Economic and Social Commission for Asia and the Pacific
Seventh Asian and Pacific Population Conference

Bangkok and online, 15–17 November 2023
Items 2 and 3 of the provisional agenda

Review of progress made towards the implementation of the Asian and Pacific Ministerial Declaration on Population and Development, as well as of the Programme of Action of the International Conference on Population and Development and the key actions for its further implementation in Asia and the Pacific

Thematic discussion on achievements, challenges, gaps and emerging issues in the implementation of the Asian and Pacific Ministerial Declaration on Population and Development, as well as of the Programme of Action of the International Conference on Population and Development and the key actions for its further implementation in Asia and the Pacific

Gender equality and universal access to sexual and reproductive health and reproductive rights in Asia and the Pacific

Summary

Asia and the Pacific is home to 60 per cent of the world’s population. It is a highly diverse region – economically, demographically and culturally. Progress has been made toward achieving the Sustainable Development Goals; however, this has been uneven on some issues and for some population groups. The diversity of the region means programmes aimed at improving gender equality and universal access to sexual and reproductive health and reproductive rights of people need to be tailored to different country contexts.

Poor sexual and reproductive health negatively impacts people’s lives, while policies that support them to have good sexual and reproductive health contribute to prosperous populations. Also needed are comprehensive sexuality education for young people, access to modern contraception, access to maternal health programmes for pregnant women, skilled birth attendance, access to education, prevention and testing for sexually transmitted infections, and treatment to address infertility and poor perinatal outcomes. A key factor that negatively affects sexual and reproductive health and rights is gender inequality and gender-based violence. Programmes that empower women and girls to participate in society fully and without fear of violence expand their agency.

* ESCAP/APP(7)/INF/3

** The present document is being issued without formal editing.
This paper provides an overview of gender equality and trends in sexual and reproductive health and reproductive rights, supplemented by examples of good practices gleaned from responses to a voluntary survey administered for the Seventh Asian and Pacific Population Conference. The paper is intended to inform deliberations during the Seventh Asian and Pacific Population Conference to be held in Bangkok and online from 15 to 17 November 2023.

I. Introduction

1. Asia and the Pacific is home to 60 per cent of the world’s population. The region includes six of the world’s ten most populous countries: Bangladesh, China, India, Indonesia, Pakistan and the Russian Federation. Together, they comprise over 3.7 billion people. Socioeconomic, demographic and cultural diversity is wide across the region and affects gender equality and sexual and reproductive health and reproductive rights.

2. Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. To maintain sexual and reproductive health, people need access to accurate information, and safe, effective, affordable and acceptable methods of contraception. They must be informed and empowered to protect themselves from sexually transmitted infections. When they decide to have children, women must have access to quality health-care services. Every individual has the right to make their own choices about their sexual and reproductive health.

3. In 1994, the International Conference on Population and Development marked a change in global attention to population matters, from a narrow focus on numbers and population targets to a broad focus on rights. It recognized that reproductive health and women’s empowerment are intertwined and both are needed to advance society. The Asian and Pacific Ministerial Declaration on Population and Development, adopted at the Sixth Asian and Pacific Population Conference in 2013, called for prioritizing policies and programmes to achieve universal access to comprehensive and integrated quality sexual and reproductive health services for all women, men and young people. It called for fostering an enabling environment for the full and equal enjoyment of human rights, including sexual and reproductive health and rights. It also highlighted the importance of investments in gender equality and the empowerment of women and girls, as well as mainstreaming the gender dimension into strategies, plans and programmes in all socioeconomic sectors. Gender equality and sexual and reproductive health and reproductive rights are cross-cutting issues that are central to achieving sustainable development.

4. Since 1994, investments in gender equality and sexual and reproductive health and reproductive rights have increased in many countries in the Asia-Pacific region. However, throughout the region, women and girls continue to experience significant inequalities in agency, participation and access to quality, safe, affordable, and responsive sexual and reproductive health services. Women’s chances of completing secondary and tertiary education are still lower than for men, and women are less likely to be in full-time employment than men. Political participation of women remains very low in

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most countries in the region, and violence against women and girls and harmful practices persist.

5. Most countries in Asia-Pacific region are experiencing significant changes in the age and sex structures of their populations due to declines in fertility and mortality, known as the demographic transition. Some countries face low fertility and rapid population ageing, while others have increasing youth populations and continue to have high birth rates. This paper explores progress in achieving gender equality and sexual and reproductive health and reproductive rights in the region. The data come from publicly available United Nations data sources and refer to Asia and the Pacific as per ESCAP definition. In some cases, data refer to Sustainable Development Goal regional groupings.

II. Sexual and reproductive health and reproductive rights

A. Fertility

6. In 2023, total fertility is estimated at 1.9 children per woman in Asia and the Pacific, below replacement-level fertility of 2.1. Fertility rates across subregions range from 1.2 children per woman in East and North-East Asia, to 2.1 in North and Central Asia, South-East Asia and the Pacific, and 2.2 children per woman in South and South-West Asia.

7. The majority of countries have experienced declines in total fertility rates since 2000. In East and North-East Asia, fertility remained fairly static from 2000 to 2015, and had fallen to 1.2 children per woman in 2023. It is projected that fertility will increase slightly to 1.4 children per woman by 2050. In North and Central Asia, the total fertility rate increased considerably from 1.7 to 2.2 children per woman between 2000 and 2015 and has remained fairly constant since then. In the other three subregions, fertility was still above replacement level in 2000. However, it began declining thereafter. In South-East Asia, there has been a steady fall from 2.6 to 2.1 children per woman between 2000 and 2023. Over the same time period, the Pacific has experienced a modest decline from 2.5 to 2.1 children per woman. South and South-West Asia has shown the sharpest decline – from well above replacement in 2000 (3.4 children per woman) to almost replacement (2.2 children per woman) by 2023, with average yearly declines similar between 2000–2015 and 2015–2023 (table 1).

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3 The projected increase in an average number of children a woman has is likely to be due to a tempo effect which occurs when the age of a mother at birth is rising (or falling), and also when people systematically postpone having a child to an older age.
Table 1
Total fertility rates (live births per woman) for Asia and the Pacific and by subregion, 2000, 2010, 2015, 2020, 2023, 2030, 2050

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B. Maternal and newborn health

8. Maternal mortality in the region has declined by a third over this century. Most reductions occurred between 2000 and 2015, with little decline thereafter. In 23 out of 45 countries in the region for which data are available, maternal mortality ratios fell by at least one half between 2000 and 2020. In 12 of these countries, maternal mortality declined by two thirds. A few countries experienced an increase between 2015 and 2023. Despite noticeable declines in maternal mortality, many countries, mostly in South-East Asia, South and South-West Asia and the Pacific, still experienced maternal mortality ratios between 100–299 per 100,000 live births in 2020.

9. Within Asia and the Pacific, there is also significant variation in maternal mortality between countries. This suggests that, while the region is heading in the right direction, it must accelerate actions to reduce maternal mortality further. If the pace of decline in maternal mortality of 2000–2020 continues into the future, it is projected that it will still be twice the Sustainable Development Goal target 3.1 of less than 70 per 100,000 live births by 2030.

10. Children face the highest risk of dying in their first month of life, with an average global neonatal mortality rate of 18 deaths per 1,000 live births in 2021. Sustainable Development Goal target 3.2 aims for every country to reach a neonatal mortality rate of below 12 deaths per 1,000 live births by 2030. In 2021, the following subregions had achieved or were close to this level: East and North-East Asia, South-East Asia, North and Central Asia and the Pacific.

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In South and South-West Asia, the rate was estimated at 22 deaths per 1,000 live births in 2021.

11. Of the 51 countries in the Asia-Pacific region for which data are available, 32 countries have already achieved the Sustainable Development Goal target of 12 deaths per 1,000 live births by 2030. Some 26 countries have at least halved their neonatal mortality rate in recent years, and 11 countries have reduced it by at least two thirds. These are significant achievements, and lessons learned could be used to assist other countries in reducing neonatal mortality.

12. Maternal and perinatal mortality largely results from inadequate or poor quality care during pregnancy, childbirth or after birth. Sustainable Development Goal indicator 3.1.2 of skilled birth attendance is generally used to capture maternal and newborn health-care utilization. In 2022, 86 per cent of births globally were attended by skilled health personnel. In the Asia-Pacific region, skilled birth attendance was nearly universal except for South and South-West Asia, where it was estimated at 89 per cent in 2021.

C. Family planning and unmet need for contraception

13. Unmet need for family planning refers to the percentage of women of reproductive age who want to stop or delay childbearing but are not using any method of contraception.6 The measure shows the gap between women's reproductive intentions and their contraceptive behaviour and helps track progress toward achieving universal access to reproductive health.

14. In 2023, unmet need for any method among married or in-union women (referred to as married) was 9 per cent in Asia and 14 per cent in Oceania.7 A total of 16 per cent of married women in Asia and 19 per cent in Oceania had unmet need for modern methods in 2023. By geographic subregions, 13 to 30 per cent of married women in all regions except in Eastern and South-Eastern Asia had unmet need for modern methods. Unmet need for modern methods ranged from 10 per cent in Eastern and South-Eastern Asia to 30 per cent in Oceania (excluding Australia and New Zealand). Of 50 countries in the Asia-Pacific region with available data, 48 countries recorded at least 10 per cent of married women with unmet need for modern methods, rising to 20 per cent in 33 countries and 30 per cent in 11 countries.

15. Unmet need for modern methods declined in Asia between 2000 to 2023 from 16.4 to 15.3 per cent. In Oceania unmet need stagnated over the same period. Central and Southern Asia has achieved the largest reduction in unmet need for modern methods since 2000 (from 24 to 19 per cent). Reductions in unmet need for any modern method have been negligible in Eastern and South-Eastern Asia, Australia and New Zealand. Eleven countries have reduced unmet need for any modern method by a quarter or more between 2000 and 2023. By 2030, unmet need for modern methods is projected to be 15 per cent in Asia and 18 per cent in Oceania.

16. Sustainable Development Goal target 3.7.1 measures to what extent the demand for family planning satisfied by modern methods is being met. In 2023, Central and Southern Asia, Australia and New Zealand, and Eastern and South-

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7 The data are aggregated according to https://unstats.un.org/unsd/methodology/m49.
Eastern Asia have reached around 75 per cent of demand satisfied by modern methods (74 to 88 per cent). Progress toward increasing the proportion of demand satisfied with modern methods has been uneven (table 2). Oceania (excluding Australia and New Zealand), at 53 per cent, still has a long way to go to reach 100 per cent of its demand satisfied by any other method. Of the 50 countries in Asia and the Pacific for which data are available, 18 countries have already fully satisfied their demand, 6 countries are close to it, and the remaining 26 countries have fallen short so far. Looking ahead, while 22 of the 50 countries in Asia and the Pacific for which data are available are likely to surpass the benchmark by 2030, the remaining 28 countries are less likely to achieve it.

Table 2
Demand for family planning satisfied by any modern method by geographical region,9 2000, 2010, 2015, 2020, 2023, 2030

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<td>Eastern and South-East Asia</td>
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<tr>
<td>Australia and New Zealand</td>
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<td>51.2</td>
<td>52.5</td>
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D. Infertility

17. Infertility is an important dimension of sexual and reproductive health and reproductive rights. Undiagnosed and untreated sexually transmitted infections play a key role in infertility, especially among young people. However, infertility has been relatively neglected, and data on infertility prevalence are limited. Studies have used various measures of infertility, with primary infertility measured as the percentage of people unable to bear a child despite one year of sexual exposure without contraceptives, and secondary infertility as occurring among those who have had at least one birth and have been trying for another birth for at least one year since the previous one.

18. Demographic measures are also used. Country-specific estimates come from a modelling exercise that measured infertility among women aged 20–44 years using survey data from 190 countries. The model observes that, in 2010, globally 48.5 million couples were unable to have a child (19.2 million and 29.3 million, respectively, unable to have a first and an additional child). South Asia accounted for over one quarter (14.4 million) of these couples.9

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8 Ibid.
19. In 2010, primary infertility exceeded 2.5 per cent in several countries of the Asia-Pacific region. Secondary infertility rates ranged from 6.0 to 13.5 per cent in South-East Asia, 7.0 to 15.8 per cent in South and South-West Asia, 8.0 to 12.7 per cent in the Pacific, and 11.0 to 19.5 per cent in North and Central Asia. Trends suggest that infertility rates have remained fairly constant over time.10

E. HIV and sexually transmitted infections

20. Sexually transmitted infections, such as chlamydia, are often asymptomatic. In 2020, an estimated 128 million new chlamydia infections were diagnosed globally. If left untreated, these infections can lead to various reproductive health issues including preterm births, low birth weight babies, ectopic pregnancies, pelvic inflammatory disease and infertility. For a pregnant woman, untreated infectious syphilis can lead to congenital syphilis, resulting in serious outcomes for her baby, including death. These infections can also increase the risk of HIV transmission. This highlights the importance of sexual health education and access to testing and treatment services, including within the domain of maternal and perinatal services.

21. Overall HIV incidence is low in the Asia-Pacific region (0.03 per 1,000 population in 2020), with the highest incidence in Oceania (0.37/1,000). During 2022, in the region, there were approximately 6.5 million people living with HIV, 300,000 new HIV infections and 150,000 AIDS-related deaths.11 Most new HIV infections (96 per cent) in the region occur among key populations12 and their sexual partners, significantly more than globally (70 per cent). Approximately 83.3 per cent of all new HIV infections in the region occur via sexual transmission, 5.3 per cent via vertical transmission – mostly subsequent to sexual transmission, and 11.4 per cent via shared drug injecting.13 Other sexually transmitted infections are highly prevalent in the region. For instance, during 2020, an estimated 44.3 million cases of gonorrhoea and 1.45 million cases of syphilis occurred within World Health Organization (WHO) South-East Asia and Western Pacific regions combined.14

F. Sexual and reproductive health of young people

22. The achievement of many Sustainable Development Goals, the realization of the demographic dividend, and the well-being and rights of young people (aged 10–24) depend on investments in this cohort's health, including regarding education and skill development. Data related to young people’s sexual and reproductive health are not uniformly available across countries, and globally available indicators are rarely categorized within the 2000–2015 and 2015–2023 periods to enable an analysis of change over time.

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10 Ibid.
12 Key populations are gay/bisexual and other men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people.
This section describes the current situation related to two indicators: the extent of child marriage and fertility among adolescents.

23. Marriage during childhood continues to be prevalent in several countries, but in many others, it has all but disappeared and is no longer gauged. Sustainable Development Goal indicator 5.3.1 measures the proportion of women aged 20–24 married or in a union before age 15 and before age 18. Globally, the percentage of women aged 20–24 married before age 18 was 19.5 per cent (figures reported during 2015–2023). In the Asian and Pacific region, for where data are available, the highest reported level was in Southern Asia, at 28.4 per cent. Central and Southern Asia and Oceania (excluding Australia and New Zealand) had the second highest rate, at 24.7 per cent, followed by Western Asia (17.7 per cent), and South-Eastern Asia (16.9 per cent).

24. Child marriage may also be quantified by the percentages of adolescent girls aged 15–19 currently married. Compared to 12 per cent globally, reported in 2023, regional data suggest that in Asia and the Pacific, percentages ranged from 5 to 6 per cent in Eastern and South-Eastern Asia and Australia and New Zealand to 10 to 11 per cent in Oceania (excluding Australia and New Zealand) and 14 per cent in Central and Southern Asia. Likewise, in 44 of the 56 countries in the region for which data are available, fewer than 10 per cent of all girls aged 15–19 were married. South and South-West Asia is the subregion with the highest rate, where the percentage of girls married was 15 or more.

25. Over the period 2000–2023, there has been a decline in child marriage in most geographical subregions in Asia and the Pacific. The largest declines were in Central and Southern Asia countries, where percentages in 2000 were highest (27.6 per cent) and in 2023 are now almost half that (14.3 per cent). Projections for 2030 suggest that between 5 and 11 per cent of women aged 15–19 will be married in all subregions of Asia and the Pacific.

26. In the Asia-Pacific region, adolescent fertility is estimated at 23.5 live births per 1,000 women (aged 15–19) in 2023, compared to 41.0 live births globally. The region has experienced a steady decline in adolescent fertility, reflecting reductions in child marriage. For example, the levels fell from 56.1 live births per 1,000 women, aged 15–19, in 2000 to a figure of 29.7 in 2015; over the period 2015 to 2023, adolescent fertility fell further to 23.5, altogether, a 32.6 point decline over the preceding 23 years, or an average annual decline of 1.8 points before 2015 to 0.8 points during the 2030 Agenda period.

27. There is considerable variation in adolescent fertility across subregions and countries in Asia and the Pacific (table 3). South-East Asia has currently the highest adolescent fertility level in the region (35.2), and East and North-East has the lowest (10.3). North and Central Asia, South and South-West Asia and the Pacific display adolescent fertility levels within 5 points of the regional mean of 23.5 (19.1 to 26.6). The most remarkable decline took place in the South and South-West Asia; adolescent fertility declined by 63 points between 2000 and 2015 (from 97.0 to 34.3, or approximately 4 points per year); this was followed by a slower further decline of 8 points between 2015 and 2023 (from 34.3 to 26.6), or about 1 point per year. It is important to note that, while several countries in South-East Asia are ageing rapidly, adolescent fertility rates remain high despite some reductions in the past decades.
Table 3
Adolescent fertility rate (live births per 1,000 women aged 15–19), in Asia and the Pacific and by subregion, 2000, 2010, 2015, 2020, 2023, 2030, 2050

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III. Gender equality

A. Gender imbalances, female agency and rights

28. Gender inequalities, power imbalances and limited female agency continue to impact women in Asia and the Pacific and are barriers to the achievement of the Sustainable Development Goals. Indicators relating to women’s ability to make decisions about their own lives are available for 15 countries of the region, and hence may not be representative of all subregions. The indicators from the 2018 Demographic Health Surveys for 10 countries and from the Sustainable Development Goal Global Data Base for the remaining 5 cover decision-making on own health care, contraceptive use and sexual intercourse. Globally, 57 per cent of women reported decision-making agency on all three indicators. Using Sustainable Development Goal regional groupings encompassing countries from Asia and the Pacific shows that 76 per cent of women reported decision-making power in Eastern and South-Eastern Asia compared to 55 per cent in Central and Southern Asia.

29. In 2023, only 21 per cent of seats in parliaments across Asia and the Pacific were occupied by women. The percentage was lowest in South and South-West Asia (16.7 per cent) and highest in South-East Asia (23 per cent). At the country level, New Zealand (50.0 per cent), followed by Timor-Leste (40.0 per cent) and Australia (38.4 per cent) have the highest shares of women holding seats in national parliaments.

B. Gender-based violence

30. The Asian and Pacific Ministerial Declaration commits to ensure that all sexual and reproductive health services include responses to gender-based violence, as part of a coordinated effort across sectors, including maternal, newborn, and child health, adolescent and youth health, family planning and HIV-related services.
31. As the most common form of gender-based violence against women, intimate partner violence remains a major concern for the region. Information is available from 45 countries in Asia and the Pacific concerning women’s experience of intimate partner violence – physical and/or sexual – in the preceding 12 months. Subregional variation is considerable. Using Sustainable Development Goal regional distributions, rates vary from 3 per cent in Australia and New Zealand to 29 per cent in Oceania (excluding Australia and New Zealand).

32. While the vast majority of gender-based violence is perpetuated against women and girls, men and boys are also affected. People who do not conform to social norms regarding sexual orientation or gender identity are often subjected to violence and many are criminalized. In emergencies, conflicts and natural disasters, the risk of violence, exploitation and abuse is heightened, particularly for women and girls.

33. The proportion of ever-partnered women disclosing they experienced physical or sexual intimate partner violence in the last 12 months was 10 per cent or less in most countries of East and North-East Asia for which data are available, six of the nine countries in South-East Asia and four of the six countries in North and Central Asia. The remaining two subregions showed considerably higher rates. In half of the ten countries of South and South-West Asia, 15 per cent or more of women experienced such violence in the 12 months preceding the survey. In most countries of Oceania for which data are available, violence was experienced by 15 per cent or more of women in the 12 months preceding the survey.

34. Data on non-partner violence are available from national surveys on the prevalence of violence against women. Experience of physical violence in the last 12 months was disclosed by 3 to 16 per cent of women in nine countries of Oceania, compared to 1 to 6 per cent in countries from other subregions. The experience of sexual violence in the last 12 months perpetrated by a non-partner (SDG indicator 5.2.2) ranged from 0 to 12 per cent of women.

35. The sex ratio at birth generally ranges from 103 to 106 male births to 100 female births. With the advent of prenatal diagnostic techniques revealing the sex of the foetus since 1980, people in countries with strong male preference have used techniques to achieve male births, deliberately terminating pregnancies carrying female foetuses, and resulting in skewed sex ratios at birth. The sex ratio at birth in Asia and the Pacific was around 106 in prior to the 1980s, and rose to 110 by 2000, remaining at this level over the period 2000–2015. As a result of legislation prohibiting the disclosure of the sex of the foetus, cash and non-cash transfer programmes benefitting girls, and significant behaviour change communication activities, the ratio fell to 107 by 2023.

36. As with other indicators, these averages mask heterogeneity across the region. In 2023, four of five subregions reported average sex ratios at birth rates of 106–107 male births per 100 female births; in East and North-East Asia, the figure was as high as 110, suggesting strong continued use of sex

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15 Indicators are drawn from the UNFPA portal and refer to the most recent DHS survey, or the SDG Global Database 2022.

16 UNFPA, Asia Pacific Regional Office, Violence against Women - Regional Snapshot (2023).
selection techniques. By 2030, the region is projected to have a normal sex ratio at birth (106), with all subregions reporting ratios in the range of 106–107.

D. Social and economic inequalities

37. Social determinants of health refer to the non-medical factors that influence health outcomes and include measurable indicators such as rural-urban residence, income, education, food insecurity, access to health care, and unemployment. These determinants contribute to inequities in sexual and reproductive health across and within countries, with those at the bottom the most likely to be disadvantaged.

38. Total fertility rates in rural areas exceed urban rates by 0.5 or more births in almost all countries. Differences of 1.0 or more births are observed between women with no education and those with more than secondary education. Similar differences are observed among women in the poorest versus richest quintiles in nine countries, mostly from South and South-West Asia and South-East Asia. Over time, there has been a narrowing between the most and the least disadvantaged women across sociodemographic characteristics. The declines in total fertility have been much sharper among the most disadvantaged.

39. Several countries in Asia and the Pacific have successfully reduced social inequalities in maternal, newborn and child health practices and outcomes over time. Hence, differences in neonatal mortality rates by place of residence have been narrow in most countries of the region.

40. Rural-urban differentials in the use of modern methods of contraception among currently married or in-union women have been modest. Where differences persist, a smaller proportion of women in rural areas currently use modern contraceptive methods. Several countries have reduced or reversed disparities in modern contraceptive use based on education or wealth status. However, in most countries, demand for family planning satisfied and modern contraceptive use have been more prevalent among more educated and wealthier women.

41. Rural-urban differences in child marriage, though negligible in most countries, have been considerable (12–14 percentage points) in some. Differentials of 20 or more percentage points between those in the poorest and richest quintiles in 8 countries and between those with no education and those with above secondary education in 10 countries have been noted. Changes over time have been inconsistent, with narrowing, widening and stagnation observed across countries.

42. Adolescent fertility rates have been higher in rural than urban areas in all cases, but the rural-urban gap has varied. Differences in adolescent fertility between the poorest and wealthiest women have been observed in six countries. Differences between women with no education and those with more than secondary education have been particularly wide and found in more countries. Narrowing these differentials over time has been sporadic, but substantial improvements have been made.

43. Rural-urban disparities in women’s experience of intimate partner violence have been relatively narrow overall. In seven countries, women in the wealthiest quintile have been five or more percentage points less likely to experience violence than those in the poorest quintile; nevertheless, in at least one country, the reverse has been true. In seven countries, women with
more than secondary school education have been five or more percentage points less likely to experience violence than women with the least education.

**IV. Existing and proposed policy responses to advancing gender equality and universal access to sexual and reproductive health and reproductive rights**

**A. Fertility**

44. Despite significant differences within the region, total fertility rates in developed Asia-Pacific countries have been persistently declining since around 2000. Arguably, low fertility in and of itself should not be seen as negative. Yet, without significant changes, such as increases in the statutory retirement age and promoting both employment and healthy ageing among older persons, some of the impacts of low fertility entail economic and social consequences like labour shortages, strained health and social services, and loss of economic activity. The possible negative fallout has prompted some pro-natalist governments to potentially compromise sexual and reproductive health and reproductive rights.

45. Several policies have already been adopted in low fertility settings to reverse the overall trend. A recent review of policies suggests the importance of supporting individual fertility desire, namely, to reduce the gap between the actual and desired number of children that individuals would like to have. The review lists a range of policy measures, including financial benefits, childcare provision, mothers’ employment, and more flexibility in combining work career and parenthood. Among the various policies implemented, the one strategy most effective in supporting families has been providing high-quality childcare services that are easily accessible and offer flexible timing aligned with parents’ working hours; this has helped lessen the childcare burden on women.

46. Other policies have been implemented, but their effectiveness has been variable when not combined with childcare services. For example, parental leave in the postpartum period has shown to have a positive effect but has varied according to the extent of parental compensation during the leave period. Flexible working hours that accommodate childcare demands may be a promising strategy, but the evidence has been mixed. It is important to note that financial incentives often have a temporary effect, as they do not lead to structural changes allowing individuals to have more children.

47. In countries where fertility is still relatively high, there is a window of opportunity to examine what policies are needed so that the rights of women and girls are promoted and protected, to allow them to make informed decisions about the number and timing of the births they wish to have. In these settings, policies are needed that help women and girls in their reproductive health decisions. Moreover, access to safe, affordable, and reliable reproductive health services is very important. Additionally, there should be further investments in women and girls so they can achieve secondary education, attend university, work in the formal labour market and benefit from social protection. The last point is particularly important and will protect them when life events threaten to disrupt their education and work-related aspirations.

B. Maternal and newborn health

48. There has been significant progress in reducing maternal mortality in Asia and the Pacific since the adoption of the Asian and Pacific Ministerial Declaration on Population and Development. However, some countries continue to experience high levels of maternal mortality. Reasons include postpartum haemorrhage, pre-eclampsia, hypertensive disorders, pregnancy-related infections and unsafe abortion. Higher levels have been reported in low-resource settings and socioeconomically disadvantaged subpopulations, such as indigenous peoples.\(^{18}\) One way forward is to invest in education and deployment of health professionals (including midwives as skilled birth attendants) who provide care during the mother’s pregnancy and birth at well-equipped health facilities, as this significantly increases the likelihood of having a safe birth and a healthy baby.

49. The WHO Ending Preventable Maternal Mortality framework has four guiding principles:\(^{19}\) (a) empowering women, girls, and communities; (b) integrating maternal and newborn health and protecting and supporting the mother-baby; (c) ensuring country ownership, leadership and supportive legal, regulatory and financial frameworks; and (d) applying a human-rights framework to ensure that high-quality care is available, accessible and acceptable to all who need it. It is important to recognize disparities in maternal and newborn health outcomes and increase efforts to reach vulnerable populations with high-quality primary and emergency sexual and reproductive health services. Governments should ensure universal health coverage for: sexual, reproductive, maternal, and newborn health care; antenatal and postpartum care; and all forms of physical and sexual gender-based violence.

50. Community engagement is key in maximizing progress towards advancing gender equality and universal access to sexual and reproductive health and reproductive rights. Investments at the local level are needed to expand health promotion and preventative services. There should be close collaboration between government entities, civil society, and community leaders so women and girls have access to sexuality education, health promotion messages that they can relate to, prevention messages including those concerning condom use, maternal screening, sexually transmitted infection testing, and treatment for infectious and non-communicable diseases such as HIV, malaria, cardiovascular disease and depression.

51. Timely, relevant and disaggregated data are key to inform policymaking at all levels and monitor progress. Data also help to identify gaps in service quality, utilization and equity. For example, maternal and perinatal surveillance systems should garner information regarding every pregnancy and birth, ensuring information is collected so that maternal services can identify gaps and follow up on these gaps. This type of data could help in early identification of women and girls who are likely to have high-risk pregnancies or need additional support in maintaining good health and well-being during pregnancy. The data would also help identify mothers who would benefit from testing for and monitoring of chronic conditions, or who might need to give birth in specialty hospitals in urban areas. Thus, the availability of data and related follow-up could contribute to reducing preterm births, sexually


transmitted infections before birth, and the risk of having a low birth-weight baby.  

C. Family planning

52. Realization of the right to decide whether, when and how often one becomes pregnant is fundamental to achieving gender equality and women’s empowerment. A rights-based approach to family planning can increase contraceptive use. An enabling environment for voluntary, rights-based family planning includes policies, laws, regulations and funding that facilitate the provision of voluntary family planning services. Consequently, girls have a more realistic chance to stay in school longer, obtain work in the formal labour market, and have increased access to sexual reproductive or maternal services and contraception, such as condoms and female contraceptives. Implementing such a rights-based approach to family planning could include investments from governments and the private sector.

53. Having well-trained and supportive community health workers can improve contraceptive counselling and services and promote facility-based childbirth care before discharge from a health facility. Another effective tool to engage with hard-to-reach communities is mobile outreach service delivery staffed by local community members who know and understand local norms. These can provide various contraceptives, maternal and sexuality education, and sexual health testing and treatment.

54. Interventions that have been proven to be successful in supporting individuals and couples to achieve their reproductive intentions include: encouraging couples in joint decision-making about family planning and reproductive health; addressing social norms concerning fertility; and strengthening individuals’ knowledge, beliefs, attitudes and self-efficacy.

D. HIV and other sexually transmitted infections

55. Sexually transmitted infections, including HIV, remain a major public health issue in Asia and the Pacific. WHO has called upon countries to renew the focus on prevention programmes such as comprehensive sexuality education. This includes information on HIV and other sexually transmitted infections, contraception, the freedom to choose a partner, and where to go for testing and other sexual and reproductive health services. Sexual and reproductive health services would also include improving communication and risk reduction skills and a focus on developing respectful relationships and family planning services, and promoting correct and consistent use of condoms, as well as access to vaccines for human papillomavirus and hepatitis B. Increased investments are also needed to address the major causes of HIV-related deaths, ensure continued engagement of people living with HIV in HIV treatment and care services, and address chronic care needs to improve the quality of life for people living with HIV.


22 WHO, Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030 (Geneva, 2022).
56. Certain subpopulations are at higher risk of sexually transmitted infections and HIV, especially young key populations. It is important to support community-led prevention efforts, including increased access to comprehensive sexuality education and preventive interventions such as condoms and lubricants, pre-exposure prophylaxis, and HIV/sexually transmitted infection testing and treatment. At the same time, countries must strengthen health systems for elimination of mother to child transmission of HIV, syphilis, and hepatitis B virus via contraception for women living with and at-risk of HIV/sexually transmitted infections, as well as screening and treatment of pregnant women and their infants.23

E. Access to assisted reproductive techniques

57. According to WHO, 17.5 per cent of the adult population – or 1 in 6 people worldwide – experience infertility.24 Infertility does not discriminate, and many people in Asia and the Pacific are among those affected by the inability to have a child at some point in their lives. Estimates of infertility prevalence are similar across countries regardless of country income level. The causes of infertility are varied, complex and often not fully understood; moreover, both men and women are affected.

58. Infertility is not yet considered a public health priority in national population and development policies and reproductive health programmes, but it is a reality for many in the region. While assisted reproduction technologies are available in some parts of the world, these technologies are still largely unavailable, inaccessible and unaffordable in low- and middle-income countries, both globally and in the Asia-Pacific region. Often, these services are also not acceptable to society due to norms, as well as ethical and religious principles. Access to sexual and reproductive health services is the primary way for people to have the best chance of having the number of children they desire.

F. Addressing the needs of the young and old

59. Child marriage and fertility in adolescence (15–19 years old) suggests that in several countries in Asia and the Pacific, young people enter sexual and reproductive life in adolescence. The harms of girls unwillingly entering sexual and reproductive life as teenagers, including child marriage, have been documented in the relevant literature.25 This has mainly focused on South Asia and Africa.26 Education is a strong protective factor against child marriage, and policies that promote girls’ completion of secondary schooling can help to reduce child marriage. In this context, interventions that support girls’ school attendance and retention through cash or in-kind transfers – notably the provision of conditional cash transfers or subsidies, such as school uniforms and supplies – have been identified as strong deterrents.

60. The provision of comprehensive sexuality education in school settings has also been advanced as a good practice for enhancing youth sexual and reproductive health and reproductive rights. Recognizing that in many

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countries, secondary school enrolment is not universal, research has indicated that gender transformative life skills education programmes provided at the community level in safe spaces to groups of adolescents can have a positive effect on building agency and reducing child marriage.

61. Also observed in some settings of South Asia and sub-Saharan Africa are positive effects of technical and vocational education and training programmes that empower young people economically and can enable the exercise of voice in marriage and childbearing decision-making. Finally, interventions must seek to modify traditional patriarchal norms, promote gender equality and address the key gatekeepers in young people’s lives, notably parents and community leaders.

62. Young people are at different stages of life and have differing needs, and how programmes are delivered varies from means used with adults. Moreover, young people are not a homogeneous group – the married and the unmarried may require different approaches. Youth- or adolescent-friendly approaches are needed to ensure that facilities ensure privacy and confidentiality. Providers must be well-trained and oriented about effectively communicating with and counselling young people and providing supportive, non-threatening and welcoming services. At the same time, efforts must be made to ensure access to information about available services, as well as the eligibility of all, including both the married and the unmarried, and boys and girls. Social media and other technological advances with which youth are familiar offer an exceptional opportunity for informing them.

63. Population ageing is very advanced and rapid in Asia and the Pacific. Today, one in seven people are aged 60 years or older. By 2050, one in four people are projected to belong to this age group. As people grow older, the number and share of women increase in the total population. The lifelong effects of sexuality and reproduction can affect all people in later life, but women maybe more affected due to their reproductive roles over the life course.

64. Issues of concern for older persons, in particular older women, in this regard are elder abuse, including physical and mental abuse, sexual and reproductive health needs and access to health services in general. Many older persons remain sexually active, and health professionals often have misconceptions and lack of knowledge to provide appropriate health services. Similar concerns affect persons with disabilities. Menopause and overall mental and physical health issues that affect older persons more than others must be addressed to prevent negative health outcomes inherent in the ageing process. As mentioned earlier, access to health services, including sexual and reproductive health services, remains a challenge for many in Asia and the Pacific. Older persons in vulnerable situations, including women, people in remote and rural areas, migrants and refugees, indigenous people and persons with disabilities are particularly affected. Ageism and age discrimination create barriers that prevent older persons from receiving adequate care.

G. Promoting gender equality and empowering women

65. In the Asia-Pacific region, gender inequality and power imbalances persist, while women’s agency to exercise choice remains limited. As articulated in the Programme of Action of the International Conference on Population and Development and the Asian and Pacific Ministerial Declaration on Population and Development, greater reproductive empowerment is key to achieving the empowerment of women.
66. Reproductive empowerment occurs when individuals expand their capacity to make informed decisions about their reproductive lives, amplify their ability to participate meaningfully in public and private discussions related to sexuality, reproductive health and fertility, and act on their preferences to achieve desired reproductive outcomes, free from violence, retribution or fear.\textsuperscript{27} Attainment of this goal requires building women’s and girls’ agency through multi-pronged initiatives that reach them in all dimensions of their lives. If coordinated investments are made to reach this outcome, capacity for and experience in decision-making can be fostered through better health and the educational, social, economic and legal institutions women and girls engage with.

67. In education, an effective strategy encompasses ensuring that women complete at least secondary school education, and that girls and boys receive adequate gender transformative life skills education in the school setting that enables them to break down traditional notions of masculinity and femininity. Women’s empowerment also requires attention to skill development, access to livelihoods beyond traditional roles and control over economic resources; microfinance, when combined with gender and empowerment training components, has been shown to play an important role in empowering women.\textsuperscript{28} Workplace interventions focusing on eliminating discriminatory hiring and sexual harassment, ensuring equal pay and opportunities, and instituting gender-transformative maternal/paternal leave policies are also needed.

68. Increased participation in public life and equitable representation in political life at local and national levels offer women opportunities for decision-making and leadership, including reviewing and enacting laws and policies to ensure a range of rights from equitable inheritance to reproductive choice and bodily autonomy.

69. The health-care system can exacerbate women’s disempowerment due to disparities in technical knowledge and perceived status differences. Health-care providers – both male and female – can be more effective in contributing to women’s agency by establishing environments that enable questioning and learning while promoting respect for women and their lived experiences.

70. Strengthening the provision of survivor-centred multi-sectoral response services for survivors of gender-based violence is critical. Policies that respect survivors as decision makers about whether, when and where they will seek assistance and services that provide options to inform and support their choices, are necessary elements of their broader empowerment.

71. Prevention of gender-based violence is a fundamental duty of society and a prerequisite for creating an environment in which women can exercise their rights without fear, harm or stigma. Empirical evidence for prevention highlights three types of programmes focused on: (a) economic empowerment, including microfinance and cash transfers; (b) social empowerment, including participatory learning, community mobilization and multimedia approaches; and (c) combinations of economic and social elements. These show effectiveness in reducing gender-based violence while improving economic


well-being, enhancing relationship quality, promoting empowerment, generating new help-seeking practices and collective action, reducing social acceptability of intimate partner violence and encouraging more egalitarian gender norms.\(^{29}\)

72. Initiatives to fight gender-based violence implemented through groups or collectives of women also suggest positive effects on female empowerment. These have successfully improved financial inclusion and other economic outcomes, women’s decision-making power, and other indicators of women’s social and economic empowerment.\(^{30}\) Positive effects in reducing gender-based violence have been documented in community mobilization interventions, forging equitable gender relationships and encouraging equitable decision-making among family members.\(^{31}\)

### H. Engaging men and boys

73. Engaging men and boys in programmes that promote equitable gender power relations, is essential to improve gender equality.\(^{32}\) Evidence suggests that without their participation it is not enough to implement programmes intended to empower women and girls. Successful models have focussed on reversing hierarchical male-female relationships and notions of male superiority. Another model has provided gender transformative education sessions together with exposure to sports activities not only appealing to boys but also fostering regular attendance. This programme has showed longer-term effects, both three and five years following implementation, in promoting gender egalitarian attitudes and reducing the perpetration of violence.\(^{33}\) Timing is also important; evidence shows that gender transformative programmes are likely to be more effective in changing traditional attitudes and practices among boys if they are delivered during early rather than late adolescence.\(^{34}\)

74. Discriminatory social and gender norms in families and communities are also entrenched within social, media, religious and educational institutions. Gender-transformative interventions can effectively address and transform these discriminatory norms at the individual, interpersonal, community and societal levels. Meaningful engagement with men and boys through evidence-based interventions is critical to sustain a change in inequitable gender and social norms. School-based programmes must provide gender transformative education for boys (and girls) and advance comprehensive sexuality education

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that promotes critical reflection about gender norms and understanding of individual human rights.

I. Reversing gender-biased sex selection

75. Male sex preference at birth has declined. Three preconditions have been identified as key: (a) preference for small families; (b) persistent strong son preference; and (c) access to prenatal diagnostic technology. Policy responses have been implemented, for example, in China, India and the Republic of Korea, to reverse gender-biased sex selection and sex-selective abortion. Laws have been established that prohibit health facilities and health-care providers from disclosing the sex of the foetus, but these have not been rigorously implemented, and their impact on sex ratios at birth has not been documented.

76. Strategies that have focused on changing attitudes towards women and girls and programmes that provide special benefits have been more effective. Cash and non-cash transfers to families with girls, scholarships for girls, and other benefits have been institutionalized (for example, in China, India and Nepal). There have also been advocacy and behaviour change advances – media campaigns and community-level outreach by opinion leaders – that have aimed to raise awareness about legal issues, penalties for violation, and, at the same time, change norms and attitudes relating to son preference and the role of daughters. Also important are efforts to sensitize communities about the longer-term consequences of sex-selective abortions observed in several settings today, namely, surplus males and missing brides resulting in non-marriage, migration-related marriage and trafficking of girls.

J. Data

77. In order to advance gender equality and sexual and reproductive health and reproductive rights, timely, relevant and disaggregated data are needed. Data collection must be complemented by sufficient investment in analysis, dissemination and use of statistical information to track progress and address the uneven availability of data for monitoring the situation in the region. Gender- and youth-related indicators are particularly limited, so too are key indicators such as access to postpartum care or safe abortion services. Furthermore, cross-country evidence of the persistence of or improvements in socioeconomic inequalities is available for just a few countries, making it difficult to assess the extent to which disparities are narrowing and the last mile is reached. Stronger commitment and capacity to report on agreed sets of indicators are needed to ensure data are available for all countries of the region, and at regular intervals, permitting tracking of the sexual and reproductive health and reproductive rights situation in the region more comprehensively and over time.

35 UNFPA, Asia and the Pacific Regional Office, Sex Imbalances at Birth: Current trends, consequences, and policy implications (Bangkok, 2012).

36 Shireen Jejeebhoy and others, Gender-biased sex selection and unbalanced sex ratios at birth in South Asia: Case studies of the situation and promising approaches to restore balance (CREHFA, New Delhi, 2015).

37 UNFPA, Asia and the Pacific Regional Office, Sex Imbalances at Birth: Current trends, consequences, and policy implications (Bangkok, 2012).
V. Conclusions and recommendations

78. Asia and the Pacific has made remarkable progress in advancing gender equality and to sexual and reproductive health and reproductive rights. However, much work remains to be done. Given wide disparities across and within countries, a one-size-fits-all approach to advancing the aforementioned topics would not achieve much success.

79. Different strategies must be employed to address the diverse needs of populations. While promoting principles of people-centred development, inclusivity and equality to ensure that individuals can decide freely on their needs, policies and interventions must also be in place to support diverse choices.

80. Health needs change over the life course. Yet, what happens in younger life often creates healthy outcomes later. The life course approach to providing health services, including sexual and reproductive health services, refers to ensuring services at every age that will benefit all people throughout their lives.

81. Gender equality and universal access to sexual and reproductive services are closely linked. Advancing both will save lives and provide health and well-being for all.