and India, marital rape is also recognized as a crime if the couple is judicially separated. This trend is at odds with international legal developments that recognize marital rape as a crime regardless of a woman's age; it is considered a crime against a woman's bodily integrity and autonomy.⁴⁹ In a recent landmark case, the Supreme Court of Nepal recognized that the law's failure to criminalize marital rape solely because of the relationship between the parties constitutes discrimination and violates Nepal's commitments under CEDAW.

Burdensome evidentiary requirements and discriminatory provisions

Burdensome evidentiary requirements and discriminatory punishments based on stereotypical notions of women serve to perpetuate a culture of violence against women by erecting barriers that often defeat women's claims for justice. Governments are obligated to eliminate such stereotypes.⁵⁰ Yet, with some exceptions, few of the countries surveyed in this

report have taken proactive steps to reverse these biases. In Bangladesh, for example, a rape victim must provide physical evidence of struggle or resistance to show that the sexual intercourse was, in fact, nonconsensual. In India, a woman's past sexual history can be used as evidence against her in a trial. In Pakistan, a woman who fails to prove an allegation of rape may be prosecuted for the crime of *zina*, or adultery, and be sentenced to prison. To seek the maximum punishment for rape, the victim must produce four male witnesses. In Nepal, the punishment for raping a woman older than age 16 is five to seven years in prison, while the maximum punishment for raping a woman engaged in commercial sex work is one year or a fine of Rs 500 (less than USD 10). These biased criminal law provisions deter women from seeking justice and allow perpetrators of such crimes to go unpunished.

Failure to address the immediate health needs of rape victims

Victims of sexual violence suffer serious physical and psychological health problems, which often go unaddressed.⁵¹ Laws that criminalize rape tend to focus on the "crime" rather than on the "person" who experiences the crime, leading to a major policy gap in addressing the short- and long-term health needs of victims of rape. For example, Bangladesh's Prevention of Oppression against Women and Children Act, which passed in 2000, is one of few laws among countries surveyed in this report that was formulated to specifically address crimes of violence against women and children. Although the act broadens the definition of crimes and increases penal sanctions against perpetrators, it does not make provision for services that address the physical and mental health needs of victims, such as counseling or reproductive health services. The medical community is ethically obligated to respond to violence against women.⁵² However, health systems are generally not equipped to recognize and treat common conditions resulting from rape, such as psychological trauma; trauma associated with unplanned, unwanted or forced pregnancies; complications from unsafe abortions; and infection with STIs, including HIV/AIDS. There is inadequate access to services that could significantly mitigate the adverse impact of these conditions, such as trauma counseling, emergency contraception, legal abortion, nondiscriminatory pre- and postnatal care, and voluntary testing for STIs.

Recommendations for Action

The right of women to be free from gender-based violence, including rape and other forms of sexual violence, has been recognized by the international community as a human right.⁵⁵ International law formally recognizes gender-based violence as a "form of discrimination which seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."⁵⁶ The Rome Treaty of 1998 explicitly

**PERCEIVED SEXUAL TRANSGRESSIONS
RESULT IN EXTRA JUDICIAL KILLINGS**

Honor crimes, which occur most frequently in Pakistan, involve the killing of a woman or girl who has allegedly shamed her family through a social transgression, such as choosing her own life partner or attempting to obtain a divorce. What violates family honor is more a matter of perception than fact. A mere suspicion of an illicit relationship may result in an honor killing. Victims of sexual violence such as rape have been murdered with impunity for allegedly violating family honor. Although honor killings do not find direct support in Pakistani law, two ordinances lend moral support to the culture of honor killing. The Qisas and Diyat Ordinance, passed in 1979, allows private individuals who are related to a victim to prescribe punishments for perpetrators of crimes, including murder. The Zina Ordinance, passed in 1979, renders rape victims liable for adultery if they are unable to prove that a crime was committed. The general recognition of "grave and sudden provocation" as a basis for reducing a charge of murder to the lesser crime of manslaughter has provided a great degree of legitimacy to the practice of honor killings. The practice has also been reinforced by corruption among law enforcement agents, who do not treat the perpetrators of honor crimes the same as other major offenders.⁵³ The government of Pakistan has vigorously condemned the practice of honor killing, stating that such acts do not find a place in Pakistan's religion or law, and that killing in the name of honor is murder and will be treated as such.⁵⁴ However, this strong statement has not been accompanied by adequate law enforcement efforts. In one recent case, however, the exception of "grave and sudden provocation" was formally denounced by a court of law and considered inapplicable in the case of an honor crime. The government of Pakistan should enact a law that bans outright all killings in the name of family honor, and prescribe appropriate punishments and compensation for the families of victims.

includes rape under certain circumstances as a crime against humanity. In order to protect women and girls against violations of human rights as a result of sexual violence, governments in the region are obligated to take the following steps:

1. Enact and rigorously enforce legislation with severe penalties against perpetrators of sexual violence against women.

2. Create effective mechanisms for reporting incidents of violence and remove burdensome evidentiary and procedural requirements and discriminatory provisions by amending relevant legal provisions and creating awareness about the changes.
3. Establish family courts and women-friendly police stations or cells nationwide to make the legal system more accessible for women. Where these entities already exist, determine their accessibility and identify barriers to access.
4. Launch programs to sensitize and train health care providers to deal effectively with crimes involving sexual violence at various stages of medical treatment, and educate law enforcement and judicial personnel about investigating and prosecuting such crimes and facilitating access to immediate medical assistance and counseling.
5. Strengthen responses to sexual violence by offering emergency contraception to victims of rape and voluntary testing for STIs.

2. Sex Trafficking

Background and key facts

Sex trafficking in South Asia has become a billion dollar industry and is considered to be the fastest growing criminal enterprise in the world.⁵⁷ India has begun to gain notoriety as one of the world's biggest "slave bazaars" especially for minor girls.⁵⁸ As the main receiving country in the region, India accounts for up to one million women and children involved in commercial sex work, according to UN estimates, although NGO estimates are much higher.⁵⁹ Bangladesh and Nepal are the main countries of origin for foreign women trafficked to India. According to NGO estimates, the typical age at recruitment is often between 10 and 14 years.⁶⁰ The growth in internal and cross-border migration by women in search of legitimate employment has added a new channel of movement that is being exploited by traffickers.⁶¹ All countries have national-level anti-trafficking laws and policies, but enforcement is weak and prosecutions are rare.⁶² Additional challenges are created by the fact that the problem is regional in scope and a high level of regional cooperation is needed to address it.

Areas of Concern

Lack of attention to health-care needs of sex trafficking victims

Despite the series of sexual crimes experienced by victims of trafficking, no government in the region has laws or policies that establish and ensure access to health care after victims are rescued or once they become engaged in commercial sex work. Due to frequent exposure to sex, women who are trafficked and eventually forced to become commercial sex

workers are constantly exposed to the risks of unplanned pregnancies and STIs, including HIV/AIDS. They have no access to reproductive health information and services, and are unable to negotiate the use of condoms with their customers. Among commercial sex workers in Bangladesh, condom use is as low as 4%.⁶³ Women who do get pregnant are often forced to have abortions.

Discrimination against commercial sex workers

The phenomenon of sex trafficking has given rise to a vulnerable population of commercial sex workers. Most countries in the region have long-standing laws that criminalize prostitution, although one country has recently passed an act that grants legal protection to those engaged in prostitution. As a result, commercial sex workers are mainly viewed as criminals, and their ability to seek legal protections against abuse and exploitation is severely curtailed by their lack of social standing and the stigma associated with their profession. The exception is a recent case in Bangladesh in which the rights of commercial sex workers were granted some recognition; those who engage in commercial sex work must now obtain a license to do so, after proving that they have no other means of livelihood. Commercial sex workers trafficked from foreign countries are particularly marginalized and unable to seek legal recourse against their exploiters or demand basic health services. The vulnerability of sex workers to discrimination has been enhanced by the onset of HIV/AIDS. Sex workers in India have been subjected to mandatory HIV testing by courts of law.⁶⁴ In one particular case, a woman's HIV status was used as a ground for denying bail.

Recommendations for Action

A number of international instruments explicitly address sex trafficking in women and girls. In addition to the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, CEDAW requires states parties to "suppress all forms of traffic in women and exploitation of prostitution of women."⁶⁵ The Convention on the Rights of the Child (Children's Rights Convention) also contains a provision preventing the "abduction, sale or traffic of children,"⁶⁶ as well as other provisions pertaining to protection against sexual abuse and exploitation,⁶⁷ and prohibition of torture and other cruel or inhuman treatment.⁶⁸ The International Covenant on Civil and Political Rights (Civil and Political Rights Covenant) provides that no one shall be held in slavery or servitude, tortured, or subjected to cruel, inhuman or degrading treatment.⁶⁹ The Vienna Programme of Action adopted by the World Conference on Human Rights in 1993 and the ICPD Programme of

Action of 1994 specifically address and strongly condemn trafficking as a form of gender-based violence that violates women's human rights.⁷⁰ Based on these international standards, governments in the region are obligated to take the following steps:

1. Strictly enforce laws that criminalize the trafficking of women and children for forced prostitution, and introduce strict penalties for men who procure sex from commercial sex workers, especially minors.
2. Allocate resources for the establishment of rehabilitation homes for young girls and women rescued from traffickers and brothel owners and provide a full range of emergency and routine reproductive health care services and information.
3. Introduce policies for the establishment of reproductive health-care services for commercial sex workers.
4. Enact laws prohibiting discrimination against commercial sex workers solely on the basis of their profession or their status as aliens.

D. EMERGING CONCERNS

Efforts to promote women's reproductive health in South Asia have traditionally been advanced through family planning and maternal and child health programs. Two more recent concerns taken on by policymakers in the South Asia region are the HIV/AIDS pandemic and concerns about the acceptability and quality of health care. The deadly spread of HIV/AIDS is slowly forcing governments to confront taboo subjects such as sex, and to frame policies that address the broader health implications of the pandemic without encroaching upon individual human rights. Inefficient health-care systems have begun to sharpen concerns about the acceptability and quality of care and the influence of gender-based discrimination and stigma on women's reproductive health-related choices. Both these issues are compelling governments to address reproductive health more broadly. Efforts to integrate various aspects of reproductive health care and concerns about patients' rights are gaining momentum.

1. HIV/AIDS

Background and key facts

South Asia accounts for 4.2 million of the total number of people living with HIV worldwide.⁷¹ India has the second largest population of persons infected with HIV. Estimates of people living with HIV/AIDS within each country vary enormously depending upon the source of information, since most governments have not gathered reliable official data and the opportunity for measuring HIV prevalence through voluntary testing continues to be very limited. Nonetheless, all countries surveyed in the region have intro-

duced official policies or strategies within broader policies that focus on the prevention of HIV/AIDS. None of the countries, however, have enacted laws that protect the rights of persons with HIV/AIDS. The strongest statement in favor of their rights is made in the Bangladeshi policy, which specifically prohibits restrictions on the rights and freedoms of individuals based on their HIV status.

Areas of Concern

Women's vulnerability to infection

The physiological vulnerability of women to HIV/AIDS is significantly compounded by the pervasive gender discrimination in the region. Current policies tend to focus mainly on disease prevention and control activities, such as providing HIV testing services, distributing and promoting the use of condoms, and screening blood donations; however, these policies have yet to introduce comprehensive and concrete strategies that address women's unique social vulnerability to the disease caused by gender-insensitive, discriminatory laws and practices, and the lack of access to services. India's National AIDS Prevention and Control Policy is an exception to the general trend; the policy recognizes that women's low legal status, poor economic opportunities and lack of access to health information and education make them particularly vulnerable to the disease, and aims to make improvements in each of these areas.

Lack of protection against discrimination among HIV-positive women

Women's vulnerability to discrimination and violence in both the private and public spheres significantly increases once they become infected with HIV. While both women and men need protections against discrimination in health care, education, employment and other public spheres of life, women need additional protections from discrimination and violence in the private sphere. Research shows that if a woman is infected with HIV by her husband, her likelihood of being abused, abandoned or even killed increases.⁷² Matrimonial laws applicable in Bangladesh, India, Pakistan and Nepal recognize infection with venereal disease as a ground for divorce. Considering women's unequal status within marriage, inadequate legal provisions for alimony and the widespread practice of child marriage, the consequences of divorce can be particularly devastating for women. Alternatively, in Sri Lanka, where a man cannot divorce his wife because she is infected with a venereal disease, the legal pressure to live with an HIV-positive spouse may ultimately constitute a threat to a woman's life.

The rights of HIV-positive pregnant women

Policies in the region are extremely limited in terms of their reference to mother-to-child transmission of HIV/AIDS. Only Sri Lanka has set a clear target for making

antiretroviral therapy available to pregnant women for the prevention of mother-to-child transmission. In India, there are reports of an increasing number of women seeking prenatal care who test positive for HIV. However, voluntary testing for HIV, counseling and treatment are still generally unavailable in government hospitals. Since the majority of births in the region take place at home and a significant number of pregnant women have no contact with the formal health system during their pregnancies, the ability of pregnant women to determine their HIV status is very limited. Criminal abortion laws and lack of access to services, even in circumstances in which abortion is legal, pose major barriers to HIV-infected women who opt to terminate their pregnancies.

Recommendations for Action

CEDAW recognizes the special vulnerability of women to HIV/AIDS and requires governments to “give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.”⁷³ The Beijing Platform further recognizes that women’s social subordination and unequal power relations to men are key determinants in their vulnerability to HIV/AIDS.⁷⁴ At the UN Special Session on HIV/AIDS, the General Assembly declared that “Gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS.”⁷⁵ The Commission on Human Rights has urged governments to take all necessary measures to protect women and children from violence, stigmatization and other negative consequences resulting from HIV/AIDS.⁷⁶ In light of their international obligations, governments in the region must take the following steps:

1. Review, amend and enforce laws, and develop targeted initiatives, to combat practices that contribute to women’s susceptibility to HIV infection and other STIs, particularly laws relating to rights within marriage and laws on sexual violence. Legislation should be introduced to prevent discrimination against women with HIV/AIDS by state agents and private parties.
2. Strengthen health programs by increasing efforts to prevent, detect and treat HIV/AIDS and STIs at the primary health-care level. All levels of health care should offer voluntary testing as well as counseling and affordable treatment. They also should guarantee that information about patients is kept confidential.
3. Recognize the rights of pregnant women infected with HIV and create access to services and treatment

necessary for the prevention of mother-to-child transmission and the termination of pregnancies.

4. Work closely with the private sector to disseminate information about safe sex practices and the human rights of persons living with HIV/AIDS in order to create greater social tolerance and support for such people and their families.

2. Essential Aspects of Health Care

Background and key facts

Laws and protocols that establish basic standards of health care, guarantee patients’ rights, create liability for medical negligence, and institute mechanisms for seeking redress in case of malfeasance by a health care provider are hallmarks of a system committed to advancing the right to health of citizens. All the countries included in the survey have established medical councils for regulating providers and taking disciplinary action. Cases of medical negligence can be brought against providers under existing criminal and civil laws in all five countries. India and Nepal also allow cases to be brought under consumer protection laws. Although no country in the region has a bill of patients’ rights, Bangladesh has made a formal commitment to adopt a charter of rights for health care providers and patients.

Areas of Concern

Limited availability and accessibility of health care

Public health-care systems in the region are generally constrained by inadequate human, technical and financial resources. Access to services is often inhibited by insufficient infrastructure, uneven distribution of existing services and lack of proximity. For example, in Pakistan, only 1,200 public family planning centers operate to serve a population of 138 million, most of which are rural and poor.⁷⁷ Lack of proximity to services can become an insurmountable barrier in the absence of reliable and affordable modes of transportation and where social restrictions on women’s mobility are rigidly enforced, such as in certain parts of Pakistan. Additional barriers to health care, such as bias toward urban areas and high rate of absenteeism, are very common across the region. In Nepal, for example, most public and private health services are concentrated in the more developed parts of the country. In Pakistan, female practitioners are concentrated in the cities. In that country, where many women can only see female clinicians, one of the main reasons cited for seeking health care in the much costlier private sector is the general unavailability of doctors of either sex in the public health system. In Bangladesh, one study revealed that there were 21,785 doctors working in the private sector, compared with 1,717 doctors in the public health sector.

Limited affordability and acceptability of health care

Individuals are compelled to seek health care from the private sector with significant out-of-pocket expenses in all five countries surveyed in the report, and in Bangladesh, Nepal and India in particular. This creates significant hardship for women whose financial dependency compromises their ability to seek health care. User fees imposed by the public-sector health systems in Pakistan and India constitute an additional burden. Most low-income women in all the countries surveyed are not covered by health insurance schemes, which are either nonexistent or extremely limited in scope. Where services are available, the acceptability of care is a major issue. Women frequently choose not to use existing services because of disrespectful treatment in clinics, a lack of acceptable treatment options and the lack of appropriate follow-up. In Bangladesh, almost half of all women who begin using a contraceptive method discontinue during their first year of use,⁷⁸ a trend that studies suggest is symptomatic of women's lack of trust and confidence in family planning providers.⁷⁹ In a study conducted in Pakistan, a significant number of respondents cited the uncooperative behavior of public health staff as the main reason why they did not use health services offered in the public sector.

Quality of health care

Standards of quality care require, among other things, the availability of skilled personnel and the use of scientifically approved drugs.⁸⁰ The qualifications of medical practitioners in the region and their ability to provide services are regulated by law. However, the recognition of traditional, non-allopathic systems of medicine, limited access to appropriately staffed and well-equipped hospitals, high costs of services and lack of effective regulation in the private sector, and poor protections from medical negligence and exploitation in the name of health care have all led to the proliferation of non-licensed and incompetent practitioners commonly known as "quacks."⁸¹ This trend has been extensively documented in India. Low-income women rely extensively on non-licensed practitioners for their health-care needs. This reliance on untrained personnel is most visible in the context of abortion, where criminal abortion laws have resulted in high death rates from unsafe abortion. Despite legalization, abortions performed by unskilled providers continue to contribute to the high maternal death rate in Nepal and India.⁸² Extensive studies reveal that in India, non-licensed practitioners have begun to exploit the health needs of people living with HIV/AIDS for whom treatment in the public health-care system is virtually nonexistent.⁸³

Quality of care is also compromised when drugs provided to the public are not safe. While all countries have laws

and formal bodies that regulate the quality and safety of drugs, major lapses have occurred, particularly with regard to contraceptives. In India, following questions about the safety of Depo Provera, the central drug administration issued an order banning its distribution in government clinics until the conclusion of further clinical trials, but it took five years for the order to be adopted.⁸⁴ Clinical trials have been conducted in many parts of the region over the last few decades, with little regard for the procedures mandating informed consent and the health and bodily integrity of the women involved in such trials.⁸⁵

Recommendations for Action

The International Covenant on Economic, Social and Cultural Rights establishes the right to health as a human right.⁸⁶ The right to health has been interpreted as encompassing certain essential elements of health care that include the availability, accessibility, acceptability, and quality of health care.⁸⁷ Inadequate attention to any one of these elements constitutes a significant barrier to women's ability to realize their reproductive health goals. In light of these standards, governments are obligated to take the following steps to advance the right to health of citizens:

1. Adopt a formal bill of patients' rights based on human rights principles.
2. Introduce policies and guidelines aimed at improving provider-client interactions and creating health-care settings and procedures that are gender sensitive and client oriented. All women should be informed of their options for treatment and care, including the likely benefits and potential side effects by trained personnel.
3. Strengthen the enforcement of laws that penalize medical malpractice and negligence. Introduce and rigorously enforce penalties against unqualified providers.
4. Create complaint mechanisms for clients with the aim of protecting patients' rights and monitoring and improving quality of care.
5. Improve the accessibility of public health services by addressing the concentration of services in urban areas, shortage of female practitioners, absenteeism, and proliferation of unskilled providers.
6. Work closely with medical and legal institutions and civil society to promote and monitor the quality of care in existing programs and develop standards for ensuring that principles of free and informed consent, noncoercion, confidentiality, privacy, nonviolence, and nondiscrimination are rigorously enforced in health-care settings.

E. VULNERABLE GROUPS

The vulnerability of certain groups of individuals to human rights violations may be heightened by a variety of factors, including their age and nationality, and whether they live in areas that are politically unstable and marked by conflict. South Asia accounts for a significant proportion of the world's adolescent population and a large number of refugees in camps in different parts of the region.

1. Adolescents

Background and key facts

Worldwide, South Asia has the largest concentration of young people in extreme poverty.⁸⁸ The incidence of early marriage and childbearing is particularly high in Bangladesh, India and Nepal, where up to half of all adolescent girls aged 15–19 are married by age 18.⁸⁹ Fewer than 10% of adolescents in India, Nepal and Pakistan use any method of contraception. HIV is also spreading rapidly in South Asia, where an estimated 1.1 million youth are infected (62% of whom are female).⁹⁰ A range of factors that are widely prevalent in South Asia, such as narrow views on female sexuality and a general lack of laws and policies that specifically recognize and promote adolescents' rights, have significantly enhanced the vulnerability of adolescents to reproductive rights violations.

Areas of Concern

Lack of a commitment to adolescents' rights

The human rights of children and adolescents have been articulated and affirmed through international treaties and consensus documents, and governments have pledged to respect the rights of adolescents through the adoption of appropriate laws and policies.⁹¹ Yet, only one country in the region, Nepal, has a policy devoted specifically to the reproductive health of adolescents. The remaining countries surveyed have policies that contain references to adolescents, but none formally recognizes or makes a clear commitment to protecting and promoting adolescents' human rights, particularly their right to health.

Lack of information and access to age-appropriate services

Studies show that women who are educated have more control over their reproductive lives than women who have little or no education.⁹² Most women in South Asia lack this potential, as the region continues to lag behind on girls' education. Low levels of education among girls limit their ability to obtain and utilize important information about their health. Social taboos on sex contribute to a general lack of knowledge about sexual and reproductive health. Consequently, adolescents in the region, especially female adolescents, are exposed to a variety of health risks that leave them helpless to avoid unplanned pregnancies, complications relat-

ed to pregnancy and childbirth, unsafe abortion, and infection with STIs, including HIV/AIDS. NGOs are playing an important role in providing some information and services to adolescents, but access is far from universal. The needs of married adolescents also remain significantly unfulfilled. In India, according to various studies, only 7.4% of married adolescents aged 15–19 use contraceptives; less than half of all married women aged 15–24 have heard of HIV/AIDS.

Child marriage

The practice of child marriage has grave implications for women's reproductive health and security. In Bangladesh, up to 51% of all girls are married by age 19.⁹³ In Nepal, 7% of girls marry before they are ten years old, 40% do so by age 15,⁹⁴ and 60% by age 18.⁹⁵ The common health risks that married adolescents are exposed to include unplanned pregnancy, complications of early pregnancy and childbirth and, in some circumstances, unsafe abortion. Child brides are also exposed to unsafe sex and the risk of infection with STIs, including HIV/AIDS. Those who try to resist sex are likely to be subjected to violence that results in even further harm. The absence of compulsory birth registration across the region has compounded the problem by making it possible to fabricate a person's age to avoid criminal liability for performing a child marriage. The complicity of government officials in the frequent performance of "mass child marriages" in different parts of India has been documented, revealing the government's failure to implement its own law.⁹⁶ In addition to exposing women to a range of health risks, early marriage has also facilitated the trafficking of young girls for forced prostitution. Child marriage has also been widely exploited by criminals who consider it to be one of the simplest ways to procure girls for prostitution.⁹⁷

Unsafe abortion

Unsafe abortion is a leading cause of death among young women worldwide.⁹⁸ While official statistics on the incidence of unsafe abortion are unavailable for South Asia, the existence of restrictive abortion laws in most countries and poor accessibility to services where abortion is legal suggest that the incidence is very high. In India, up to half of all maternal deaths among adolescents aged 15–19 are reportedly due to unsafe abortion. Adolescents are generally more exposed to the danger of unsafe abortion than older women because of their relatively greater lack of access to and information about health services and higher risk of unplanned pregnancy, particularly among married adolescents. Social taboos about sex make it impossible for unmarried adolescents to seek information and services where there are no mechanisms for ensuring confidentiality. In Nepal, where abortion is legal on broad grounds, a

minor needs to obtain the consent of a third party to have an abortion. It has been noted that parental consent requirements for abortion increase the rate of unsafe abortion among adolescents.⁹⁹

Sexual violence

Studies on sexual violence in South Asia reveal that “no age is a safe age,”¹⁰⁰ and that a significant proportion of rape victims tend to be minors.¹⁰¹ Sexual intercourse with a girl under the age of 16 is considered statutory rape in India, Nepal and Sri Lanka. In Bangladesh, statutory rape is considered to occur only if the girl is under 14. In Pakistan, if a minor cannot prove an allegation of rape, she is liable to be tried as an adult for the crime of Zina or adultery. In certain situations, sexual violence takes the extreme form of sexual slavery. As mentioned earlier, studies show that the typical age at recruitment for sex work is between 10 and 14 years.¹⁰² Girls between 9 and 15 years of age are reported to fetch a premium in the commercial sex market.¹⁰³ A new dimension to this crisis of sexual violence against adolescents has emerged with the spread of HIV/AIDS. The belief that sex with a virgin can cure HIV/AIDS has enhanced the potential for further abuse of minors.¹⁰⁴ Sexual abuse is also common, but the lack of a legal definition for many forms of sexual abuse has led to the underreporting of such crimes, so violations experienced by victims remain largely unaddressed.¹⁰⁵

Recommendations for Action

The Children’s Rights Convention contains key provisions relating to the rights of adolescents. The convention clearly establishes children’s right “to the enjoyment of the highest standard of health and to facilities for the treatment of illness and rehabilitation of health.”¹⁰⁶ It requires states parties to take appropriate measures “to develop family planning education and services.”¹⁰⁷ It also recognizes that in all matters relating to children, the best interests of the child should take precedence over all other considerations, including the personal will of parents and guardians.¹⁰⁸ The Children’s Rights Convention was also the first international human rights treaty to explicitly recognize sexual violence and abuse, which constitute a major threat to adolescents’ reproductive and sexual health.¹⁰⁹ In light of these obligations, governments in the region must take the following steps:

1. Introduce comprehensive policies that formally recognize the reproductive rights of adolescents and establish age-specific reproductive health programs for married and unmarried adolescents; programs should include information and services regarding safe and consensual sex, contraception, safe abortion, safe pregnancy, and prevention of STIs, including

HIV/AIDS.

2. Adopt a uniform minimum age at marriage for both women and men, regardless of their religious affiliation and customary practices, and enforce existing laws that prohibit child marriage.
3. Introduce sex education and life-skills programs at all levels of education—primary, secondary and tertiary. Policies should also reflect the special needs of marginalized adolescents, such as street children, refugee and internally displaced children, and out-of-school youth.
4. Create programs to sensitize the community, including health-care providers and law enforcement officials, regarding the need to protect the girl child and female adolescents against all forms of sexual violence, including rape, incest, trafficking, and customary forms of gender-based violence.

2. Refugees

Background and key facts

Women and children constitute 80% of the world’s refugees.¹¹⁰ There are a significant number of refugees spread across South Asia. Two of the most visible, localized refugee populations are the Afghan refugees in Pakistan and the Bhutanese refugees in Nepal. The number of Afghan refugees in Pakistan peaked at three million in 2001. For over a decade, more than 100,000 Bhutanese of Nepalese origin have been living in camps administered by the UN High Commission for Refugees (UNHCR) in southeastern Nepal. The lack of adequate attention to women’s routine reproductive health-care needs in refugee camps and the failure to protect women from different forms of gender-based violence have resulted in sustained hardship for refugee women and major violations of their reproductive rights.

Areas of Concern

Lack of specific policies for refugees

The governments of Nepal and Pakistan have hosted refugees for decades, yet neither has a clear policy devoted to the basic needs of refugee populations. These governments have relied heavily on international aid and support for their programs without making much effort to address the immediate needs of refugee women and children. Studies reveal that while family planning services are generally available in refugee camps in Pakistan, the services are not widely used and the rate of contraceptive discontinuation is high.¹¹¹ Postabortion care and emergency contraception are also not available, and adequate precautions are not taken in the use of medical instruments to prevent the spread of infection, including HIV/AIDS.¹¹² Due to the primary focus on maternal health needs, the needs of adolescents remain

unattended. These shortcomings in services have clearly taken a toll on the lives of refugee women: a study of 12 Afghan refugee settlements conducted between January 1999 and August 2000 revealed that 41% of deaths among women of reproductive age were due to maternal causes, and 60% of infants were born dead or died soon after birth.¹¹³

Lack of protection from gender-based violence

Women's vulnerability to violence in refugee situations is exacerbated by their dependence on male authority figures, including male refugees, local relief officials and law enforcement agents.¹¹⁴ In Afghan refugee camps in Pakistan, the incidence of domestic violence, incest and honor killings is reported to be high. In 2002, Human Rights Watch investigated several cases of gender-based violence in Nepalese refugee camps. Their report found that UNHCR and the government of Nepal failed to take adequate steps to protect refugee women and children from gender-based violence.¹¹⁵ Rape, sexual harassment, child marriage, forced marriage, and domestic violence are some of the common forms of violence found in the camps in Nepal.¹¹⁶

Recommendations for Action

The basic human rights of refugee women and children, including the rights to life, health and nondiscrimination, are recognized by major international treaties, such as the Civil and Political Rights Covenant, CEDAW and the Children's Rights Convention.¹¹⁷ International human rights norms require governments to ensure that all individuals within their territories, regardless of citizenship, enjoy the equal protection of the law.¹¹⁸ The five-year review of ICPD recognized refugee concerns and called for greater reproductive health and family planning efforts for displaced adolescents and women.¹¹⁹ In addition, it emphasized training for health and relief workers in emergency situations in "sexual and reproductive health-care services and information."¹²⁰ At the five-year review of the Beijing Conference, the international community stressed the need for a "more holistic support for refugee and displaced women" that integrated a gender perspective into the design and implementation of assistance to victims of humanitarian emergencies and conflict situations.¹²¹ Based on their commitments under international law, governments hosting refugee populations are obligated to take the following steps:

1. Introduce formal policies that recognize the rights of refugees and establish comprehensive guidelines for their protection and care.
2. Provide refugee women with access to comprehensive reproductive health care, including the broadest possible range of contraceptives for women and men,

voluntary testing and treatment for STIs, including HIV/AIDS, and access to safe abortion services.

3. Create complaint mechanisms and support groups for refugee victims of sexual and domestic violence, and provide counseling and emergency medical care for such victims.
4. Investigate and prosecute sexual crimes against refugee women, whether such crimes are perpetrated by private parties, relief officials or agents of the host state.

The remaining chapters of this report presents a factual account of laws and policies that relate to specific reproductive health issues as well as to women's rights more generally. It discusses each country separately, but uniformly organizes the information in four main sections that enable country comparisons. The first section of each chapter lays out the country's basic legal and political structure. The next section details the laws and policies affecting the reproductive health and rights issues that have been recognized by the international community. A general discussion of women's legal status follows and, finally, each chapter closes with a discussion of the reproductive health and rights of adolescents.

ENDNOTES

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