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Problems, Factors and Consequences Associated with South Asian Women in Realising Their Rights to Sexual and Reproductive Well-being

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***Abstract**: Sexual and reproductive rights are the integral parts of women's human rights. Women's ability to exercise sexual and reproductive rights has a significant impact on the level of women's empowerment in a society. But many women in the world cannot exercise their sexual and reproductive rights since patriarchal ideologies and regulations do not allow them to even realise those rights. As a result, women cannot make independent decisions about their own sexual and reproductive rights and they have to confront many difficulties with their bodies and lives. Such a situation is very much phenomenal in South-Asia. In this essay attempts have been made to examine the main problems that many South-Asian women face in realising their rights and consequently, the difficulties they face.*

1.0 Introduction

Every human being irrespective of gender, age, class and creed, has the right to live in safety and to have access to healthcare. However, women sometimes find it difficult to enjoy the benefits of fundamental human rights, including rights related to sexual and reproductive well-being. Sexual and reproductive well-being is essential for all dimensions of our lives (Cornwall and Welbourn, 2002: 2). The neglect and denial of sexual and reproductive health and rights create many health-related problems throughout the world (Butler, 2004: 2). In the context of any poverty-stricken patriarchal social structure the issue is even more alarming. In a patriarchal social structure many women's economic dependency contributes directly to their inability to gain control over their reproductive and sexual lives (Freedman, 1995: 7). On the other hand, the value of women in such social systems is primarily determined by the services they provide as wives, sexual partners to men and as producers of and carers for children. The control over women's sexual and reproductive lives in this context is justified by the cultural and religious systems that prevail in patriarchal society (Freedman, 1995: 7). Women under such circumstances have to face many harsh realities throughout their lives. Hence, it becomes difficult for them to realise their rights to sexual and reproductive well-being since they are not free to exercise

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their rights. In this essay, I shall try to identify the problems many women face in realising their rights as well as the difficulties that confront them as a result. I shall discuss the issues particularly in the context of Bangladesh. In addition, I shall try to relate the situation prevailing in Bangladesh to two other South Asian countries namely, India and Pakistan, since Bangladesh bears a strong socio-cultural resemblance to them. It is to note that most of the South Asian people live in these three countries.

2. 0 Women's Rights to Sexual and Reproductive Well-being

Sexual and reproductive rights have recently received considerable attention internationally, particularly after the International Conference on Population and Development (ICPD) held in Cairo in 1994. This Conference recognised that all aspects of reproductive health, including sexual health, are important to improve the quality of life for women, children and communities (Glasier and Gulmezoglu, 2006: 1550). For women, complete wellness is impossible without a state of trouble free sexual and reproductive health. Sexual and reproductive rights are, thus, the integral parts of universal human rights (UNFPA, 2000a: 2).

The International Planned Parenthood Federation (IPPF) Charter on Sexual and Reproductive Rights, published in 1996, has set out twelve rights as key human rights issues. These rights, which are particularly important for women living anywhere in the world, have been summarised below.

i) *The Right to Life* ensures that women who are currently at risk by reason of pregnancy must be protected; ii) *The Right to Liberty and Security of the Person* recognises that all persons must be free to enjoy and maintain their sexual and reproductive lives. Women have the right to be free from genital mutilation and should not be subjected to forced pregnancy, sterilisation or abortion; iii) *The Right to Equality, and to be Free from all Forms of Discrimination* aims to protect one's sexual and reproductive life from any forms of discrimination on grounds such as sex, race, religion, age etc.; iv) *The Right to Privacy* recognises that all sexual and reproductive health care services should be confidential, and all women have the right to their own reproductive choices, including abortion; v) *The Right to Freedom of Thought* states that all persons have the right to freedom of thought and speech related to sexual and

reproductive health and they must be protected from restrictive interpretation of religion, beliefs and customs; vi) *The Right to Information and Education* preserves the right of all persons to have information and education about the issues like the risks and effectiveness of methods of fertility regulation and prevention of unplanned pregnancies; vii) *The Right to Choose Whether or Not to Marry and to Found and Plan a Family* protects persons from marriages that are forced upon them; viii) *The Right to Decide Whether or When to Have Children* preserves women's right to regulate their fertility process; ix) *The Right to Health Care and Health Protection* includes the rights to information, access to the highest quality of health care, and protection from harmful traditional health care practices; x) *The Right to the Benefits of Scientific Progress* includes the rights of access to new, safe and acceptable reproductive technologies; xi) *The Right to Freedom of Assembly and Political Participation* states the rights to form an association to promote sexual and reproductive health and rights; xii) *The Right to be Free from Torture and Ill Treatment* includes the rights of children, women and men to be protected from sexual exploitation, abuse and harassment (IPPF, 2003: 8-22).

3. 0 Women's Problems in Realising Rights to Sexual and Reproductive Well-being

It is a matter of great regret that various socio-economic and cultural barriers do not allow women to realise their right to sexual and reproductive well-being. I shall now discuss some of the common problems which many South Asian women face in this regard.

3.1 Lack of Education: Education is indispensable in improving sexual and reproductive well-being. Better educated women are more likely to have a greater say in their sexual and reproductive rights and well-being. However, inequality exists in access to education. South Asia as a region has the largest gender gap in the world, 62% of young women can read and write compared to 72% of young men (World Bank, 2007: np). In Bangladesh girls' dropout rate from school by the age of 16 is five times that of boys (Field and Ambras, 2005: 4). Moreover, the education system in South Asia itself also tends to be ambivalent about sex education and teachers often find sexual and reproductive issues very embarrassing and shameful to discuss (Bott and Jejeebhoy, 2003: 21). In Bangladesh women are at risk of facing catastrophe because of an AIDS epidemic

since they have limited access to sexual information (Cash et al. in Hadi and Parveen, 2003: 38). Sex education through schools is not offered in Bangladesh (Islam et al. 1999 in Hadi and Parveen, 2003: 39) and communication between parents and children on topics of sexuality and reproduction is very limited (Bott and Jejeebhoy, 2003: 21). Cultural set-up of South Asian society is as such, issues like sex, reproduction, pregnancy, contraception, sexually transmitted diseases are not normally discussed among the adult members of the family. In fact, girls and women in this region lack adequate formal and informal education on issues of sexual and reproductive well-being. As a result, it becomes very difficult for them to realise and to exercise their rights to sexual and reproductive well-being.

3.2 Practise of Early Marriage: Early marriage is a cause of the early dropout of girls from formal education. In such marriages females have little power or sense of self-reliance and this directly affects their sexual and reproductive well-being. Compelled by the cultural norms, girls in Bangladesh usually marry well before their eighteenth birthday (Burket, Mary K et al, 2006: 2). A study reveals that many Bangladeshi girls are married soon after puberty, partly to free their parents from an economic burden and partly to protect the girls' sexual purity. Poor girls may be taken as a third or fourth wife of a much older man and spend their lives as sexual and domestic servants (UNICEF, 2001: 2). In Bangladesh girls are married off early because of tradition and also because dowry prices double if they are older when they enter the marriage market (Mamhud, 2000; Bangladesh Observer, 1999; The Independent, 1999 in Forum on Marriage and Rights of Women and Girls, 2000: 12). Poverty forces many parents to have their daughters marry as soon as possible since it is very difficult for them to manage a huge dowry for grown-up girls. Marriage before the age of 18 is practised in South Asian countries and in both India and Pakistan very early marriage (before 15 years) is also practised (Singh and Samara, 1993: 151). Any form of early marriage is a violation of human rights and makes young women extremely helpless since, in most of the cases, they are not allowed to make their own decisions about their sexual and reproductive rights such as when and whom to marry, whether or when to have sexual relations and when to bear a child (Bott and Jejeebhoy, 2003: 11). After marriage a young woman only learns to use her labour in the household activities and to use her body for her husband's sexual pleasure (Barakat and Majid, 2003: 5).

3.3 Inequality between Genders: Women's sexual and reproductive health is affected by existing gender inequality in society. Gender inequality pressurises women to marry early, to begin child bearing immediately and to engage in sexual activity as an obligation (Butler, 2004: 3). Gender inequality is a fact of life in South Asian societies where women are subordinated to men and are socially, culturally and economically dependent on them (Narayan et al., 2000 in Fikree and Pasha, 2004: 823). Although women in Bangladesh constitute nearly half of the population but they have less participation in economic, political and decision making processes which is very important in making decisions about reproductive and sexual well-being. In many societies preference for males is very powerful, and it results in long lasting neglect, deprivation and discriminatory treatment of the females throughout their lives (Hersh, 1998: np). From a South Asian perspective sons are perceived to be social, economic and religious utilities and daughters are seen as an economic burden (Arnold F. et al., 1998 in Fikree and Pasha, 2004: 823). A boy is treated as an asset to the family since it is expected that he will shoulder the familial responsibilities and honour of the family. Conversely, a daughter is simply a burden (Zaman, 1999: 41) says. Women, therefore, try to secure their position in the family by producing male children (Ahmad, 1991: 37). But it is women who are actually blamed if girls are born in the families. In India, every sixth infant death is a result of practises arising from preferences for sons (Heise LL. et al, 1994 in Hersh, 1998: np) that lead to the cruel practise of female infanticide (Singh J, 2000; Bindra S, 2003 in Fikree and Pasha, 2004: 824). In fact, women in South Asia rarely have any say about their sexual and reproductive well-being since, in terms of social and cultural expectations, women are always expected to be sexually available and compliant for their husbands (Rashid, 2006: 37) and to act as a production industry for male offspring.

3.4 Poor Healthcare Provision: Health care provision has a direct impact upon women's sexual and reproductive health. Most of the Bangladeshi women start child-bearing at an early age and despite the high risks, very few seek modern and professional health care during pregnancy or at childbirth (Khanam, 1994: 20). Poor quality health services, difficulties in transportation and great cost have prevented many Bangladeshi women from seeking medical care and from reaching a medical facility

(Pitchforth et al., 2006: 224). A study in Bangladesh reveals that even in a public hospital where maternity services are supposed to be free, a poor family has to pay an average of 7% of its annual household income to cover the substantial cost of a single case (Khan, 2005:1). This money covers many expenses, including items that the hospital is supposed to provide free, such as tests, medicine and food (Khan, 2005, 3). This is one of the reasons why poor people in Bangladesh opt for indigenous reproductive practises. In India women's medical services have a lower priority within the structure of health service provision than services for children and men (Jeefry et al., 1989: 216). The public reproductive health service is very poor in Pakistan (NIPS, 2001 in Sattar et al.: 221) and the majority of Pakistani women do not use public reproductive health services since their mobility is very restricted (NIPS, 2001 in Sattar et al.: 222). In rural areas where most South Asian people live, only 8.8% of deliveries are attended by a skilled attendant in Bangladesh, in India the figure is 33.5%, and in Pakistan it is 24.1% (UNFPA, 2005: np). Moreover, the doctor to patient ratio is also a significant indicator of the level of health care facilities for sexual and reproductive illness. Physician density per 1000 population is only 0.26 in Bangladesh, in India it is 0.60 and in Pakistan it is 0.74 (WHO 2007: np). In addition, only 5% of government expenditure is allocated to the health sector in Bangladesh, 3% in India and only 1% in Pakistan (Bhutta, 2004: 818). With such poor health care provision it is difficult for women and girls to have a healthy reproductive and sexual life. Poor healthcare provision does not give them the opportunity to realise their rights and stands as an obstacle to enjoy healthy sexual and reproductive life.

3.5 Problems with Using Contraceptive Methods: A woman needs to protect her body from infection, unwanted pregnancy and unsafe abortion. It is an essential part of her sexual and reproductive well-being. The use of contraception by both a woman and her husband can help in this regard. According to the report of 'Women of the World-South Asia', approximately 54% of married women aged 15-49 use some sort of contraception in Bangladesh. The figure is around 48% in India and only 27.6% in Pakistan (Centre for Reproductive Rights, 2004: 29, 69, 153). This means that most women in these countries do not use contraception. In Bangladesh and Pakistan religious misinterpretation always forms an obstacle to effective family planning programmes. In Bangladesh the

introduction of contraception methods for family planning faced aggressive opposition from many religious fundamentalists, and the fear of religious reprisals continues to make many women unwilling to accept certain contraceptive services, particularly sterilisation (Amin and Hossain, 1995: 3). The preference for sons also restricts women in using contraception. In India, a study reveals that women's future contraceptive use is connected with the number of living sons among their surviving children (Malhei and Jerath, 1997: np). A similar practise also prevails in Bangladesh where a couple who has only daughters tends to be less receptive to family planning and contraceptive use (Ullah and Chakrabarty, 1993: np). Gender based power inequalities lead to the belief that men should control women's sexuality and childbearing capacity. If women practise family planning by adopting contraceptive methods such control is curtailed (Blanc, 2001: 196). This is a fact of life for many women in South Asia since they have lower social status and less autonomy than men and such lower status is associated with lower fertility control (Saleem and Bobak, 2005: 2). In these circumstances it is difficult for women to realise and exercise their rights to sexual and reproductive well-being because they cannot make independent decisions about when to use contraceptives and when to not, which methods to adopt and which not to adopt.

If women are unable to realise and exercise their sexual and reproductive rights the consequences will be very serious. I shall now try to explore some of the factors and consequences related to their sexual and reproductive well-being in the context of these countries.

4. 0 Factors and Consequences

Following major difficulties are faced by many women in Bangladesh, Pakistan and India since they are not in a position to realise their rights to sexual and reproductive well-being.

4.1 Early Marriage and its Impact on Young Females' Sexual and Reproductive Well-being: Early marriage is a very common phenomenon in these countries. It is a great bar for women to realise their sexual and reproductive rights. It results in early motherhood and has severe consequences for young mothers and their babies. The maternal mortality rate in South Asian countries is too high for women aged between 15 and 19 years (Hersh, 1998: np). In recent years adolescent childbearing has become an issue of increasing concern in Bangladesh where early

marriage, combined with low levels of contraceptive use, has resulted in children being born early (Maitra and Pal, 2007: 1). Around 30% of adolescent females in Bangladesh are already mothers. In Bangladesh, pregnancy and motherhood occur before adolescents are fully developed physically and this leads them to particularly acute health risks during pregnancy and childbirth (Barakat and Majid, 2003: 9). A UNICEF study revealed that in India and Pakistan young married women are under considerable societal and familial pressure to prove their fertility (Chatterjee and Lambert, nd: np). During 1992-93, 48.6% of Indian women gave birth to at least one child by the age of 20. The figure was 30.5% in Pakistan between 1990 and 1991 (Sing, 1998:121). It is due to extreme social pressure which not only forces young girls to marry early but also to bear children early and such South Asian mothers are twice as likely as older women to die from pregnancy related problems (World Bank, 2007: np). If it is the situation young married females' sexual and reproductive lives are extremely vulnerable.

4.2 Multiple Child-bearing and its Impact on Women's Sexual and Reproductive Well-being: The rate of multiple child-bearing among women of all ages in South Asia is still very high and it creates many complicated problems. On average, Bangladeshi women have nearly 3.46 pregnancies in their lifetime. Indian and Pakistani women have 3.01 and 5.08 pregnancies respectively (Centre for Reproductive Rights, 2004: 29, 69, 153). It is a fact that frequent pregnancies for women in this region is due to the pressure for giving birth to male offsprings. That is why women in these countries have to sacrifice their sexual and reproductive rights by producing children at frequent intervals, which is a leading cause of maternal mortality. One in every forty two women in Bangladesh, one in every fifty-five women in India and one in every eighty women in Pakistan are at risk of maternal death (Centre for Reproductive Rights, 2004: 30, 69,116, 154). In Bangladesh, 25% of all deaths of women are caused by maternal death. Most of the deliveries are conducted by untrained hands and many of the deaths are due to obstetric complications such as haemorrhage and infection, lack of antenatal care, septic abortion etc. (Chowdhury, 1994: 31). On the other hand, as women are the most deprived members of the families, little emphasis is given to their nutritional needs, calorie intake or medical care (Farouk, 2005: np). About 45% of Bangladeshi mothers are malnourished and 70% of

pregnant women suffer from anaemic (Centre for Reproductive Rights, 2004: 44). Multiple childbearing, in fact, brings a lot of harm to women's sexual and reproductive well-being.

4.3 Unwanted Pregnancy and its Impact on Women's Sexual and Reproductive Well-being: Unwanted pregnancy creates many problems for South Asian women. Many women in this region do experience unwanted pregnancies because they are not allowed to independently exercise their sexual and reproductive rights. Globally about 48% of women aged 15-44 have experienced one unwanted pregnancy during their lifetime. The consequences of unwanted pregnancy are serious and impose burdens on children, women, men, families, and their societies (Moos, 2003; Brown and Eishenberg, 1995; Klima 1998 in Khan et al. 2006: 1, 2). Abortion is one of the leading causes of death of women in Bangladesh who want to end pregnancies which are unplanned, consequences of non-marital relations or of marriages that are yet to be recognised by the family members and pregnancies caused by sexual abuse (Barakat and Majid, 2003: 10). Abortion is illegal in Bangladesh unless the pregnancy is life-threatening, but menstrual regulation is allowed. To receive such services a woman needs her husband's consent and unmarried women do not have access to such services. Since they have no other alternative they opt for risky abortions (Chowdhury, 1994: 32). However, all sorts of abortion practises are still very unsafe in Bangladesh and 14% of all obstetric deaths are due to abortion complications (Barakat and Majid, 2003: 10). In Pakistan abortion is severely restricted and women are liable to prosecution (Bott and Jejeebhoy: 2004: 17). Pakistan allows abortion only if pregnancy is life threatening. Even such abortion services are rarely available in government establishments and many doctors are unwilling to offer it because of religious and personal beliefs (Centre for Reproductive Rights, 2004: 171). Hence, Pakistani women who really need it find themselves in an extremely disadvantaged position. A study revealed that in 1997 almost two-thirds of all abortions were done by poorly trained individuals in Pakistan (Centre for Reproductive Rights: 171). Abortion is legalised in India. However, in India abortion is done even in the fifth month of pregnancy and many of them are done by untrained practitioners (Shanti, 2005: 158). It is estimated that 20% of India's maternal mortality is due to unsafe abortion (Mira Shiva, 1991 in Centre for Reproductive Rights, 2004: 158).

4.4 Sexually Transmitted Diseases (STDs) and Their Impact on Women's Sexual and Reproductive Well-being: Sexually transmitted diseases are the second most common reason for loss of health in women around the world (Glasier et al., 2006: 1596). South Asia is no exception. Indian women are in the most vulnerable position in the region in terms of sexually transmitted diseases. If one considers only the statistics of HIV/AIDS, a very alarming picture is revealed. In 2001, 1.5 million Indian women had HIV/AIDS, and 16,000 Pakistani women were infected by HIV/AIDS in 2002 (Centre for Reproductive Rights, 2004: 87 172). In countries like Bangladesh and Pakistan where polygamy is widely practised women are more likely to be sexually infected by their husbands. However, it is very difficult for a woman to ask her husband to be tested, to seek treatment, or even to use a condom (Chowdhury, 1994: 34). In the context of Bangladesh a condom is viewed as a tool for fertility control rather than safe sex. Therefore, if a wife insists that her husband uses a condom, it may imply that she is unfaithful to her husband (Rashid, 2006: 73). A study in Bangladesh reveals that, in exchange of security and respectability, women overlook their husbands' behaviour and tolerate extramarital relations and co-wives (Rashid, 2006: 72). For most of the Bangladeshi women the risk of being beaten, divorced or abandoned and the fear of losing a source of emotional and financial support exceed the health risk of acquiring an STD (Chowdhury, 1994: 34). This is a form of violence against women. Sexually transmitted diseases are dangerous since they can cause permanent damage to women's sexual and reproductive systems.

5.0 Conclusion

The exercise of sexual and reproductive rights is very important for every woman in the world in order to have a healthy and safe life. It helps women to gain confidence and to make individual decisions about their own bodies and lives. The above discussion demonstrated that women's sexual and reproductive rights might sometimes be curtailed and they might not be allowed to exercise them on various grounds. Such practises are also increased when gender-discriminatory practises prevail in a particular society. South Asian women from Bangladesh, India and Pakistan face many problems in realising their rights to sexual and reproductive well-being and accordingly suffer from different physical and psychological difficulties. It should be noted that, in these countries,

women's sexual and reproductive lives are often controlled by men, and women have to lead their sexual and reproductive lives in the ways men desire since the practises of patriarchy are traditionally embedded in the nature of these societies. Moreover, women's economic dependency on men has limited their scope to gain control over their bodies and rights. This is a violation of human rights, a practise of humiliating human dignity and, as such, should not be allowed to continue. The declarations of international conventions in regard to women's sexual and reproductive well-being should be properly implemented at the state level, and people must be motivated about the core value of women's sexual and reproductive well-being since healthy women is a reflection of a healthy nation.

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