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Statement submitted by Asian-Pacific Resource and Research Centre for Women (ARROW), a non-governmental organization in consultative status with the Economic and Social Council*

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

* The present statement is issued without formal editing.

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Statement

Rural Women and Sexual and Reproductive Health and Rights

Asian-Pacific Resource and Research Centre for Women (ARROW), based in Malaysia, is an ECOSOC accredited NGO that has been working since 1993 to advance women's health and rights, empowering women through information and knowledge by monitoring international commitments, advocacy and mobilization. We work with national partners across the Asia-Pacific region and national and regional partners from the global South.

Women's experiences in various communities are very diverse yet there is a common thread among rural women's issues—rural women are "subjugated by cultural, social and patriarchal norms that have become institutionalized." They face "inequities based on gender [which] are rooted in organized oppression through class, caste, race and ethnicity," among other factors. (ARROW for Change, Rural Women and Sexual and Reproductive Health and Rights). A fundamental aspect of this is the control of women's sexuality and undermining women's sexual and reproductive health and rights. If women and girls do not have the right and access to make decisions on their own body, their sexuality, they are further pushed into poverty with unwanted pregnancies, poor health outcomes and increased impact on their health and well-being.

About 830 women die from pregnancy or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303,000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented (Lancet 2016). Maternal mortality is higher in women living in rural areas and among poorer communities. (WHO 2016). The unmet demand for family planning in developing countries, is generally greatest among women in the poorest 20 per cent of households. The poor are more likely to be rural, young, less educated and living in households with more children: 80 per cent of the extreme poor and 75 per cent of moderate poor live in rural areas, 45 per cent are younger than 15 years old (World Bank 2016).

Without access to contraception, poor women, particularly those who are less educated and live in rural areas, are at heightened risk of unintended pregnancy. This may result in health risks and lifelong economic repercussions. The lack of power to decide whether, when or how often to become pregnant can limit education, delay entry into the paid labour force and reduce earnings (UNFPA, State of World's Population 2017). This continues the cycle of poverty, further marginalizing the women in poor, rural and hard to reach areas.

Further, social determinants such as poverty, educational status, food and nutrition, water and sanitation affect health outcomes. Caste, class, religion, gender-based inequalities, disability, and geographical location further worsens the condition and adversely impact the health of women, children, and young people. In addition, difficult geographical terrain also limits access to health services and information. There are no shortcuts to achieving equitable access to good quality comprehensive reproductive health services (ARROW, Fulfilling Women's Right to Continuum of Quality Care).

In many developing countries, women who are poor, in the bottom 20 per cent of the income scale, and particularly those who are in rural areas, are far less likely to have access to contraceptives and to care during pregnancy and birth than their wealthier urban counterparts. Among adolescents, who face the extra vulnerabilities associated with being young, those in the poorest 20 per cent of households in

developing countries have about three times as many births as adolescents in the richest 20 per cent of households. Those in rural areas have twice as many births as their counterparts in cities (UNFPA, State of World's Population 2017).

Rural women have always been the unsung heroes of food and agricultural production. Unseen by the world, forgotten by the public, and least prioritized by politicians, rural women toil night and day to feed their families, communities, and people from all around the world. They perform crucial roles as seed savers and land tillers, as community leaders, and family managers. Yet, rural girls and women are still the ones who eat the last and the least, who are not sent by their parents to school, who are forced into early marriage, who die giving birth or who are weakened by closely spaced births, who hide in their homes during menstruation, who are forced to have unsafe abortions, who have never seen a doctor or a nurse, who have had their genitals cut, and who everyday face stigma and violence, trapped in patriarchal power structures that pervade deep into unequal socio-economic structures. (ARROW, Our Stories, Our Journey; Empowering Rural Women on Sexual and Reproductive Health and Rights, 2014).

Additionally, out of pocket or self-financing is the largest source of healthcare financing in South Asia. This has been both regressive and iniquitous, especially for poorer households at the threshold of subsistence. Within this, abortion services are among the most privatized services for women, legal or illegal. But those who study health systems and policies tend to avoid specific types of health services, and discuss health systems as a whole (Marge Berer, Reproductive Health Matters 2010).

Poor women in rural areas have less access to quality antenatal and obstetric care than wealthier women in urban areas. An estimated one quarter of pregnant women in developing countries today lack access to skilled birth attendants, and many have no alternative but to deliver on their own (UNFPA, State of World's Population 2017). The poor in low and middle-income countries have limited access to health services due to limited purchasing power, residence in underserved areas, and inadequate health literacy. This produces significant gaps in health care delivery among a population that has a disproportionately large burden of disease (Marge Berer, Reproductive Health Matters 2010).

Recommendations:

- Measures to achieve gender equality and empowerment of rural women should encompass full range of sexual and reproductive health and rights.
- States must address unmet need for all SRHR information and services including contraception for rural women by providing comprehensive sexuality education and quality SRHR services including modern contraception, irrespective of their marital status and reach out especially to women in rural areas.
- States should ensure Ensuring a Continuum of Quality Care (CQC) across a woman's life cycle — from preconception and pregnancy, to postpartum/post-abortion and menopause, and across various locations, e.g., home, community, and health facilities — is important to reduce adolescent, maternal, new-born, and child mortality and morbidity and improve women's reproductive health.
- States should ensure that the number of domestically trained health workers is commensurate with the health needs of the population, subject to progressive realization and resource availability. In this context, appropriate balances must be struck between, for example, the number of health workers at the community or primary level and specialists at the tertiary level.

- States should make full range of contraceptive and abortion services available to all women but with special attention to women in the hard to reach areas.
- States must increase the number of community health workers in rural, hard to reach and peri-urban areas, trained in SRHR service provision and innovative behaviour change communication programs.