## Core Essay

# Sexual and Reproductive Health and Rights for All in Southeast Asia
Realising the Aspiration of the UN Social Development Goals

## Rosalia Sciortino and Peter Aggleton

### SDGs commitment to universal access to sexual and reproductive health services

The imperative to reduce inequalities and leave no one behind is meant to infuse all the United Nations Social Development Goals (SDGs), including those with a focus on sexual and reproductive health (SRH). Universal access to SRH services and rights is called for to ensure healthy lives and well-being (Target 3.7 under SDG 3 on health) and to contribute to gender equality (Target 5.6 under SDG 5 on gender equality and women's and girls' empowerment). Achieving SRH and rights for all is also expected to positively impact on sustainable development and the environment, and contribute to fairer communities and societies (Ghebreyesus and Kanem 2018). The aspiration is to reach the entire population and, in particular, poor, marginalised and vulnerable populations, with comprehensive good quality services and to make sure that every individual can exercise "the right to make decisions that govern their bodies, free from stigma, discrimination, and coercion" (Starrs et al 2018, p. 2642).

The policy and programmatic shift required to realise this pledge of universal access to SRH services and rights is, however, significant, since it entails interrogating and addressing the root causes and underpinning structures that keep uneven social and economic development in place. Here we ponder on the factors that shape, influence and place limits on equality and universal SRH and rights in Southeast Asia and on what it would take to tackle them. In particular, we identify three main drivers of disparity and exclusion that contribute to unequal SRH outcomes and demand urgent action if justice in and through sexual and reproductive health is to be achieved, namely: the maldistribution of wealth and wellbeing; entrenched patriarchy; and the growing rise of authoritarianism and populism.

### Maldistribution of wealth and wellbeing

In recent decades, the countries of Southeast Asia have enjoyed high economic growth through economic liberalisation and integration of national markets in the global economy and regionally. This macro-economic success has come, however, with significant social and environmental costs and has consistently failed to lead to 'shared prosperity' trickling down to the neediest. Disparities across and within countries remain striking with a recent SDG progress report pointing to Southeast Asia as the only sub-region within Asia Pacific with widening in-country inequalities (UNESCAP 2018). Although income levels do not necessarily translate into health outcomes, a close correlation between them can be observed in this region where the more advantaged countries have significantly better health and welfare indicators when compared to the less advantaged ones. For instance, in 2017, life expectancy in Singapore, Brunei Darussalam and Thailand was on average ten years higher than that in Myanmar, Cambodia and Lao PDR (ASEAN 2018). Moreover, within countries, poor people are at a greater risk of dying from preventable

diseases such as tuberculosis and malaria (and, if women, of unwanted pregnancy) than their richer counterparts. Across the region, infant and maternal mortality rates are higher in rural areas, especially in remote locations with lower levels of infrastructure, including health service development and housing. In a similar way, girls living in rural areas, with less education and from poorer households are more likely to be married or engaged early and at increased risk of early pregnancy, STIs and gender-based violence.

Health divides also reveal large inequalities in access to health personnel, equipment and services within and across countries. Public spending on health remains low, with governments advancing the privatisation and marketisation of health care at the cost of public provision. A mix of social health insurance is offered to the poor for limited services. What we see in many countries is "a two-tier health care system, with deluxe priority care for the better off and a rump, underfunded public sector for the rest'" (Ormond, Mun and Khoon 2014, p. 3). Even when national health schemes have been shown to increase affordability, such as in Thailand and, more recently, in Indonesia, the quality of care offered to lower-income and to migrant patients, when they have access, is significantly poorer than that available to their wealthier counterparts.

Privatisation also impacts on access to SRH supplies and services, standards of care and SRH outcomes. The cost of reproductive health services in private facilities is generally higher than in public facilities. In low-resource countries such as Laos and Cambodia, their use is prohibitive or implies burdensome, if not catastrophic, out of pocket expenses for a majority of the population. Existing universal health care (where available) is no panacea either as in most countries, it only covers basic mother-and-child care. In Indonesia, for instance, the national health insurance scheme does not include the Pap-smear and mammography as diagnostic tools --even if the highest cancer occurrence in the country are women's reproductive cancers. Neither does it include infertility treatment, forensic medical examination for victims of rape, and HIV testing in the package of services covered (YKP 2018). Furthermore, resource allocation frequently ignores groups deemed not to be entitled to SRH services on gender and moral grounds- for example, young people, unmarried women and LGBTIQ persons - leaving them dependent on private practitioners for care irrespective of their economic status.

**Patriarchy and Populism**

Patriarchy remains well-entrenched in Southeast Asia even if there is much talk about women's empowerment and leadership in national plans and development programmes. Culturally diverse countries subscribe to the same overarching discourse of 'Asian values' framing women as subservient to men as the household heads, including on sexual and reproductive matters. This social construction of a heteronormative 'ideal' continues to be regarded as natural in spite of the growing reality of women-headed, single-person, same sex and separated families throughout Southeast Asia, and the many different roles women have always played at home and in society.

Over and over again, governments fail to take into account women's autonomy, needs and choices. Positions vary from pro-natalist stances for religious or demographic reasons in the Philippines, Brunei, Malaysia and Singapore to the enforcement of family planning programmes using long-term contraceptives, as in Indonesia and Vietnam. Decisions are further entrusted to the couple, if not the male partner, rather than the individual woman. As normative values locate sexuality and reproduction within the family, SRH education and services are not provided to single women and adolescents. The social fear of girls being or becoming sexually active and pregnant outside of wedlock contributes to the high rate of early marriages and so does the

shame of pregnancy at an early age, as premarital sex is taboo. Maternal mortality remains a persistent problem with deaths per 100,000 live births as high as 357 in Laos, 305 in Indonesia, 221 in the Philippines, 190 in Myanmar, 180 in Cambodia and an average of 197 regionally in 2015 (ASEAN 2017) as technical interventions have improved availability of health care, but failed to address the underlying socio-economic and gender root causes.

Skewed gender values have also shaped the HIV epidemic and national responses to it, with women largely ignored in prevention efforts when not sex workers. Efforts to control women and their sexuality heinously manifest themselves in a multitude of violent and harmful practices from female genital mutilation, to sex selection. Intimate partner violence is pervasive, and rape continues to be condoned as men's sexual entitlement (and thus not needing a woman's consent) and as 'deserved' punishment for deviant women. Bullying, on-line harassment and gang rape are on the rise and in conflict situations, rape is widely used as a weapon of war. Most countries have laws to criminalise violence against women, but protection does not extend to unmarried couples and sexual minorities, nor does it include all forms of violence such as sexual harassment and marital rape.

The attainment of economic and gender inclusion is even more challenged today because of the rise of authoritarianism and of nationalist and religious populism throughout the region. This puts at risk the tenuous progress achieved by women's groups and civil society in the 1980s and 1990s, with the emergence of alternative human-right based discourses and movements stressing women's rights, SRH rights and, more recently, LBGTQI rights. Democratic forces that at the time seemed to have punctured, at least in parts of Southeast Asia, the dominance of centralised regimes, are experiencing a backlash – no different in this respect from the rest of the world. Referring back to timeworn justifications of stability, development and traditional values, governments are clamping down with greater intensity on freedom of association, speech and information, and are curtailing civic space. When not by the government, pressure on civil societies and progressive standpoints is placed by the numerous fundamentalist and nationalist groups that have proliferated in recent years. This is particularly the case in countries in which narrowly defined identity politics that denies diversity through a call to adhere to rigid ethno-religious or heteronormative gender practices is increasingly employed to gain popularity, win elections or simply stay in power. In such a constraining climate, contestation over SRH and rights, gender equality and sexual diversity is becoming more intense. Harnessing the conservative message of Asian values, religious groups across Southeast Asia have generally subscribed to their moral offshoots, opposing any rethinking of domestic roles, gender, sexual diversity and SRH.

**Technical Know-how is Not Enough**

Considering the regressive trends engulfing the region and the nature of the underlying drivers of inequity in development and SRH and rights, it is reasonable to assume that these cannot be addressed simply by adding investments and technical know-how, or expanding access to services. Instead, they require an approach that challenges entrenched power and champions social change. A paradigm shift is required in the way we tackle SRH problems and their underlying causes, which implies moving: 1) from creating opportunities for the left behind to 'shared prosperity' and redistribution across socio-economic groups; 2) from a technical to an empowering approach to addressing patriarchy and heteronormativity; and 3) from a developmental to a political framework for 'inclusive societies' to promote and ensure basic freedoms and respect of human rights.

In more detail, a more equitable distribution of wealth and wellbeing urgently requires an overhaul of the economic system to correct national and supranational market arrangements in such a way that no longer endless growth and consumerism, but greater equity is pursed. Alternative economic models that aim for "good lives for all within the limits of one planet" (Peck 2013, para 20) require measures such as ending perverse subsidies, land reform, community land trusts, unconditional basic incomes, and cap-and-share systems. Fiscal redistribution mechanism including inheritance and progressive taxes and greater spending on social protection and transfers to the poorest should also be implemented while enforcing tax compliance of the many that fail to meet even the most basic tax requirements. For the SDGs not to be perceived as 'bluewash', a system reboot of corporate practices beyond public-private partnerships and social corporate responsibility (CSR) will have to occur if business is to become more accountable to society and the environment (Peck 2017).

In the health sector, efforts should be made to challenge the progressive privatisation and commodification of health, reclaiming health as a public and not a private good. Governments need to increase public spending and provide greater regulatory oversight to keep corporate providers in check. New public systems and schemes are required that prioritise care according to health need rather than capacity to pay. Prevention and promotion need to be placed at the centre of public health, which implies an allocation of financial and human resources away from treatment and hospital-centred care. In the push for universal health care, gender and socio-economic equity should be consciously built in - eliminating all double standards and ensuring the needs of women and vulnerable groups are met by subsidised premium payments and coverage packages. In particular, comprehensive SRH services should be made a number one priority in health financing and provision. National health insurance schemes should cover all core services including safe abortion, prevention and treatment of sexually transmitted diseases and reproductive health cancers and infertility, and not discriminate according to age, gender, sexuality and civil status (Sen and Govender 2015).

This implies working to spell out and challenge patriarchy in all its manifestations. Policy and programmes need to recognise that women's empowerment in the public as well as in the domestic sphere, and especially in sexual and reproductive decision making, is a precondition for attaining SRH and rights. Evidence has steadily grown about the positive association between women's empowerment and SRH, yet most programmes and interventions are of a technical rather than a transformative nature. Even gender mainstreaming and male-involvement interventions too often shy away from a feminist analysis of the power structures at stake, settling for some form of paternalist protectionism. Change should also come to development programmes describing women as yet one more vulnerable group, to avoid belittling more than half of humanity and their entitlements. The deconstruction of the entrenched patriarchal-heteronormative paradigm that forces women into subservient roles (and men into dominant ones) should be a priority for SRH struggles, and more needs to be done to normalise men's work and role at home. States across Southeast Asia are to be held accountable and pressured to make formal strategies and mechanisms for the advancement of women, operative beyond the level of rhetoric. For a start, sex-disaggregated data and non-discriminatory measures should become mandatory for all government institutions and services.

The upholding of women's, SRH rights and other rights requires a full rejection of ethnic and religious populism, fundamentalism, radicalism and of the politicisation of religion. For each and

every one of us, the current global and regional context requires taking a position, breaking the silence and becoming vocal in defence of gender, sexuality, religious and ethnic diversity and human rights. Moving from a developmental to a political perspective for inclusive societies, new mechanisms for participation and accountability are needed in order to reclaim civic space for alternative voices and action. Advocacy for SRH and LBGTIQ rights can be strengthened by building cross-sectoral alliances that condemn all forms of violence, persecution, discrimination and abuse and promote SRH grounded in principles of human rights. In all of this, the SDGs can no longer be framed as apolitical. Rather, states should be scrutinised and held accountable for their actions towards women, SDG commitments and all of those who are marginalised and ignored (Sriskandarajah 2017).

From this, it may be concluded that a structural approach to bringing justice to and through SRH must address the causes of social exclusion and promote diversity. In so doing, it must question the current economic order, patriarchy and other divisive power relations, promote human rights and support civil society. Only through such a transformative approach will it be possible to move beyond the rhetoric of SDG aspirations and transform society in such a way that indeed no-one is left behind.

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