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INTERNATIONAL**



MAKING THE FAIR CHOICE: KEY STEPS TO IMPROVE MATERNAL HEALTH IN ASEAN

BRIEFING TO THE ASEAN INTERGOVERNMENTAL COMMISSION ON HUMAN RIGHTS

INTRODUCTION

On 14-15 October 2011, the ASEAN Intergovernmental Commission on Human Rights (AICHR) will meet in Manila, Philippines, to hold a Human Rights Conference on Promoting Maternal Health. The conference aims to assist reaching the UN Millennium Development Goal on Maternal Health (MDG 5) by starting a process within the Association of Southeast Asian Nations (ASEAN) to develop best practices and regional approaches on reducing maternal mortality and morbidity, and improving maternal health in Southeast Asia. The regional meeting follows a pledge made by ASEAN states last year to “address maternal and child mortality, poor reproductive health; to enable access to safe contraception, safe family planning methods and emergency maternal obstetrical care facilities”.¹

Amnesty International welcomes ASEAN’s commitment to ensure that access to maternal and reproductive health care information and services will be provided by its member states to improve the lives of women and girls within the region. However, the adoption of declarations, laws and policies should be followed by concrete action to ensure full protection, respect and fulfilment of women’s human rights in general, and their sexual and reproductive rights in particular. Despite progress, women and girls continue to face barriers within ASEAN in accessing maternal health care services and information, not least as a result of discriminatory laws, policies, practices and attitudes.

Amnesty International’s ongoing research throughout the world, including in specific ASEAN states, has led us to conclude that governments should ensure that essential health care services are of sufficient quality, are culturally appropriate and available and accessible to all, including the most vulnerable and marginalized women, and that there is no discrimination in the provision of such services on grounds such as ethnicity, religion or marital status. Lastly, governments must address underlying factors that contribute to women and girls dying in pregnancy and childbirth or suffering the consequences of unwanted pregnancy. Currently, these are not accounted for in MDG 5.

In this submission, Amnesty International outlines to the ASEAN Intergovernmental Commission on Human Rights the key human rights issues, standards and recommendations that should inform the Commission in its deliberations, research and recommendations to ASEAN governments. The briefing is based on Amnesty International’s research within the context of a worldwide campaign to Demand

Dignity, within which maternal health and sexual and reproductive rights of women and girls feature prominently.²

The first section highlights Amnesty International's concerns with regard to gender discrimination and maternal health worldwide. The second section focuses on recent case studies in two ASEAN member states – Indonesia and the Philippines - where Amnesty International has conducted research or campaigning action on gender discrimination and maternal health. The third section highlights relevant international human rights law and standards, and the final section provides recommendations to ASEAN member states which, if implemented, would improve the situation of women and girls, especially as regards to their sexual, reproductive and maternal health rights.

1. GENDER DISCRIMINATION AND MATERNAL HEALTH

Women and girls around the world are often subjected to multiple forms of discrimination in their day to day lives. Laws, policies and practices often deny them an equal status in society and control over their lives and wellbeing. One of the worst forms of such discrimination is the denial of their sexual and reproductive rights. One of the most abject manifestations of such discrimination is the large number of preventable maternal deaths and injury suffered by women and girls around the world. Women and girls have the right to the highest attainable standard of health, but they face legal, economic and social obstacles in access to health information and care. Women and girls have the right to determine whether and when they become pregnant, but they are often denied access to family planning, contraception and information and the ability to exercise control over their own bodies.

Health care systems in many countries are often inaccessible to women and girls living in poverty. Women living in impoverished rural areas and those belonging to marginalized indigenous communities often face numerous barriers in accessing maternal health care services. Amnesty International's research in different countries has shown that there are critical social and economic factors that underlie both the failure of health systems to deliver life-saving services for women and girls and the inability of so many women and girls to reach the services that do exist.³ These factors include gender inequities in families and communities – often grounded in discriminatory laws – and the profound discrimination and exclusion from health systems of poor and marginalized communities.

Women's and girls' enjoyment of their sexual and reproductive rights is essential to efforts to eliminate preventable maternal mortality and morbidity (see box below "What are sexual and reproductive rights?"). These include their right to access reproductive health services free from the threat of stigma and criminalization. Yet every day, women and girls are denied their right to make informed decisions about whether – and in which circumstances – to be sexually active, to become pregnant, and to be mothers. Many women have neither protection from nor access to remedies for violations of their human rights by governments and abuses by individuals or communities.

WHAT ARE SEXUAL AND REPRODUCTIVE RIGHTS?

Sexual and reproductive rights are grounded in human rights that are recognized in international and regional human rights treaties and standards and in national constitutions and other legislation. The realization of sexual and reproductive rights requires respect for rights relating to physical and mental integrity, including the rights to life, to liberty and security of person; to freedom from torture and other cruel, inhuman or degrading treatment; and to privacy and respect for family life; as well as rights related to freedom of conscience and expression and freedom from discrimination. These rights correspond directly to the principles underpinning sexual and reproductive rights – the physical and mental integrity of the individual, his or her autonomy, and the principle of non-discrimination on grounds such as gender, race, national origin, sexual orientation, disability or socio-economic status.

Sexual and reproductive rights are central to the realization of every individual's human rights. Respect for these rights is essential to human dignity and to the enjoyment of physical, emotional, mental and social well-being. Their fulfilment enhances life and personal relationships and helps to achieve gender equality and empowerment. All people must be allowed to enjoy their sexual and reproductive rights free from coercion, discrimination and violence.

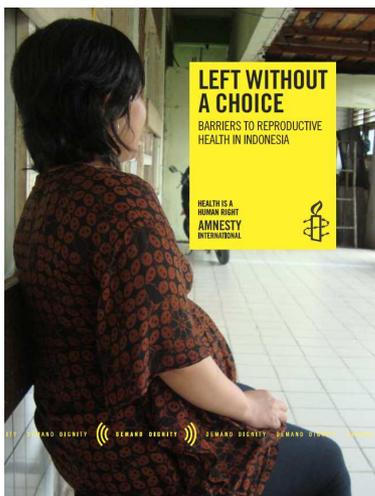
The table below provides a summary of some of the main components of sexual and reproductive rights:⁴

SEXUAL RIGHTS	REPRODUCTIVE RIGHTS
Freedom to choose whether or not to be sexually active; planning	Access to services and information on contraception and family
Freedom to engage in consensual sex; adolescents;	Access to sexual health education, including for children and
Freedom to engage in sex that is not linked to reproduction. morbidity	Access to goods & services to prevent avoidable maternal mortality &
	Non-discriminatory access to fertility treatments;
	Ethical use of new reproductive technologies;
	Freedom from forced sterilization, forced abortion and forced pregnancy.
Access to prevention and treatment of sexually transmitted diseases, including HIV/AIDS;	
Elimination of forced marriage (including of children) and harmful traditional practices endangering sexual and reproductive health;	
Freedom from female genital mutilation (FGM)	

2. ASEAN MEMBER STATES IN FOCUS: INDONESIA AND THE PHILIPPINES

The two case summaries are taken from existing research and campaigning work done by Amnesty International in Southeast Asia.

INDONESIA



Over the last 20 years, the Indonesian government has adopted various health strategies and policies to improve reproductive health within poor and marginalized communities. However, maternal mortality continues to pose a big challenge to the country's achievement of MDG targets by 2015. The Indonesian government acknowledged in 2010 that it will be unable to achieve its MDG target of reducing the maternal mortality ratio by three quarters between 1990 and 2015 unless its efforts are intensified.⁵ In order to reach the target of 102 maternal deaths per 100,000 live births by 2015, Indonesian authorities would have to halve the current Maternal Mortality Ratio.⁶ In 2010, Amnesty International published the report *Left Without a Choice: Barriers to Reproductive Health in Indonesia*. The report highlights multiple barriers faced by women and girls to enjoying their sexual and reproductive rights in Indonesia – barriers which are rooted in gender discrimination. Some of the barriers they face result directly from laws and policies

implemented by the state that discriminate against women and girls. Other barriers arise from discriminatory attitudes and practices amongst health workers and other members of the community, which the state is failing to challenge. These laws, policies and failure to act constitute violations of Indonesia's international human rights obligations to protect women and girls from discrimination, as well as violations of the right to health, in particular reproductive health. The failure to ensure that women and girls can realize their sexual and reproductive rights free from discrimination, coercion and the threat of criminalization is undermining Indonesia's ability to achieve the MDGs, and in particular MDG 3 on gender equality and MDG 5 on improving maternal health.

Under Indonesian law only legally married couples can have access to sexual and reproductive health services, excluding all unmarried people from these services (see the case of Enni). A number of women and doctors interviewed by Amnesty International stated that reproductive health services, including contraceptives, would not be given to unmarried women and girls.

THE CASE OF ENNI

At the time of Amnesty International's research in 2010, Enni was a 39 year old woman who was not yet married. She became pregnant in 2009 after she was reportedly raped in Eastern Indonesia.

At the beginning of her pregnancy, Enni went to see a doctor; however she stopped when her pregnancy was beginning to be noticeable to others. She decided to stay home instead. At the time of Amnesty International's visit in March 2010, she was seven months pregnant and did not want to go to hospital because she was worried about what other people might say as she is not married. If she faced obstetric complications, she told local NGOs that she might be too ashamed to access services at the local state hospital. Local NGOs told Amnesty International that should she require an operation (such as a caesarean section), she would need to have the consent of her husband which is not possible in her situation as she is not married.

Enni gave birth to a baby boy; however she decided not to keep him, because she could not afford to raise a child. She has given the baby up for adoption to a richer family who lives in Western Indonesia.

They also told Amnesty International that they would be reluctant to provide these services to a married woman until she has had at least one child, for fear of being blamed if a couple cannot have children. Under Indonesian law contraception procedures or treatments which contain a health risk require the husband's permission. Midwives also request written permission from a husband to provide certain types of contraceptives or access to certain procedures.

Abortion is criminalized in most cases. A woman or a girl (aged eight and above) seeking an abortion or a health worker providing one may be sentenced to up to four and ten years imprisonment, respectively. This has meant that abortions in Indonesia are often performed clandestinely in unsafe conditions. According to official government figures, unsafe abortions account for between 5 and 11 per cent of maternal mortality in Indonesia. A 2001 study conducted by the University of Indonesia estimated that there may be up to two million induced abortion cases per year in Indonesia – 30 per cent of them among unmarried women.

Abortion is legally available to women and girls who become pregnant as a result of rape, or in the event of pregnancies that are life-threatening for the mother or the foetus, but even then it requires additional criteria to be met, which are unjustified and constitute discrimination. For example, to access legal abortion services in the event of pregnancies that are life-threatening for the mother or the foetus, the Health Law requires a husband's consent. The two legal exceptions for abortion, particularly in the case of rape survivors, are not well known, even amongst health workers.

Decriminalizing abortion in Indonesia would ensure that neither women nor health workers face criminal prosecutions simply for seeking an abortion or providing appropriate medical assistance. When women and doctors no longer face the threat of criminalization, safe abortion services are more likely to be accessible to a larger number of women – thus limiting the number of unsafe abortions which pose a risk to women's health, and in some cases lead to death or injury.

Amnesty International found that some groups of women and girls face additional threats to their sexual and reproductive rights because the state has failed to protect them in contexts where they are vulnerable. Domestic workers, for instance, face specific risks of abuse because they are not fully protected by law as workers, while their work conditions put them at greater risk of rape, and they are at risk of abuse during pregnancy.



Demonstration on International Women's Rights Day highlighting how the government has failed women in Indonesia. March 2010. © AI

Amnesty International is calling on the Indonesian government to repeal all laws and regulations, at both the central and local levels, that violate sexual and reproductive rights, ensuring that women and girls can realise their rights to be free from coercion, discrimination and the threat of prosecution and punishment.

THE PHILIPPINES

The maternal mortality ratio in the Philippines is 94 per 100,000 live births⁷ but for some regions the figures are much higher. Fourteen percent of all deaths of Filipino women aged 15-49 are maternal deaths,⁸ and the Philippines is unlikely to meet its MDG 5 target of reducing its maternal mortality ratio to 52 per 100,000 live births by 2015.⁹

Each year, there are nearly 1.5 million unintended pregnancies in the Philippines.¹⁰ In 2008, 54 percent of the pregnancies that occurred in the Philippines were unintended. Three in 10 Filipino women at risk for unintended pregnancy do not use or practice contraception, and these women account for nearly seven in ten unintended pregnancies.¹¹

Because of the illegal status of abortion and other factors, estimates and data on the number of abortions are difficult to establish, but in March 2011, Philippine President Benigno Aquino III said that there are around 500,000 "induced miscarriages" every year in the country,¹² In 2008, 90,000 women were estimated to have sought treatment for complications from unsafe abortion, and around 1,000 of them died.¹³

In the Philippines, the government's policies on sexual and reproductive health services restrict the ability of women to have control over whether and when to become pregnant, and effectively deny them enjoyment of their sexual and reproductive rights. Women living in poverty are the most affected by these policies, which fail to support them in preventing mistimed, unintended or unwanted pregnancies, drive them further into poverty, and harm their health and wellbeing (see Elisa's case).

THE CASE OF ELISA

Elisa only planned to have three children. But not having the freedom to exercise her reproductive rights in the Philippines, she ended up being a mother to eight children before she was able to persuade a health worker to let her have a sterilization operation.

“My husband told me I was crazy if I thought he’d use condoms. He said they’re just a nuisance. What I wanted, what we wanted, was really just to have three children. So after my third child was born, I went to [a government] hospital and asked to be sterilized through ligation. But the doctor said I was not allowed to have that procedure done unless I bring my husband’s written consent.

So, I went home not understanding why I could not be sterilized. [Another doctor agreed to perform the sterilisation operation, but for a fee of Php10,000 (estimated USD200), which she could not afford to pay.] So, in no time, I got pregnant again. This time, with my fourth child. After that, I went to another private clinic, but they turned me away, saying that I really need my husband’s consent to have a ligation operation. I asked them why, when it was me that was going to be sterilized and not my husband.

They advised me to use condoms instead. So, we used condoms, but my husband would take them off before we finished having sex. This went on, and I got pregnant with my seventh child. After I gave birth to my eighth child, I went straight to a health centre. I went immediately, as soon as I could stand up, have a bath and leave the house. I didn’t want to get pregnant for the ninth time, not again. They asked me if my husband gave his consent to this, and I said he did. The truth was that I told my husband that I was merely going for a check-up. I had to lie in order for me to get the ligation that I had wanted to get before my five unplanned pregnancies.”¹⁴

Some government policies restrict access to certain reproductive health services, and the Catholic Church has strongly advocated the criminalisation of all abortions as well as the government’s restrictive policy on contraception. For example, “natural” family planning methods (periodic abstinence or withdrawal) are prioritised and publicly encouraged over other methods of contraception. The emergency contraceptive Postinor has been banned since 2001,¹⁵ and most contraception is not provided free of charge.

A number of laws at the local level also restrict the ability for women and girls to access reproductive health information and services. For example, *barangay* (local district within a city or town) ordinances were passed in Ayala Alabang *barangay* in Manila and in seven *barangays* in Bataan province. In February 2011 the local council of Ayala Alabang passed an ordinance which bans sex education, condoms, contraceptive pills and other contraception devices. The local ordinance required people buying condoms to present a doctor’s prescription and penalized anyone who advertised birth control plans or sold contraception without a prescription. The council cited section 37 of Republic Act 5921, which says “no drug or chemical product or device capable of provoking abortion or preventing conception... shall be delivered or sold to any person without a proper prescription by a duly licensed physician”.¹⁶ The next month, seven *barangays* in Bataan followed suit.¹⁷

A Reproductive Health bill (RH Bill)¹⁸ is currently being discussed within the Senate and House of Representatives. The bill, of which the first version was tabled in Congress as early as 1999, aims to help women avoid unplanned, mistimed and unwanted pregnancies. The RH Bill promotes both natural and modern family planning methods, and provides for post-abortion care as well as various maternal health measures and reproductive health education. It seeks to remove recognised obstacles to individuals’ access to information and services related to sexual, reproductive and maternal health, and further commits to prioritise access to healthcare for women and children living in poverty.

The RH Bill has the potential to make a strong contribution to the realization of human rights – in particular sexual and reproductive rights – in the Philippines. It is anchored on “(1.) Freedom of choice, which is central to the exercise of right, must be fully guaranteed by the State, and (2.) Respect for, protection and fulfilment of reproductive health and rights seek to promote the rights and welfare of couples, adult individuals, women and adolescents”.¹⁹



Amnesty International Philippines joins street demonstration for International Women's Day, March 2011. © AI

3. HUMAN RIGHTS OBLIGATIONS AND KEY INTERNATIONAL HUMAN RIGHTS STANDARDS²⁰

THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which has been ratified by all ASEAN states,²¹ requires state parties to eliminate discrimination against women in all its forms.²² “Discrimination against women” is defined as any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.²³

Among other provisions, CEDAW guarantees the right of women, on the basis of equality with men, to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.²⁴ All States Parties to CEDAW must “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”²⁵ The CEDAW Committee has affirmed that “access to health care, including reproductive health is a basic right”.²⁶ It has also stated that “[m]easures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women.”²⁷

The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) prohibit discrimination on the grounds of sex in relation to all the rights guaranteed by these treaties.²⁸ Under the ICCPR, there is also a self-standing right to equality and non-discrimination.²⁹ Both the ICCPR and the ICESCR have been ratified by six ASEAN Member States (Cambodia, Indonesia, Laos, Philippines, Thailand, and Viet Nam).³⁰ Both treaties are yet to be ratified by Brunei Darussalam, Malaysia, Myanmar and Singapore.

The CEDAW Committee has clarified that the realization of women’s right to health requires the

removal of all barriers interfering with “access to health services, education and information, including in the area of sexual and reproductive health.”³¹ The ESCR Committee has similarly stressed the need for “the removal of legal and other obstacles that prevent men and women from accessing and benefiting from healthcare on a basis of equality.”³² The CEDAW Committee has also stated that “[b]arriers include requirements or conditions that prejudice women’s access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport.”³³

According to the CEDAW Committee, certain groups of women, in addition to suffering from discrimination as women, also suffer from multiple forms of discrimination based on “race, ethnic or religious identity, disability, age, class, caste or other factors”.³⁴ Such cumulative discrimination impairs women’s access to sexual and reproductive health care.

According to the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, marginalized women, such as women living in poverty and ethnic minority or indigenous women, are “more vulnerable to maternal mortality”.³⁵ Principles of equality and non-discrimination, explains the Special Rapporteur, give rise to the need to “promote more equitable distribution of health care, including provision in rural or poor areas, or areas with high indigenous or minority populations”.³⁶ According to the CEDAW Committee, states must pay particular attention to the rates at which they have reduced maternal mortality “in vulnerable groups, regions and communities”.³⁷

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The ICESCR provides for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.³⁸ The Covenant requires states to take steps to provide for “the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child”. The ESCR Committee, the body responsible for monitoring this treaty, has stated that this treaty obligation must be: “[U]nderstood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and [postnatal] care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”³⁹

The UN Convention on the Rights of the Child (CRC), which has been ratified by all ASEAN Member States,⁴⁰ provides for the “right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”⁴¹ The CRC also binds state parties in pursuing “full implementation of this right” and, in particular, to “take appropriate measures to... ensure appropriate pre-natal and post-natal health care for mothers⁴²... [and]... develop preventive health care, guidance for parents and family planning education and services”.⁴³

CEDAW requires state parties to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”.⁴⁴

While the right to health under the ICESCR is subject to progressive realization and availability of resources, according to the ESCR Committee there are some obligations that are subject to neither resource constraints nor progressive realization, but are of immediate effect. These immediate obligations include ensuring the realization of the right to health on a non-discriminatory basis; the provision of primary health care, safe water and adequate sanitation; and equitable distribution of all health facilities, goods and services. The ESCR Committee has explained that the ICESCR requires state parties to ensure that health care services, goods and facilities connected to preventing maternal mortality must be available, accessible, acceptable and of good quality.⁴⁵

ESSENTIAL ELEMENTS OF THE RIGHT TO HEALTH

Health information and health care facilities, goods and services have to be available, accessible, acceptable and of good quality. In practice, these four interrelated and essential elements of the right to health mean:

Availability - governments must ensure that functioning public health and health care facilities, goods and services, as well as programmes, are available. This includes the underlying determinants of health such as access to safe water, adequate sanitation, nutrition and also hospitals, clinics and other facilities; trained medical and professional personnel receiving domestically competitive salaries; and essential drugs.

Accessibility – health facilities, goods and services have to be accessible to everyone without discrimination

Acceptability – all health facilities, goods and services have to be respectful of medical ethics and are culturally appropriate

Quality – health facilities, goods and services have to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs, and hospital equipment.

Under international human rights treaties, women are entitled to a range of health services which play an important role in improving maternal health, including:

- Primary health care services throughout a woman's life;⁴⁶
- Education and information on sexual and reproductive health;⁴⁷
- Sexual and reproductive health care services, such as family planning services;⁴⁸
- Prenatal health services;⁴⁹
- Skilled medical personnel to attend the birth;⁵⁰
- Emergency obstetric care;⁵¹ and
- Postnatal health services.⁵²

THE RIGHT TO LIFE

The ICCPR guarantees that “[e]very human being has the inherent right to life”.⁵³ The Human Rights Committee has emphasized that the “inherent right to life” should not be understood in a restrictive manner and requires states to take positive measures to ensure protection of this right.⁵⁴ It has highlighted the obligation of state parties to take all possible measures to increase life expectancy.⁵⁵

In its concluding observations and recommendations, while monitoring states' implementation of the ICCPR in relation to the right to life, the UN Human Rights Committee has consistently expressed concern over high maternal mortality rates.⁵⁶ It has recommended:

“So as to guarantee the right to life, the State party should strengthen its efforts in that regard, in particular in ensuring the accessibility of health services, including emergency obstetric care. The State party should ensure that its health workers receive adequate training. It should help women avoid unwanted pregnancies, including by strengthening its family planning and sex education programmes, and ensure that they are not forced to undergo clandestine abortions, which endanger their lives.”⁵⁷

4. CONCLUSION AND RECOMMENDATIONS

Mothers should not die or suffer considerable harm from preventable causes during pregnancy and birth. Under international human rights law and standards, states, in ASEAN as elsewhere, are responsible for the death and harm when they fail to address these causes, which are often closely linked to discrimination in laws, policies, practices and societal attitudes.

Amnesty International calls on the ASEAN Intergovernmental Commission on Human Rights (AICHR) to help ASEAN member states take concrete steps to guarantee and protect maternal health, and sexual and reproductive rights. These steps include:

- Enact and implement legislation to achieve the highest attainable standard of maternal health and to respect, protect and promote the sexual and reproductive rights of women and girls. Further, undertake a review of all laws, regulations and policies which are discriminatory towards women and girls to bring them into line with international human rights law and standards, in particular the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). For example, states should not restrict women's access to health care services on the ground that women do not have the consent of husbands, partners, parents or health authorities;
- Ensure that a comprehensive reproductive health education programme is included in the national school curriculum. Age-appropriate materials should be developed in a way so that adolescents, regardless of their level of education or marital status, can fully access information on the prevention of unwanted early pregnancies and sexually transmitted diseases including HIV/AIDS. These materials should be non-discriminatory and should not reinforce the stereotyping of women's and men's roles;
- Remove barriers in access to health care, ensure freedom from discrimination, and guarantee equitable distribution of health facilities, services, and resources. This should include adequate national budget allocation for maternal health care, safe contraception and other reproductive health services and information. It should also include the development and implementation of national health strategies, in particular on sexual, reproductive and maternal health that are consistent with international human rights law and standards;
- Ensure that those affected adversely by laws, government policies and official and social practices – or by the failure of these – have access to information about their human rights and are enabled to identify the violations of their human rights as such and challenge them. They must have access to platforms where their voices are heard, and to fora - whether these are political, administrative or judicial - in which governments, both at the local and central levels, can be held accountable; and
- Ensure that ASEAN state parties to the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the UN Convention on the Rights of the Child (CRC), the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) incorporate the legal provisions set out in these treaties in their respective national legislation, if they have not already done so. Those ASEAN member states which have not yet ratified the ICESCR and the ICCPR, Brunei Darussalam, Malaysia, Myanmar and Singapore should do so at the earliest opportunity with full consultation with civil society organizations, and incorporate their provisions into national law.

ENDNOTES

- 1 Ha Noi Declaration on the Enhancement of Welfare and Development of ASEAN Women and Children, (agreement no. 8), 28 October 2010, para 8.
- 2 For further information about Amnesty International's campaign on maternal health and sexual and reproductive rights, please visit www.amnesty.org.
- 3 Amnesty International has done research on maternal health and sexual and reproductive rights in Sierra Leone, Burkina Faso, South Africa, Indonesia, Nicaragua, Peru and the USA. Further, maternal health and sexual and reproductive rights represent key priorities for Amnesty International's worldwide Demand Dignity campaign. Our goal is to stop and prevent human rights violations that result in preventable maternal death and injury and to safeguard women's and girls' sexual and reproductive rights. Critical to this work is the empowerment of women and girls to have the education, information and autonomy to make decisions about their life plans, including their sexual and reproductive lives.
- 4 This table was produced by Amnesty International.
- 5 Ministry of National Development Planning (BAPPENAS)/ National Development Planning Agency, Report on the Achievement of Millennium Development Goals Indonesia 2010, (2010 MDG Report), p67
- 6 See 2010 MDG Report, Supra No 5, p122
- 7 Trends in maternal Mortality 1990-2008, WHO, UNICEF, UNFPA, World Bank
- 8 Statement by Esperanza Cabral, Philippine Health Secretary, at the 43rd Session of the Commission on Population and Development, United Nations, New York, 13 April 2010. See: http://www.un.org/esa/population/cpd/cpd2010/Country_Statements/AgendaItem4/PHILIPPINES.PDF
- 9 Philippines National Statistics Office, Maternal Mortality Slightly Declined, MDG Target May Not Be Achievable (Preliminary Results from the 2006 Family Planning Survey), <http://www.census.gov.ph/data/pressrelease/2007/pr0718tx.html>, accessed 6 October 2011.
- 10 Padilla, Clara Rita (EngGndeRights), Reasons Why We Need the RH Law, published at abscbnnews.com, 16 August 2010.
- 11 Guttmacher Institute and Likhaan, Meeting Women's Contraceptive Needs in the Philippines, 2009.
- 12 President Aquino's Response to the Issues raised during the consultation forum with the Civil Society Organizations (CSO), Cagayan de Oro City, 23 March 2011 .
- 13 Forsaken Lives: The Harmful Impact of the Philippine Criminal Abortion Ban, Center for Reproductive Rights, 2010.
- 14 Transcribed from Elisa – Reproductive Rights for Filipino Women, Amnesty International, November 2009. See: <http://www.youtube.com/watch?v=LuntDNsQGcc> accessed 6 October 2011,
- 15 EngGndeRights present their shadow report to CEDAW [2006], published March 2010. <http://www.engenderights.org/?q=node/39> accessed 10 October 2011
- 16 "Barangay Ayala Alabang requires prescription to buy condoms", Gma News, 24 February 2011. See: <http://www.gmanews.tv/story/213863/barangay-ayala-alabang-requires-prescription-to-buy-condoms>, accessed 10 October 2011.
- 17 "After Ayala Alabang, 7 Bataan barangays require prescription for condoms", [abs-cbnnews.com](http://www.abs-cbnnews.com), 28 March 2011. See <http://www.abs-cbnnews.com/nation/regions/03/28/11/after-ayala-alabang-7-bataan-barangays-require-prescription-condoms>, accessed 10 October 2010.
- 18 Senate Bill 2865, An Act providing for a national policy on reproductive health, responsible parenthood and population development, and for other purposes.
- 19 RH Bill- Philippines: full text of reproductive health and related measures. See: <http://www.likhaan.org/content/sec-3-guiding-principles-6> accessed 10 October 2011.
- 20 Other relevant human rights standards include:
Cairo Programme of Action

Chapter 7: the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Chapter 8: programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family-planning services. In order to reduce high-risk pregnancies, maternal health and safe motherhood programmes should include counselling and family-planning information.

Beijing Declaration and Platform for Action

Para 96: The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

UN Human Rights Council Resolution 11/8 (2009)

Para 2: recognizes that most instances of maternal morbidity and mortality are preventable, and that preventable maternal mortality and morbidity is a health, development and human rights challenge, which also requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.

21 The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was ratified by Brunei Darussalam in 2006; Cambodia in 1992; Indonesia in 1984; Laos in 1981; Malaysia in 1995; Myanmar in 1997; the Philippines in 1981; Singapore in 1995; Thailand in 1985 and Viet Nam in 1982.

22 Article 2, CEDAW.

23 Article 1.

24 Article 16 (1) (e).

25 Article 12 (1).

26 Committee on the Elimination of Discrimination against Women, General Recommendation 24 (Women and health), 5 February 1999 , para 1.

27 CEDAW Committee, General Recommendation No. 24 (Women and Health), para 11.

28 Article 2, ICCPR; Article 2, ICESCR.

29 Article 26, ICCPR.

30 The International Covenant on Economic, Social and Cultural Rights (ICESCR) has been ratified by Cambodia (1992), Indonesia (2006), Lao PDR (2007), the Philippines (1974), Thailand (1999), and Viet Nam (1982).

31 Committee on Economic, Social and Cultural Rights, General comment 14: The right to the highest attainable standard of health, UN Doc. E/C.12/2000/4 (2000), para 21; CEDAW Committee, General Recommendations No. 24 (Women and health), para 21 (b).

32 See also Committee on Economic, Social and Cultural Rights, General Comment No. 16, Article 3 (The equal right of men and women to the enjoyment of all economic, social and cultural rights), UN Doc. E/C.12/2005/4, 2005, para. 29.

33 CEDAW Committee, General Recommendation No. 24 (Women and Health), para 11.

34 See Committee on the Elimination of Discrimination against Women, General Recommendation No. 25 on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures, 2004, para 12. .

35 Report of the Special Rapporteur on the right to health during the 61st session of the UN General Assembly, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13 September 2006, para 10.

36 Report of the Special Rapporteur on the right to health, during the 61st session of the UN General Assembly, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13 September 2006 para 28(b).

37 CEDAW Committee, General Recommendation No. 24, para. 26. See also, the commitment of States enshrined in the Beijing Platform for Action, para. 32, to "intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their

empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people.”

38 Article 12.

39 ESCR Committee, General Comment No. 14, , para 14.

40 The UN Convention on the rights of the Child (CRC) was ratified by Brunei Darussalam in 1995; Cambodia in 1992; Indonesia in 1990; Laos in 1991; Malaysia in 1995; Myanmar in 1991; the Philippines in 1990; Singapore in 1995; Thailand in 1992 and Viet Nam in 1990.

41 Article 24.

42 Article 24 (2) (d).

43 Article 24 (2) (f).

44 Article 12 (2).

45 ESCR Committee, General Comment No. 14, para 11.

46 ESCR Committee, General Comment No. 14, para 21; and CEDAW Committee, General Recommendation No. 24, Supra No 104, para 8.

47 See Articles 17 and 24 of CRC; CRC Committee, General Comment 4 (Adolescent health and development in the context of the Convention on the Rights of the Child, Supra No 104, paras 26 and 28; ESCR Committee, General Comment No. 14, , para 11; and CEDAW Committee, General Recommendation No. 24, para 18.

48 Article 12, CEDAW; ESCR Committee, General Comment No. 14, para 14.

49 ESCR Committee, General Comment No. 14, para 14; Article 12, CEDAW; Article 24 (2) (b), CRC.

50 ESCR Committee, General Comment No. 14, para 12 (d) and para 36. These paragraphs refer to “skilled medical personnel” in a general sense (para 14) and then “sexual and reproductive health”, among other things (para 36).

51 ESCR Committee, General Comment No. 14, para 14.

52 ESCR Committee, General Comment No. 14, Article 12, CEDAW; Article 24.2(b), CRC.

53 Article 6, ICCPR.

54 Human Rights Committee General Comment No. 6 (The right to life), April 1982, para 5.

55 Human Rights Committee General Comment No. 6 (The right to life), Supra 204, para 5.

56 See for example, Concluding Observations of the Human Rights Committee on Zambia, UN Doc. CCPR/C/ZMB/CO/3/CRP.1, July 2007, para 18. For other examples see Centre for Reproductive Rights, *Bringing Rights to Bear: Preventing Maternal Mortality and Ensuring Safe Pregnancy*, October 2008.

57 Concluding Observations of the Human Rights Committee on Mali, UN Doc. CCPR/CO/77/MLI, 16 April 2003, para 14.