

AWARENESS. ANALYSIS. ACTION.

SEXUAL AND REPRODUCTIVE HEALTH
AND RIGHTS IN THE PACIFIC



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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE PACIFIC

Produced by the Sexual and
Reproductive Health and Rights
Working Group

Secretariat of the Pacific Community



Suva, Fiji, 2015



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- ◆ Development Alternatives with Women for a New Era
- ◆ Diverse Voices and Action for Equality
- ◆ Fiji Women's Rights Movement
- ◆ International Planned Parenthood Federation
- ◆ Oceania Society for Sexual Health and HIV Medicine
- ◆ Pacific Islands Forum Secretariat
- ◆ Pacific Youth Council
- ◆ Secretariat of the Pacific Community
- ◆ United Nations Population Fund

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Introduction

A number of United Nations treaties and other international and regional policies and consensus documents make a commitment to providing citizens with the highest attainable standard of sexual and reproductive health and rights. The most notable of these are highlighted in the diagram on the opposite page.

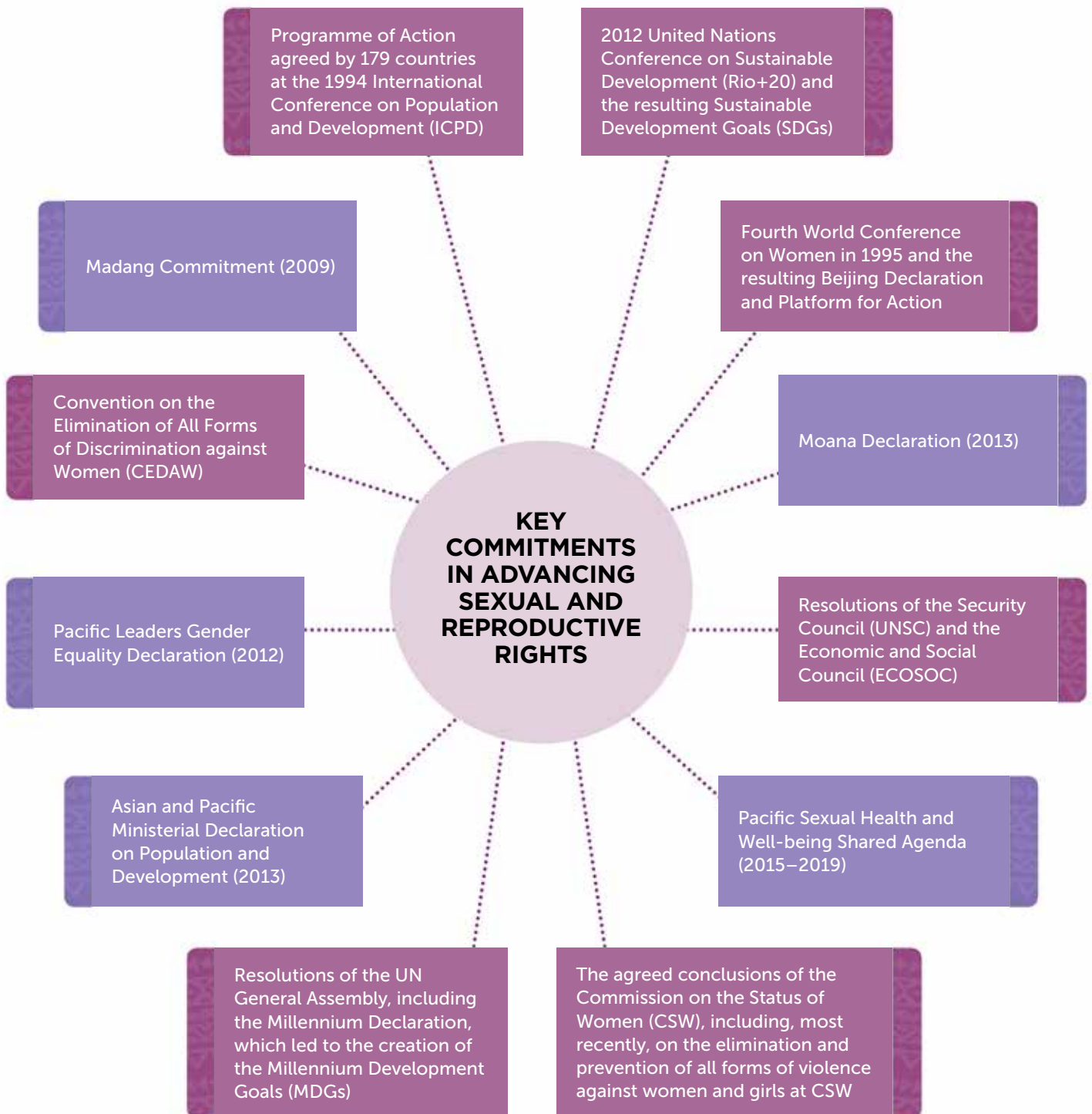
At home in the Pacific region, there has been some significant progress towards achieving the SRHR goals embedded in these commitments. The number of Pacific Island countries with national population policies is steadily increasing and the integration of sexual and reproductive health into primary health programmes has also improved.¹ Reducing child mortality is an area where the Pacific region is doing particularly well, with 10 of the 14 Forum island countries on track to achieving this goal.² The small island states of Cook Islands, Fiji, Nauru, Niue, Palau, Republic of the Marshall Islands, Samoa, Tonga and Tuvalu have also made notable progress in reducing maternal mortality, reporting close to 100 per cent skilled birth attendance.³ These gains would not have been possible without a consistent and unified effort from SRHR advocates across government and civil society.

Despite this progress, immense challenges remain and, overall, in many Pacific Island countries and territories (PICTs), poverty, vulnerability and exclusion are on the rise.⁴ Specific SRHR issues in the Pacific region include endemic levels of gender-based violence; low contraceptive prevalence rates (below 50 per cent across the Pacific); stigmatisation, discrimination and a lack of confidentiality in many health services; hyper-endemic levels of sexually transmitted infections (on average one quarter of sexually active young people in the Pacific have an STI); and high rates of teenage pregnancy.

2014–2015 is a critical time for the global sexual and reproductive health and rights (SRHR) agenda. The year 2014 marked 20 years since the ground-breaking Cairo Consensus emerged from the 1994 International Conference on Population and Development (ICPD), and 2015 marks 20 years since the Fourth World Conference on Women in 1995 and the resulting Beijing Declaration and Platform for Action, as well as the deadline for achieving the MDG targets. Never has there been such a crucial time for SRHR advocates around the world to unite and ensure that SRHR remains a global priority in the Post-2015 UN Development Agenda.

In the Pacific, an important first step in ensuring SRHR in the region is prioritised is to address the shortage of practical information on SRHR that is tailored to the unique needs and challenges of the region. To fill this gap, the SRHR Working Group has produced this manual. It has practical, evidence-based tools and information to help practitioners understand key concepts in SRHR, analyse the needs of vulnerable and marginalised groups, and take action to ensure that all Pacific Islanders claim their right to the highest possible standard of health and wellbeing.

2. The 14 Forum island countries are Cook Islands, FSM, Fiji, Kiribati, RMI, Nauru, Niue, Palau, PNG, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.

**KEY**

Regional commitments

International commitments

How to use this manual

This manual is structured in three modules:

Module 1: Awareness

In this module you'll learn about some of the key concepts in SRHR, the legal and policy frameworks that guide SRHR at an international, regional and national level and the specific issues in the context of the Pacific region.

Module 2: Analysis

In this module you'll gain a better understanding of the needs and challenges of a number of vulnerable and marginalised individuals and groups who face the greatest barriers to claiming their sexual and reproductive health and rights.

Module 3: Action

In this module you'll find out how to take action to advance SRHR across five key areas. This section includes practical strategies and best practice case studies being carried out in the Pacific region.

Keep an eye out for the following icons throughout the manual!



INVESTIGATE

Every Pacific Island country is different. Throughout the manual we'll be encouraging you to find out what is happening in the context of your country or community.



WORKING GROUP TIP

Throughout the manual you'll find useful information and advice from the SRHR Working Group members.



REFLECT & DISCUSS

Throughout the manual we'll be encouraging you to stop and reflect on key points and discuss your thoughts with those around you.



ACTIVITY

Use these practical activities to get a better understanding of the issue at hand. You can use these in your work team or in a classroom setting.



QUIZ

At the end of each learning objective you'll find a short quiz to help you test your skills and knowledge on SRHR.

Module 1

Awareness

In this section we'll explain exactly what we mean by the term sexual and reproductive health and rights (SRHR) and provide an overview of key legislative and policy frameworks and specific SRHR issues in the Pacific region.

Learning objectives:

- 1 Define key concepts in sexual and reproductive health and rights.
- 2 Understand sexual and reproductive health and rights legislative and policy frameworks.
- 3 Recognise the role of civil society organisations in advancing sexual and reproductive health and rights.
- 4 Identify sexual and reproductive health and rights issues in the Pacific context.

1

Define key concepts in sexual and reproductive health and rights

Our understanding of SRHR is influenced by our personal and professional context. For example:



If you are a community worker: you probably have a good understanding of the sexual and reproductive health needs of the community you work in.



If you are a policy maker: you might have a good understanding of the sexual and reproductive health needs of entire population groups.



If you are an activist: you might be familiar with specific needs and barriers faced by vulnerable and marginalised groups.



If you are a lawyer: you might have a good understanding of the legal obligations of the government to provide services to its citizens.



If you are a health worker: you might have a good understanding of the symptoms and treatment options for different health conditions.

Before we go any further, it is important that we have a shared understanding of what we mean when we talk about sexual and reproductive health and rights.



**REFLECT
& DISCUSS**

How has your personal and professional background influenced your understanding of sexual and reproductive health?

Sexual and reproductive health and rights (SRHR)

You are going to see the abbreviation SRHR throughout this manual, so it is important that you understand exactly what it means.

In other publications you may see references to phrases such as 'sexual and reproductive health' (without mention of rights) or 'reproductive rights' (without mention of sexual rights). In our opinion, this terminology is incomplete – we prefer to use the term 'sexual and reproductive health and rights' or SRHR for short.

SRHR encompasses our sexual and reproductive health and our sexual and reproductive rights, but it is much more than that. SRHR is an approach to sexuality and reproduction that acknowledges the crucial link between them.

Simply put, without the realisation of human rights we cannot achieve good sexual and reproductive health and without good sexual and reproductive health we cannot realise our human rights.

Let's break down the individual components of SRHR and look closer at their meanings.

Sexual and reproductive **health** and rights

Let's start by looking at the word 'health'. This is important, because there are different ways of defining the concept of health, depending on the context you are working in.

Some people use a strictly medical definition of the term health – the idea that the presence or absence of disease and illness determines whether we are sick or healthy. SRHR advocates, however, prefer to use the much more holistic definition of health put forward by the World Health Organization (WHO):

➤ *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.⁵*

WHO's definition of health refers to what is known as the 'social determinants of health', which are the conditions in which people are born, grow, live, work and play and how they affect our health, safety and wellbeing.⁶ The social determinants of health are enshrined in the 1986 Ottawa Charter for Health Promotion, which lists eight fundamental conditions and resources required to achieve good health:

1. peace
2. shelter
3. education
4. food
5. income
6. a stable eco-system
7. sustainable resources
8. social justice and equity

These social determinants of health are important when discussing SRHR because they help us realise that focusing on individual behaviour change (such as contraceptive use) is not enough to achieve long-term sexual and reproductive health unless we also address the underlying social conditions that create poor health outcomes in the first place. These underlying drivers of poor sexual and reproductive health are complex, interlinked and often deeply entrenched in our cultural and religious beliefs.

Throughout this manual, we will introduce you to some of the social determinants of health that affect people's access to sexual and reproductive health services in the Pacific region.

Sexual and reproductive health and rights

The International Conference on Population and Development Programme of Action defines reproductive health as:

► *...a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.⁷*

Sexual and reproductive health and rights

WHO has offered the following working definition of sexual health:ⁱ

► *...a state of physical, emotional, mental and social well-being in relation to sexuality. Sexual health is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained, and maintained, the sexual rights of all persons must be respected, protected and fulfilled.⁸*

ⁱ This working definition was developed through a consultative process with international experts beginning with the Technical Consultation on Sexual Health in January, 2002. They reflect an evolving understanding of the concepts and build on international consensus documents such as the ICPD Programme of Action and the Beijing Platform for Action. These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

WHO has identified the following key elements relating to sexual health:

- ◆ Reproductive tract infections (RTIs) and STIs (including HIV)
- ◆ Unintended pregnancy and safe abortion
- ◆ Sexual dysfunction and infertility
- ◆ Violence related to gender and sexuality
- ◆ Young people's sexual health and sexual health education
- ◆ Sexual orientation and gender identity
- ◆ Mental health issues related to sexual health
- ◆ The impact of physical disabilities and chronic illnesses on sexual wellbeing
- ◆ The promotion of safe and satisfying sexual experiences



INVESTIGATE

What are some of the critical sexual and reproductive health issues facing your country?

What is the difference between sexual health and reproductive health?

People have sex for a whole range of reasons. Reproduction is one of these reasons but there are many others, including pleasure or to earn an income. In some cases, people are forced to have sex against their will. Because sex does not always result in reproduction and is not always carried out for that purpose, it is important to have a definition of sexual health that is separate and distinct from reproductive health.

The main difference between sexual health and reproductive health is that sexual health encompasses areas of a person's life and well-being outside of the reproductive system and its functions and processes; the core area of focus of reproductive health. For example, sexual health includes sexual assault and violence, mental health and sexual orientation and gender identity. While there are differences between the two terms, it is important to remember that they are closely linked. For example, it is not possible to achieve reproductive health and well-being without first achieving sexual health and well-being. Similarly, reproductive health has been identified as an entry point for improved sexual health.⁹

When viewed holistically and positively, sexual and reproductive health:

- ◆ is about wellbeing, not merely the absence of disease;
- ◆ involves respect, safety and freedom from discrimination and violence;
- ◆ depends on the fulfillment of certain human rights;
- ◆ is relevant throughout the individual's lifespan, not only in the reproductive years, but also during youth and old age;
- ◆ is expressed through diverse sexualities and forms of sexual expression; and
- ◆ is critically influenced by gender norms, roles, expectations and power dynamics.¹⁰



REFLECT & DISCUSS

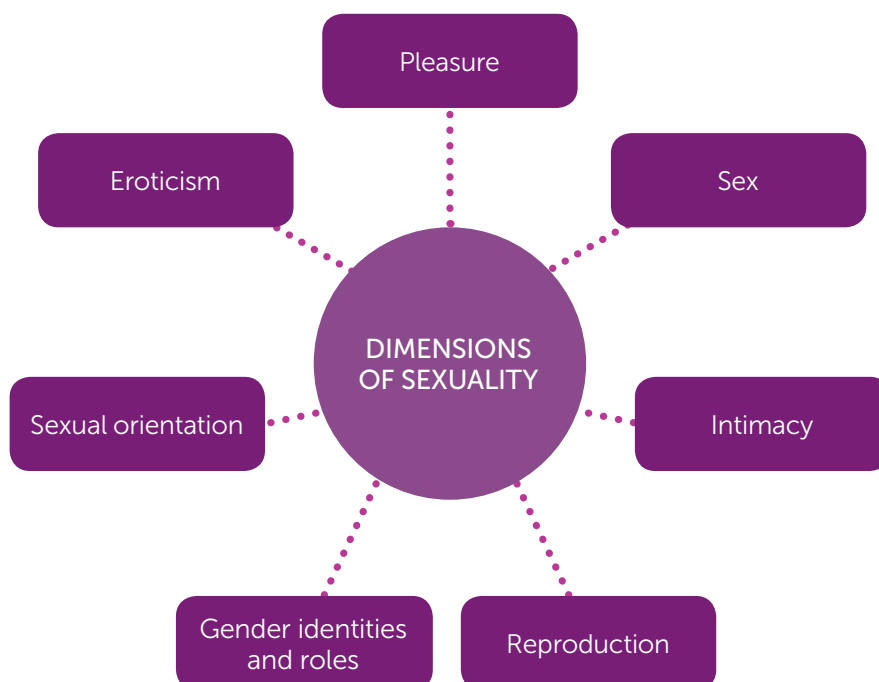
WHO defines both sexual health and reproductive health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

What does this mean? Why is it important to take a holistic approach to sexual and reproductive health?

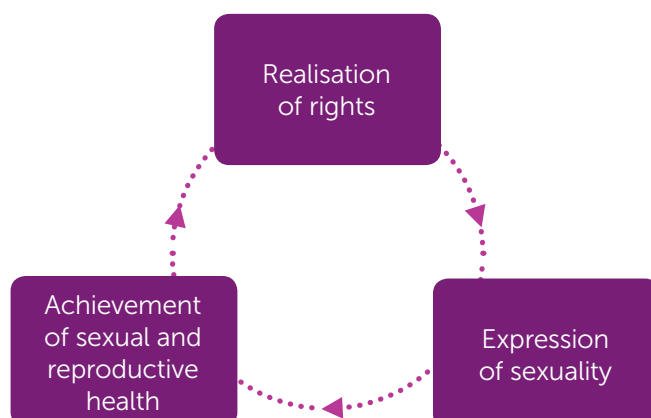
Sexual-ity and reproductive health and rights

Have you ever wondered about the difference in meaning of the words 'sex' and 'sexuality'? The term sex refers to the physical and biological characteristics that make us male or female but the term sexuality has a much broader meaning. Sexuality includes sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical legal, historical, religious and spiritual factors.¹¹

Unlike sex, sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. It is not possible to realise one's sexual health without consideration or expression of one's sexuality, which underlies many behaviours associated with sexual health.



A person's ability to freely express their sexuality, without fear of discrimination or violence, is crucial to both the achievement of good sexual and reproductive health and the realisation of SRHR (and therefore human rights more broadly).



**REFLECT
& DISCUSS**

Are you able to fully express your sexuality without fear of violence and discrimination? Why/why not?

Sexual and reproductive health and rights

Human rights are the basic freedoms and protections that we are all entitled to. Among them are our sexual and reproductive rights. Our basic human rights were set out in the Universal Declaration of Human Rights (UDHR), adopted by the United Nations General Assembly on 10 December 1948.

Sexual and reproductive rights are not a separate and distinct set of human rights; rather, they refer to certain rights that are already recognised in international and regional human rights documents and in national laws, which are critical to the realisation of SRHR.

All members of the community, regardless of their age, ethnicity, religion, sexuality, ability or marital status, have the right to the highest standard of sexual and reproductive health.

This is enshrined in Article 25 of the UDHR, which states that:

➡ *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...*

Other articles of UDHR, including Articles 3, 5, 16, 26, also relate to the realisation of SRHR.

In this section, we'll discuss the definitions of sexual and reproductive health and rights and what it means to take a rights-based approach to sexual and reproductive health. In the next section, you'll learn about some of the key international human rights frameworks and how they are being used to ensure that Pacific Islanders enjoy the highest standard of sexual and reproductive health.

Sexual and reproductive health and rights

Building on their definition of reproductive health, the International Conference on Population and Development Programme of Action uses the following definition of reproductive rights:

► *... reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.¹²*

Sexual and reproductive health and rights

WHO has offered the following working definition of sexual health:ⁱⁱ

► *They include the right of all persons, free of coercion, discrimination and violence, to:*

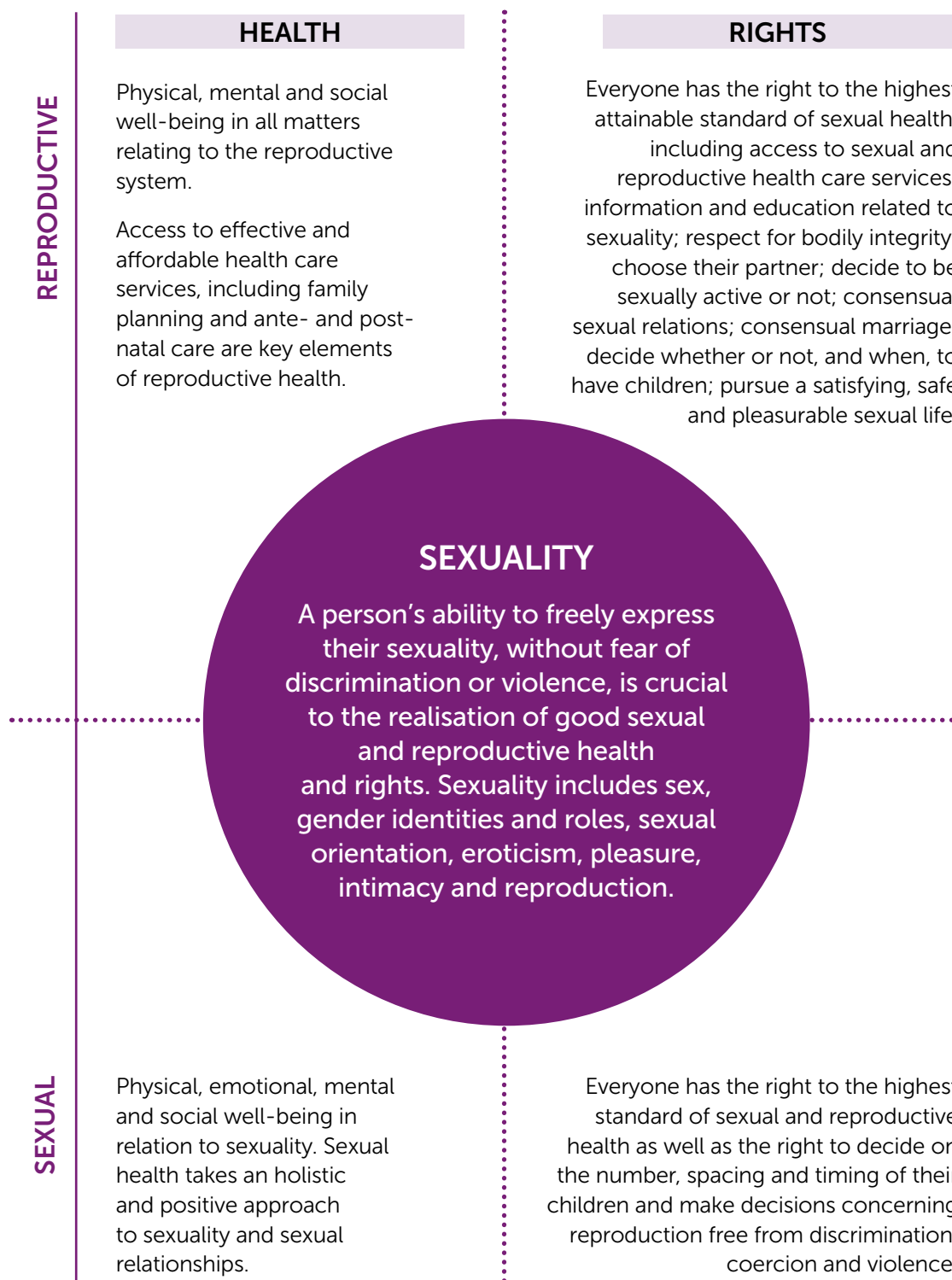
the highest attainable standard of sexual health, including access to sexual and reproductive health care services;

- ◆ *seek, receive and impart information related to sexuality;*
- ◆ *sexuality education;*
- ◆ *respect for bodily integrity;*
- ◆ *choose their partner;*
- ◆ *decide to be sexually active or not;*
- ◆ *consensual sexual relations;*
- ◆ *consensual marriage;*
- ◆ *decide whether or not, and when, to have children; and*
- ◆ *pursue a satisfying, safe and pleasurable sexual life.¹³*

There is a growing consensus that sexual and reproductive health cannot be achieved and maintained without respect for, and protection of human rights. At the same time, good sexual and reproductive health is essential to realising a wide range of basic human rights.

ⁱⁱ This working definition was developed through a consultative process with international experts beginning with the Technical Consultation on Sexual Health in January, 2002. They reflect an evolving understanding of the concepts and build on international consensus documents such as the ICPD Programme of Action and the Beijing Platform for Action. These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS



Taking a rights-based approach to sexual and reproductive health

In recent years there has been increasing recognition that a rights-based approach is crucial in ensuring communities achieve optimal sexual and reproductive health.

A rights-based approach to sexual and reproductive health seeks to integrate the norms, standards and principles of international human rights agreements into national laws, policies and plans to promote health and development.

Examples of human rights critical to the realisation of sexual and reproductive health include:

- ◆ the right to life, liberty, autonomy and security of the person;
- ◆ the right to education and access to information (including on sexual and reproductive health issues);
- ◆ the right to privacy;
- ◆ the right to non-discrimination;
- ◆ the right to be free from torture or cruel, inhumane or degrading treatment or punishment;
- ◆ the right to self-determination within sexual relationships; and
- ◆ the right to the highest attainable standard of health, including sexual health.

ESSENTIAL ELEMENTS OF A RIGHTS-BASED APPROACH TO SRHR*

Availability: There must be an adequate number of functioning health care facilities, services, medicines and programmes to serve the population.

Accessibility: People must be able to access health facilities and services without discrimination, particularly the most vulnerable populations.

Acceptability: Health facilities, services, and goods must be culturally appropriate and take into account the interests and needs of minorities, indigenous populations, and different genders and age groups.

Quality: Sexual and reproductive health care must be of good quality, meaning that it is scientifically and medically appropriate and that service providers are adequately trained and supported in their roles.

*Adapted from www.reproductiverights.org

You'll find some practical strategies for advancing SRHR in Module 3 of this manual.



ACTIVITY

My rights in a picture

Time

30 minutes

Materials

Activity

Resource 1:

My Rights in a Picture Worksheet on Page 130.

Overview

This activity will help you imagine what it would look like if SRHR were a reality for all. It is also a useful activity to teach other people, especially children, about SRHR.

Instructions

Using the worksheet provided on page 130 (or create your own) draw a person whose sexual and reproductive rights have been met. Use statements like the ones shown in the example below.

I am in a respectful relationship, free from violence.

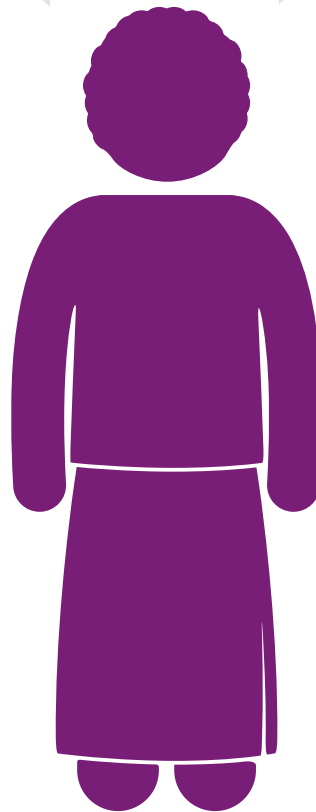
I am able to protect myself from STIs and HIV.

I am empowered to decide the number of children I want and when to have them.

I am free to express sexuality without discrimination.

I am a participating and productive member of the community.

I am easily able to access quality and appropriate SRH services and information.





ACTIVITY

Sexual and reproductive rights report card

Time

30 minutes

Materials

None

Overview

This activity will help you map the extent to which sexual and reproductive rights are being realised in your country.

Instructions

As a group, discuss the extent to which the following sexual and reproductive rights have been realised in your country or community. Record your answers below.

Sexual and reproductive rights	Achieved	Not achieved	Partially achieved	Don't know
All persons have the highest attainable standard of sexual and reproductive health.				
All persons can access sexual and reproductive health care services.				
All persons can seek, receive and impart information related to sexuality.				
All persons are able to access sexuality education.				
All persons are able to choose their partner.				
All persons can decide whether to be sexually active or not.				
All persons are able to partake in consensual sexual relations (not forced into sex).				
All persons are able to partake in consensual marriage (not forced into marriage).				
All persons are able to pursue a satisfying, safe and pleasurable sexual life.				
All couples and individuals can decide on the number, spacing and timing of their children and have the information and means to do so.				
All persons are able to make decisions concerning reproduction free of discrimination, coercion and violence.				
All persons are able to freely choose and express their sexual orientation and gender identity, without criminalisation or discrimination.				

Useful resources

Title: The Ottawa Charter for Health Promotion.

Author: World Health Organization (WHO) (1986).

Link: www.who.int/healthpromotion/conferences/previous/ottawa

Title: The Social Determinants of Sexual and Reproductive Health: Informing future research and programme implementation.

Author: World Health Organization (WHO) (2010).

Link: www.who.int/social_determinants/tools/WHO_SocialDeterminantsSexualHealth_2010.pdf

Title: Social Determinants of Sexual and Reproductive Health.

Author: Women's Health West (2011).

Link: <http://whwest.org.au/resource/social-determinants-of-sexual-and-reproductive-health-report-2011/>

Title: Defining sexual health: report of a technical consultation on sexual health.

Author: World Health Organization (WHO) (2006).

Link: www.who.int/reproductivehealth/publications/sexual_health/defining_sh

Title: Know Your Rights.

Author: Regional Rights Resource Team (RRRT).

Link: www.youtube.com/RRRTpacific

Title: Realizing Sexual and Reproductive Rights. A human rights framework.

Author: Amnesty International (2011).

Link: www.amnesty.org/en/library/info/ACT35/006/2012

Title: A Human Rights Based Approach to Programming.

Author: UNFPA/Harvard School of Public Health (2010).

Link: <http://www.unfpa.org/public/op/preview/home/publications/pid/491>

Title: The Universal Declaration of Human Rights.

Author: United Nations (1948).

Link: <http://www.un.org/en/documents/udhr/>

Understand legislative and policy frameworks that promote sexual and reproductive health and rights

There are a number of legislative and policy frameworks at international, regional and national levels that work together to enhance SRHR. These laws and policies achieve change in a number of ways, including by encouraging Pacific Island countries to provide comprehensive sexual and reproductive health services to their citizens in line with international standards and providing sanctions against those who discriminate against individuals in the delivery of such services.

Law: An enforceable code that regulates the behaviour of individuals, organisations and governments. Laws should reflect the values of the society that creates them and respond to changing needs within that society.

Policy: A rule that sets out how a government, organisation or group plans to approach a certain issue. Simply put, a policy is the rationale, or purpose of the law that describes how it will be implemented in practice.

International legislative and policy frameworks are the agreements and strategies developed and monitored by the United Nations. These include the UN Human Rights Treaty System (made up of various conventions that member states can ratify) and other consensus agreements and outcomes documents.

Regional legislative and policy frameworks are the agreements and strategies supported by regional organisations, such as the Pacific Islands Forum, Pacific members of parliament and civil society organisations.

National legislative and policy frameworks are the laws and policies that govern the actions of individual countries. These laws and policies are different from country to country but in theory should be guided by the principles set out in regional and international agreements (although this is not always the case).

International legislative and policy frameworks

Sexual and reproductive health is among the *'most sensitive and controversial issues in international human rights law, but they are also among the most important.'*¹⁴

Commitments towards SRHR are included in a number of international human rights conventions and consensus documents, which together influence the global agenda for the achievement of sexual and reproductive health and rights.

This section of the manual examines three of the most critical international frameworks relating to SRHR:

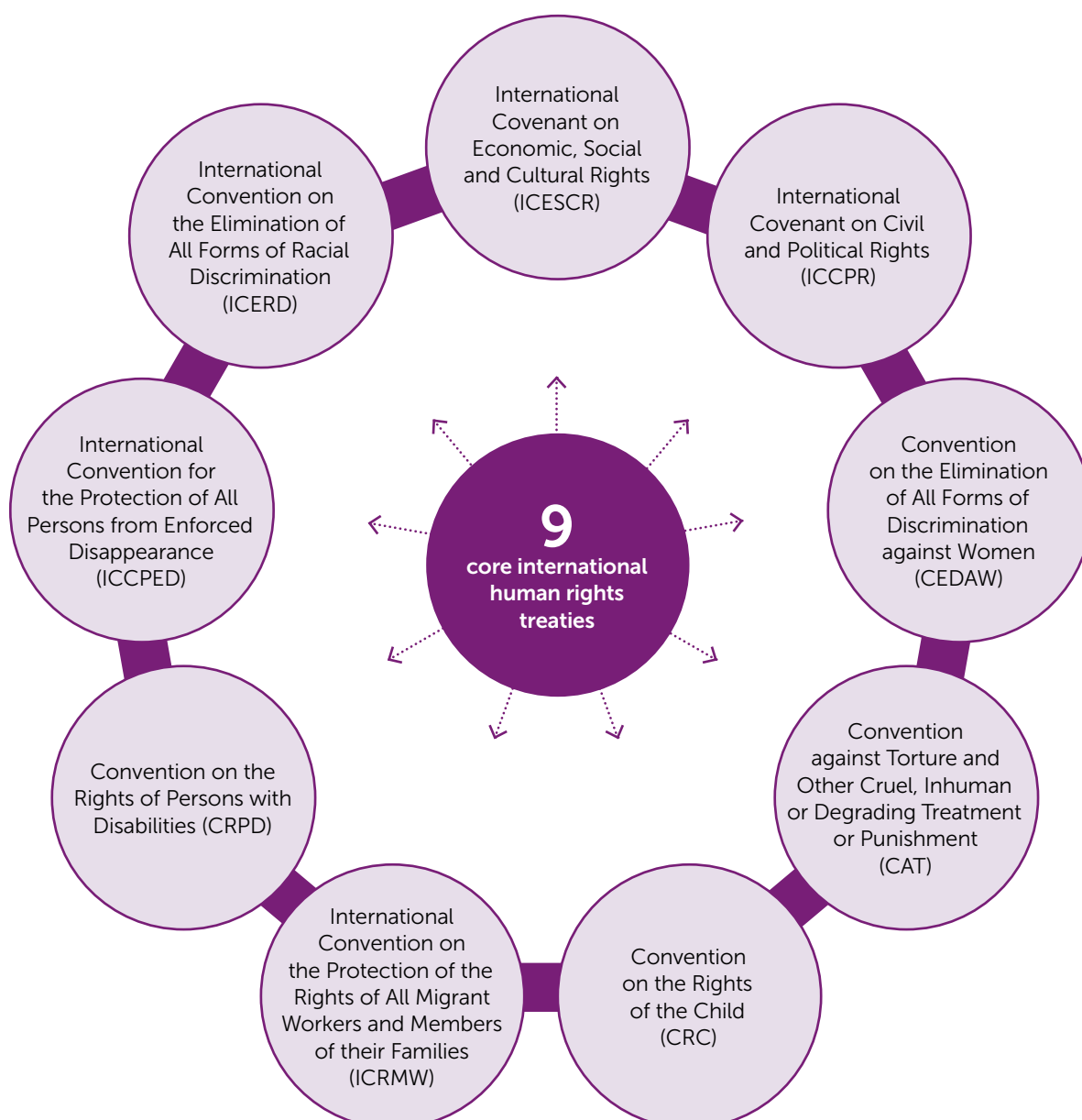
- ◆ The UN human rights treaty system;
- ◆ The ICPD Programme of Action (PoA) and subsequent reviews;
- ◆ The Post-2015 UN Development Agenda.

This is not an exclusive list of all of the international agreements relating to SRHR. Further information about some international agreements relating to specific population sub-groups (including women, youth and people with disabilities) can be found in Module 2 of this manual.

1. The UN human rights treaty system

While the Universal Declaration of Human Rights represented the first internationally agreed definition of human rights, it is not directly legally binding. It did, however, lay the groundwork for a system of enforceable human rights treaties that were developed in the years following.

The UN human rights treaty system consists of nine core international human rights treaties to which member states can subscribe by becoming a party. Together, these treaties set international standards for the protection and promotion of our human rights, including our sexual and reproductive rights:



Sexual and reproductive health and rights in the human rights treaty system

Most of the nine human rights treaties mention sexual and reproductive rights to some extent, although some focus on it in more detail than others.

The International Covenant on Economic, Social and Cultural Rights (ICESCR)

References to sexual and reproductive health in ICESCR include Article 12, which recognises the right to the enjoyment of the highest attainable standard of physical and mental health and Article 15, which recognises the right to enjoy the benefits of scientific progress (including medical technology and advancements) and its applications.

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)

Some abuses of SRHR are so severe that they amount to torture, including harmful cultural practices such as female genital mutilation (FGM) and forced medical treatment (including sterilisation) of people with disabilities. CAT obligates States to protect their citizens against these forms of torture and other cruel, inhuman or degrading treatment.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Article 10 requires member states to provide equal access to educational information to help ensure the health and wellbeing of families, including information and advice on family planning.

Article 12 prohibits discrimination in the field of health care and ensures equal access to health care services including family planning.

Article 14 states that women in rural areas have access to adequate health care facilities, including information counselling and family planning services.

Article 16 gives women the right to choose their spouse and the number and spacing of their children, and to have access to the information, education and means to exercise these rights.

The International Covenant on Civil and Political Rights (ICCPR)

ICCPR protects a number of sexual and reproductive rights. For example, Article 6 recognises the right to life, Article 9 asserts that everyone has the right to liberty, Article 17 protects the right to privacy, while Article 7 states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment, including being subjected to medical or scientific experimentation without their full consent.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW)

Around the world, migrant workers, particularly women, routinely have their human rights violated in ways that affect their sexual and reproductive health. For example, migrant workers risk being trafficked into sexual slavery or experience violations of their SRHR at work, such as forced pregnancy and HIV tests.

The Convention on the Rights of Persons with Disabilities (CRPD)

Article 22 asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.

Article 23 requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life.

Article 25 requires that states ensure equal access to health services for persons with disabilities, with specific mention of sexual and reproductive health services.

The Convention on the Rights of the Child (CRC)

In many countries, children are especially vulnerable to sexual exploitation and abuse, particularly in times of war and conflict. CRC recognises the right of children to the highest attainable standard of health and access to health facilities, and the right to protection from all forms of sexual exploitation and abuse.



INVESTIGATE

Which of these nine human rights treaties has your country ratified?

2. The ICPD Programme of Action (PoA)

The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and sexual and reproductive health. At the ICPD, 179 countries, including Pacific Island countries, adopted a twenty-year Programme of Action (PoA) that placed the right to sexual and reproductive health, as well as gender equality and women's empowerment, at the core of its recommended population development strategies.

The ICPD PoA, sometimes referred to as the Cairo Consensus, sets out a series of priority issues, including population and development, gender equality and equity, reproductive health and rights, and adolescents and youth. It describes the actions needed in response, with agreed goals and a twenty-year timeframe for achieving them, and identifies the bodies responsible for action. The ICPD PoA is rooted in principles of human rights and respect for national sovereignty and religious and cultural differences.



You may hear the ICPD PoA referred to as the 'Orange Bible' because the cover is orange and it contains lots of important information!

The following Pacific Island countries were represented at the 1994 ICPD:



Progress towards the ICPD PoA

In December 2010, in light of the fact that many governments were unlikely to meet the goals and objectives of the ICPD PoA by 2014, the UN General Assembly mandated a comprehensive review of its progress. In doing so, it passed Resolution 65/234, which called to extend the ICPD PoA beyond 2014 without renegotiation of the existing agreement.

The objective of the ICPD Beyond 2014 Global Review was to deliver the most comprehensive evidence base of achievements, gaps and outstanding issues in relation to the implementation of the ICPD PoA since its initial negotiation in 1994. To gather these data, the ICPD Beyond 2014 Secretariat worked in partnership with civil society, governments and technical experts to develop a global survey tool that gathered information against a number of key indicators relating to each ICPD thematic area.

Overwhelmingly, the evidence supports the ICPD consensus that the respect, protection, promotion and fulfillment of human rights are necessary preconditions to improving the development, dignity and wellbeing of all people. It also supports the premise of the ICPD PoA that sexual and reproductive health and rights and an understanding of the implications of population dynamics are critical foundations for sustainable development.

Unfortunately, however, the review also found that few governments have achieved either the deep and broad progress in specific sectors or the multi-sectoral implementation envisioned by the Programme of Action. For example, few countries have made measurable progress toward integrated sexual and reproductive health services or managed to provide comprehensive education on human sexuality to all adolescents and youth. Further, the report notes that the empowerment of women and gender equality remain unfulfilled objectives of the ICPD PoA and that many individuals and groups, including women and girls; young and older persons; persons with disabilities; people living with HIV and AIDS and lesbian, gay, bi-sexual, transgender, queer, intersex (LGBTQI) persons continue to be exposed to discrimination and violence.

The Pacific component of the review was undertaken in 2012 and it collected up-to-date data to measure progress towards ICPD goals. Fourteen independent PICTs were surveyed: Fiji, Papua New Guinea, Solomon Islands, Vanuatu, Federated States of Micronesia, Kiribati, Nauru, Palau, Republic of the Marshall Islands, Cook Islands, Niue, Samoa, Tonga and Tuvalu.

The review found that substantial resources, both human and financial, had been devoted to building capacity and extending and delivering services to communities. It also acknowledged the remaining challenges, mostly posed by the geography of the Pacific and the small, scattered populations, which make economies of scale difficult to achieve.

The Pacific Regional ICPD Review report, a regionally focused report that fed into the larger Global Review Report — The Framework of Actions for the follow-up to the Programme of Action of the ICPD Beyond 2014 — stresses that the population growth rates of some countries are still too high to ensure viable, sustainable futures, and the slow rate of economic development has not kept pace with population growth. The report also emphasises that the realisation of rights and social protection for vulnerable and marginalised groups such as women and children, the elderly, youth and persons with disabilities, is still inadequate. Integrated and comprehensive approaches to achieving sexual and reproductive health and rights across the region are yet to be fully established. Enabling women to enjoy full participation in social, political and economic life remains elusive for most PICTs and the incidence of gender-based violence was reported as very high in many.

The report concluded that the following priority actions should be taken to strengthen SRHR in the Pacific region.

- ❖ Develop and implement policies that address the SRHR needs of vulnerable groups.
- ❖ Integrate quality into all primary health care facilities in all countries.
- ❖ Ensure that maternal health services are available at the community level and that skilled health personnel are trained on maternal health issues, including emergency obstetric care services.
- ❖ Broaden the range of quality contraceptive services to all vulnerable groups and young people.
- ❖ Ensure that the SRHR needs of young people and persons with disabilities are discussed with them, budgeted for and then met to the highest possible standard.
- ❖ Continue to devote attention and resources to building community awareness of the risks and lifetime impacts of maternal deaths, unintended adolescent pregnancies, STIs and HIV, as well as to address the need for behaviour change.
- ❖ Facilitate access to an essential package of reproductive health services and commodities at all health facilities, including in humanitarian situations.
- ❖ Devote resources to researching and understanding behaviours of Pacific peoples so that programmes on maternal health, family planning and STIs are based on best evidence.

ICPD Beyond 2014

In September 2014, a Special Session of the UN General Assembly endorsed the findings of the ICPD Global Review and governments committed to intensified efforts to address gaps and emerging challenges.

This report and its key themes will become the core advocacy document to ensure that population and development issues, in particular, sexual and reproductive health, receive adequate attention in the Post-2015 UN Development Agenda.



**REFLECT
& DISCUSS**

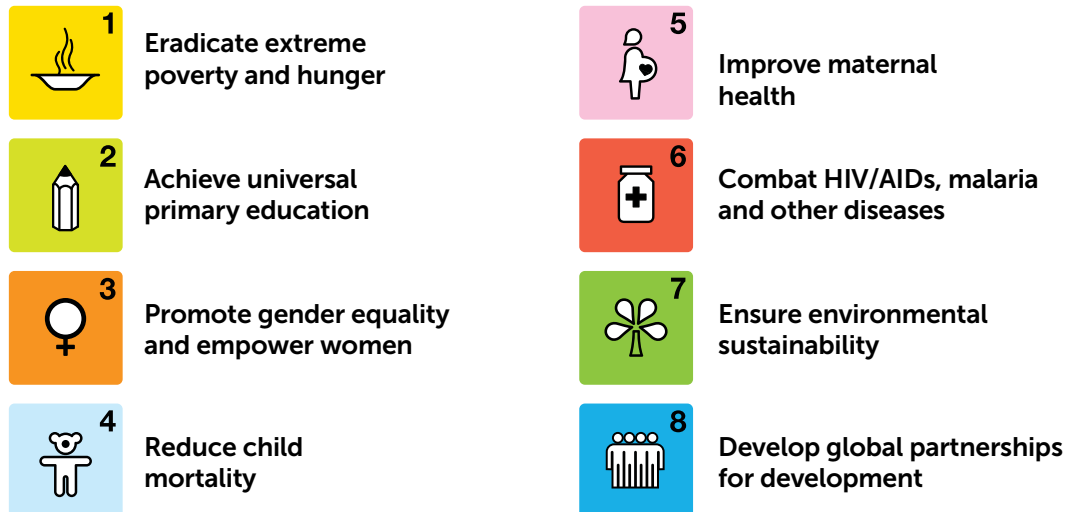
Select one of the above priority actions recommended by the ICPD 20+ review.

What are some practical strategies needed to achieve this recommendation in your country or community?

3. The Post-2015 UN Development Agenda



Millennium Development Goals

The Millennium Development Goals (MDGs) have served as a shared framework for global action and cooperation on development since 2000. They are a set of eight goals, set by United Nations member countries in 2010, that have the overall objective of halving world poverty by the year 2015. The MDGs consist of eight core commitments to:



The development of the MDGs marked a turning point in the history of global development. Unlike previous approaches, they represented a genuine global compact, which integrated targets from previous major UN conferences, including ICPD.

Did the MDGs work?

-  Some say that the MDGs have helped to raise global awareness about poverty, attract political attention and generate action.¹⁵
-  Some say that by not devoting enough attention to inequalities the MDGs may have contributed to the neglect of marginalised groups and even widened social and economic inequalities.¹⁶ Also, issues not covered by the MDGs, including sexual health, were left off the agenda and have struggled to get sufficient attention and resources over the life of the MDGs.

What next?

2015 marks the end of the MDGs and an opportunity to create a new global framework to end poverty, advance human rights and promote sustainable development.

Under the overall leadership of the Secretary-General, the United Nations has embarked on the important task of facilitating a global conversation on the Post-2015 UN Development Agenda. The new framework will be informed by consultations with CSOs, subject matter experts, academics and the private sector, and will be decided on by UN Member States in September 2015.

The following timeline provides an overview of the processes and consultations that have informed and will continue to inform the development of the post-2015 framework.

UN High-level Plenary Meeting on the Millennium Development Goals

Member States requested the Secretary-General to initiate thinking on a post-2015 development agenda and include recommendations in his annual report on efforts to accelerate MDG progress.

2010

2012

Civil society consultations

Civil society organisations (CSOs) around the world held consultations with many stakeholder groups.

UN consultations

UN country consultations took place in over 80 countries, in addition to 11 global thematic consultations. Additionally, over seven million people nominated their priority issues in the My World survey.

See <http://vote.myworld2015.org/>

The UN High-Level Panel of Eminent Persons on the Post-2015 Development Agenda

The panel report, A new global partnership: eradicate poverty and transform economies through sustainable development, sets the minimum standards for the next steps of the post-2015 process.

See http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf

The United Nations Conference on Sustainable Development (Rio+20)

The outcome document of Rio+20, The future we want, set out a mandate to establish an Open Working Group to develop a set of sustainable development goals (SDGs). The document gave the mandate that the SDGs should be coherent with, and integrated into, the UN development agenda beyond 2015.

See <https://sustainabledevelopment.un.org/futurewewant.html>

Sustainable development goals

The proposal of the Open Working Group, which included 17 proposed sustainable development goals, was presented to the UN General Assembly.

During the 68th session of the General Assembly, Member States decided that the outcomes document of the Open Working Group would be the main basis for integrating sustainable development goals into the future development agenda.

See <https://sustainabledevelopment.un.org/content/documents/1579SDGs%20Proposal.pdf>

Member State Negotiations

This is the official decision-making process used by the UN to reach consensus on global decisions. From September 2014 to September 2015, the UN General Assembly will debate the new development framework.

For a detailed guide on how the negotiations work, see www.un-ngls.org/orf/d_making.htm.

2014

President of the General Assembly (PGA) office events

The PGA office held a number of high-level sessions and thematic debates between February and June 2014, which will set the scene for the Member State negotiations.

September 2015

Post-2015 Summit

Member State negotiations will conclude at the Post-2015 Summit in September 2015, which will be co-chaired by Denmark and Papua New Guinea.



Further information on the global conversation on the post-2015 development agenda can be found at the 'World We Want 2015' Website, which is jointly owned by United Nations agencies and civil society organisations – <https://www.worldwewant2015.org/>

<p>SUSTAINABLE DEVELOPMENT GOALS</p>	 <p>GOAL 1 END POVERTY IN ALL ITS FORMS EVERYWHERE</p>	 <p>GOAL 2 END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE AGRICULTURE</p>
	<p>GOAL 1 End poverty in all its forms everywhere</p>	<p>GOAL 2 End hunger, achieve food security and improved nutrition and promote sustainable agriculture</p>
 <p>GOAL 3 ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES</p>	 <p>GOAL 4 ENSURE INCLUSIVE AND EQUITABLE QUALITY EDUCATION AND PROMOTE LIFELONG LEARNING OPPORTUNITIES FOR ALL</p>	 <p>GOAL 5 ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS</p>
<p>GOAL 3 Ensure healthy lives and promote well-being for all at all ages</p>	<p>GOAL 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all</p>	<p>GOAL 5 Achieve gender equality and empower all women and girls</p>
 <p>GOAL 6 ENSURE AVAILABILITY AND SUSTAINABLE MANAGEMENT OF WATER AND SANITATION FOR ALL</p>	 <p>GOAL 7 ENSURE ACCESS TO AFFORDABLE, RELIABLE, SUSTAINABLE AND MODERN ENERGY FOR ALL</p>	 <p>GOAL 8 PROMOTE SUSTAINED, INCLUSIVE AND SUSTAINABLE ECONOMIC GROWTH, FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL</p>
<p>GOAL 6 Ensure availability and sustainable management of water and sanitation for all</p>	<p>GOAL 7 Ensure access to affordable, reliable, sustainable and modern energy for all</p>	<p>GOAL 8 Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all</p>

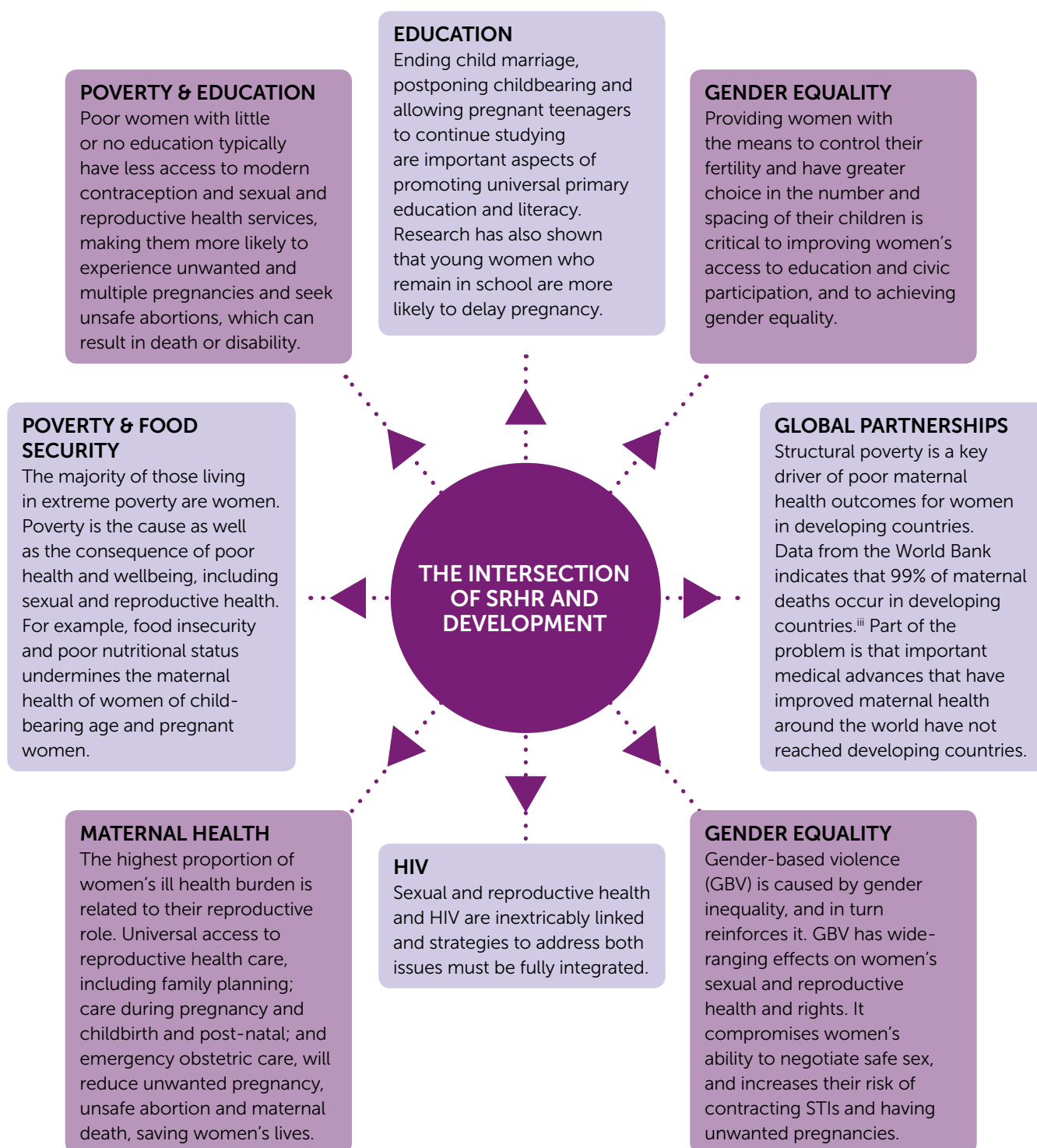
 <p>GOAL 9 BUILD RESILIENT INFRASTRUCTURE, PROMOTE INCLUSIVE AND SUSTAINABLE INDUSTRIALIZATION AND FOSTER INNOVATION</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 10 REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 11 MAKE CITIES AND HUMAN SETTLEMENTS INCLUSIVE, SAFE, RESILIENT AND SUSTAINABLE</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>
<p>GOAL 9 Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation</p>	<p>GOAL 10 Reduce inequality within and among countries</p>	<p>GOAL 11 Make cities and human settlements inclusive, safe, resilient and sustainable</p>
 <p>GOAL 12 ENSURE SUSTAINABLE CONSUMPTION AND PRODUCTION PATTERNS</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 13 TAKE URGENT ACTION TO COMBAT CLIMATE CHANGE AND ITS IMPACTS*</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 14 CONSERVE AND SUSTAINABLY USE THE OCEANS, SEAS AND MARINE RESOURCES FOR SUSTAINABLE DEVELOPMENT</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>
<p>GOAL 12 Ensure sustainable consumption and production patterns</p>	<p>GOAL 13 Take urgent action to combat climate change and its impacts</p>	<p>GOAL 14 Conserve and sustainably use the oceans, seas and marine resources for sustainable development</p>
 <p>GOAL 15 PROTECT, RESTORE AND PROMOTE SUSTAINABLE USE OF TERRESTRIAL ECOSYSTEMS, SUSTAINABLY MANAGE FORESTS, COMBAT DESERTIFICATION, AND HALT AND REVERSE LAND DEGRADATION AND HALT BIODIVERSITY LOSS</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 16 PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTIONS AT ALL LEVELS</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>	 <p>GOAL 17 STRENGTHEN THE MEANS OF IMPLEMENTATION AND REVITALIZE THE GLOBAL PARTNERSHIP FOR SUSTAINABLE DEVELOPMENT</p> <p>SUSTAINABLE DEVELOPMENT GOALS www.sustainabledevelopment.un.org/topics/sdg</p>
<p>GOAL 15 Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss</p>	<p>GOAL 16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels</p>	<p>GOAL 17 Strengthen the means of implementation and revitalize the global partnership for sustainable development</p>

Sexual and reproductive health and rights in the new development agenda

For sustainable and equitable development to be achieved, SRHR should be a central component of the new development agenda, both in its own right, and as an issue that intersects with issues across the development agenda.

The potential of people to fully realise their SRHR is influenced by a range of socio-economic factors, including food security and nutrition, access to education, gender inequality, access to services, government investment in health, social justice, terms for trade and international debt, and national and international development priorities.

The following diagram provides some examples of how SRHR intersects with other development themes.



ⁱⁱⁱ The World Bank (2012). *Over 99 percent of maternal deaths occur in developing countries*. Available from <http://data.worldbank.org/news/over-99-percent-of-maternal-deaths-occur-in-developing-countries>.


**REFLECT
& DISCUSS**

What are some other ways that SRHR intersect with broader development themes?

Tip: refer to *Sexual and Reproductive Health and Rights in the Post-2015 Agenda: Taking their rightful place* (listed under useful resources) for ideas.

Regional legislative and policy frameworks

Around the world, various geographical regions have established a range of methods and processes of collaborative decision-making (often referred to as 'machinery') to confront common challenges. There are many examples of cooperation and collaboration in the Pacific region, the main regional machinery being the Pacific Islands Forum.

This section of the manual examines five key regional frameworks relating to SRHR in the Pacific region:

- ◆ Pacific Sexual Health and Well-being Shared Agenda (2015–2019);
- ◆ The Moana Declaration (2013);
- ◆ Asian and Pacific Ministerial Declaration on Population and Development (2013);
- ◆ The Pacific Leaders Gender Equality Declaration (2012); and
- ◆ The Madang Commitment (2009).

This is not an exclusive list of all of the regional agreements relating to SRHR in the Pacific. Further information about some regional agreements relating to specific population sub-groups (including, women, youth and people with disabilities) can be found in Module 2 of this manual.

1. Pacific Sexual Health and Well-Being Shared Agenda 2015–2019

The Pacific Sexual Health and Well-Being Shared Agenda (2015–2019) provides guidance and strategic direction to strengthen the sexual health response in the Pacific region. It was endorsed by ministers for health of all 22 Pacific Island countries and territories (PICTs) at the Pacific Health Ministers Meeting, held in Honiara, Solomon Islands on 10 July 2014. The Shared Agenda replaced the Pacific Regional Strategy on HIV and other STIs, which expired at the end of 2013.

The Shared Agenda is unique because it shifts the focus from a medical approach to a comprehensive rights-based approach to sexuality and sexual health. The overall goal of the Shared Agenda is to attain the highest standards of sexual health and wellbeing and realise sexual and reproductive rights for all people in the Pacific. It aims to achieve this through five key strategies:

- ◆ strengthen the generation of strategic information to inform policy, planning, and programming;
- ◆ establish, strengthen and expand integration and linkages between services for STIs/ HIV, sexual and reproductive health and other related services;
- ◆ strengthen and roll out strategic health communication and comprehensive sexuality education (CSE);
- ◆ empower key stakeholders to create inclusive environments through legal, social, structural, and policy reform; and
- ◆ tailor services and programmes to meet the needs and rights of key populations.

2. The Moana Declaration (2013)

The Moana Declaration was the outcomes document of the Pacific Conference of Parliamentarians for Advocacy on ICPD Beyond 2014, held in Suva in August 2013. This meeting was one of the Pacific region's key contributions to the global ICPD review.

The Moana Declaration makes a number of commitments relating to the promotion of sexual and reproductive health in the Pacific, including ensuring that sexual and reproductive health is an integral part of national development strategies, health plans and public budgets, with clearly identifiable allocations and expenditure, and that all Pacific Islanders have access to their sexual and reproductive health and rights.

The Moana Declaration was presented at the 6th Asian and Pacific Population Conference in Bangkok in September 2013 as a united approach to SRHR in the Pacific region.

The Pacific Island countries highlighted on the following map have endorsed the Moana Declaration.



3. Asian and Pacific Ministerial Declaration on Population and Development (2013)

The Asian and Pacific Ministerial Declaration on Population and Development, the outcome document of the Sixth Asian and Pacific Population Conference (APPC), sets the population and development agenda for the Asia Pacific region over the next decade.

In endorsing the declaration, states resolved to ensure access to a strong health-care system that provides a range of high quality, affordable services to address diversified health needs, including sexual and reproductive health needs. They also resolved to promote the right of women and girls to enjoy the highest attainable standard of health, including sexual and reproductive health, in order to achieve gender equality. States expressed grave concern at acts of violence and discrimination against individuals on the grounds of their sexual orientation and gender identity, and committed to working to reduce vulnerability and eliminate discrimination based on sex, gender, age, race, caste, class, migrant status, disability, HIV status, and sexual orientation and gender identity, or other status.

States reaffirmed that expanding access to sexual and reproductive health information and education, together with high quality sexual and reproductive health services, is essential for achieving the goals enshrined in the Beijing Platform for Action (BPA); the ICPD PoA, including key actions for the further implementation of the PoA; and the MDGs and recommendations arising from their subsequent reviews.

4. The Pacific Gender Equality Leaders Declaration (2012)

The Pacific Gender Equality Leaders Declaration was unanimously endorsed by member countries during the 43rd meeting of the Pacific Islands Forum, which took place in Cook Islands between 28 and 30 August 2012. It brought new determination and invigorated commitment to efforts to lift the status of women in the Pacific and empower them to be active participants in economic, political and social life.

Leaders expressed their deep concern that, despite gains in girls' education and some positive initiatives to address violence against women, overall progress in the region towards gender equality is slow. In particular, leaders are concerned that women's representation in Pacific legislature remains the lowest in the world; violence against women is unacceptably high; and that women's economic opportunities remain limited:

➤ *Leaders understand that gender inequality is imposing a high personal, social and economic cost on Pacific people and nations, and that improved gender equality will make a significant contribution to creating a prosperous, stable and secure Pacific for all current and future generations.¹⁷*

The declaration made a number of specific commitments to improving women's SRHR, including:

- ◆ ensuring that reproductive health (including family planning) education, awareness, and service programmes receive adequate funding support;
- ◆ implementing progressively a package of essential services (including, protection, health, counselling and legal) for women and girls who are survivors of violence; and
- ◆ incorporating articles from the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) into legislative and statutory reforms and policy initiatives across government.

5. The Madang Commitment (2009)

The Madang Commitment is the outcomes document of the eighth Meeting of Ministers for Health for the Pacific Island Countries. The topics explored at the meeting include: maternal, child and adolescent health; strengthening health systems and primary health care; and prevention of HIV and other STIs. Some key recommendations of the Madang Commitment are:

- ❖ to strengthen health systems of Pacific Island countries in a holistic, integrated, equitable and efficient manner in order to improve health outcomes, with intensified support from partners;
- ❖ to implement a comprehensive approach to sexually transmitted infection (STI) control through provision of clinical and prevention services, including comprehensive condom programming, targeted interventions and ensuring reliable data to inform STI programming;
- ❖ to build on existing efforts towards a comprehensive approach to HIV care and antiretroviral therapy, moving from clinical care to a continuum of care for people who live with HIV, and being sure to involve people living with HIV and civil society organisations;
- ❖ to implement gender-sensitive responses to support women to address gender inequalities and gender-based violence;
- ❖ to strengthen ongoing services that contribute to good maternal, child and adolescent health, paying particular attention to family planning to prevent unintended pregnancies, including among adolescents and teenagers; and
- ❖ where MDG 4 and MDG 5 are at risk of not being achieved, to strengthen the current efforts to reduce under-five and maternal mortality rates (most urgently needed in Papua New Guinea).

National legislative and policy frameworks

Each Pacific Island country has its own national legislative and policy framework to address SRHR and related issues. In theory, these laws and policies should be influenced by the broader regional and international agreements set out above, but there are other things that determine how national legislative and policy frameworks are developed.

First, let's take a look at how legislation and policy are developed in most Pacific Island countries.

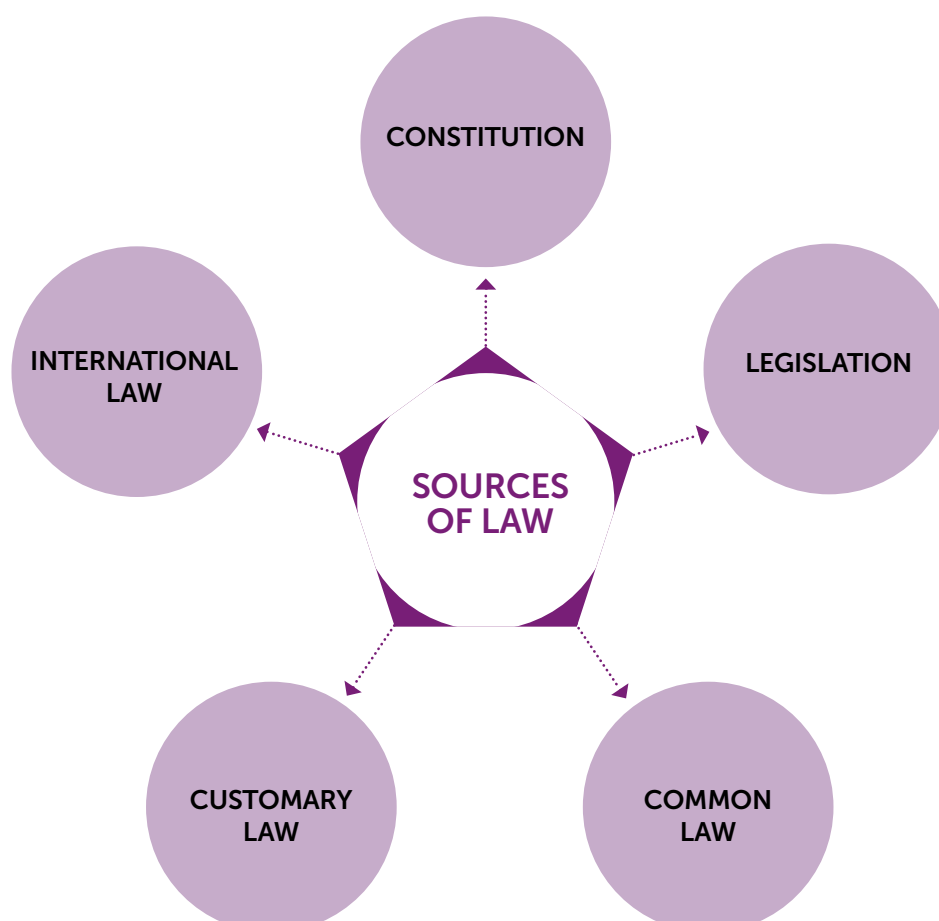
Legislation

The law, and its application, is a powerful instrument for advancing SRHR. There are five main sources of law in most Pacific Islands countries.

Most Pacific Island states, having once been either a colony or protectorate of the former British Empire, adopted a British-style legal system that influenced the ways legislation is created and amended.

The laws that exist today in these Pacific Island countries were adopted in the following ways:

- ◆ Colonial inheritance: Inheriting laws through colonial powers was one way Pacific Island states' laws were created. In some Pacific Island countries, laws that were inherited from colonial powers exist to this day.
- ◆ Legislative process: This is the most common law-making method and occurs when laws are made by the legislature or parliament. Laws passed by parliaments are known as acts of parliament.
- ◆ Judicial precedent: This is a decision of the court used to inform future decision making. Judges interpret and develop laws through this method.
- ◆ Customary practices: Many Pacific Island countries recognise customary law within the formal setting of their legal systems. An issue of concern is the ability of customary law to play a key role in the sentencing of sexual offences within the formal criminal justice system.
- ◆ International law: As discussed, various Pacific Island states are signatories to a range of international human rights treaties. In theory, this obligates them to enshrine the principles of these agreements in their national laws and policies.



Policies

Policies, including the people who develop and influence them, play a pivotal role in establishing an enabling environment for SRHR. A policy can refer to a specific vision or plan, such as a country's national policy on health, gender, disability or education, or it can refer to a government or organisation's broader perspective or approach to a particular issue.

The creation or amendment of a law or policy can be triggered by a number of things, including:

- ❖ the community expressing concern over a particular issue;
- ❖ a shortcoming in law or practice becoming evident;
- ❖ new scientific or legal developments emerging;
- ❖ ratification of an international treaty or agreement; and
- ❖ endorsement of an international or regional consensus document.

When it comes to SRHR, laws and policies are mutually dependent on each other. In order to be effective, a policy must be supported by adequate legislation that provides people with enforceable rights to justice and access to sexual and reproductive health services. Similarly, a law must be informed by a policy that is based on evidence and the lived realities of a country's citizens.

Laws, policies and the realisation of sexual and reproductive health and rights

Laws and policies can act as both barriers and enablers to the realisation of SRHR among individuals, groups and entire populations.

Enablers

The law can provide legal protections and rights and can create an environment that enables SRHR. These laws are known as 'protective laws'. They include:

- ❖ Child protection laws: These laws provide children with rights to protection from abuse, neglect, exploitation and violence. They can also facilitate access to sexual and reproductive health information, commodities and other services.
- ❖ Laws that provide right of access to services: These laws stipulate the right of all citizens to access sexual and reproductive health services and make it unlawful to deny such services.
- ❖ Laws that prohibit breach of confidentiality: These laws make it unlawful to disclose someone's health information (such as HIV status) to other people, except in certain circumstances, such as the disclosure of information to a child's parent or guardian).
- ❖ Anti-discrimination laws: These laws make it unlawful to discriminate against a person in delivery of health care services. Anti-discrimination laws are most helpful if they specify a broad range of prohibited grounds of discrimination, including age, marital status, HIV status, health status, disability, pregnancy, sexuality, gender or gender identity.

Some of the protective policies that act as enablers to SRHR include:

- ◆ national STI/HIV strategies and plans;
- ◆ national sexual and reproductive health, adolescent health and population policies; and
- ◆ policies on health services standards.



WORKING GROUP TIP

It is important to remember that laws and policies do not always reflect the reality on the ground. This is particularly the case for policies which, unlike laws, cannot compel or prohibit conduct; they can only guide actions to achieve a desired outcome. Access to SRHR continues to be restricted by cultural and religious norms, stigma and discrimination, resource constraints, police practices and lack of clarity caused by conflicting laws and policies.

Barriers

While protective laws and policies can enable SRHR, inadequate or restrictive laws and policies can operate as barriers to the realisation of SRHR. Aspects of laws and policies that are detrimental to the realisation of SRHR include:

- ◆ age restrictions, or the requirement of parental consent, to access information, services (such as HIV or STI testing), or commodities (such as contraceptives and condoms);
- ◆ requirement of marriage or spousal consent to access sexual and reproductive health services;
- ◆ failure to ensure privacy and confidentiality, which results in people avoiding services due to stigma, embarrassment and fear of disclosure of personal information to their family, community or police;
- ◆ certain laws, including laws that prohibit homosexuality and same-sex conduct, drug use, abortion and sex work;
- ◆ 'user pays' policies. Many people lack access to independent finances and cannot afford health care fees, health insurance or transport costs associated with travelling to health services; and
- ◆ a lack of service standards. Service standards can address practical issues affecting accessibility, such as location and opening hours of services, and can also help to combat discrimination in delivery of health care services.¹⁸



REFLECT & DISCUSS

Even though it clearly violates an individual's right to freely choose and express their sexual identity and orientation, nine PICTs (Cook Islands, Kiribati, Nauru, Papua New Guinea, Palau, Samoa, Solomon Islands, Tonga and Tuvalu) still criminalise homosexuality or same-sex conduct.

What impact are these laws likely to have on the sexual health of LGBTQI persons?



ACTIVITY

Legislation and policy scan**Time**

Varies

Materials

Activity

Resource 2:

Legislative and
Policy Scan
Worksheet on
page 131.

Overview

This activity will help you gain a deeper understanding of how national laws and policies in your country act to prevent or enable SRHR.

Instructions

- ◆ Complete the worksheet on page 131 by listing the national law and policy that relates to each SRHR issue. If you have limited time, you may choose to focus on just one of the issues mentioned.
- ◆ In a group, discuss how the national law or policy may act as either a barrier or enabler to the realisation of SRHR. Note: In some cases a law and policy may include both barriers and enablers.

Useful resources

Title: The United Nations Human Rights Treaty System Fact Sheet.

Author: UN Human Rights Office of the High Commissioner (2012).

Link: <http://www.ohchr.org/documents/publications/factsheet30rev1.pdf>

Title: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014.

Author: UNFPA Pacific (2013).

Link: <http://countryoffice.unfpa.org/pacific/?reports=7583>

Title: Population, Reproductive Health and the Millennium Development Goals.

Author: UNFPA (2003).

Link: <http://www.unfpa.org/public/home/publications/pid/2481>

Title: The Pacific Sexual Health and Wellbeing Shared Agenda 2015–2019.

Author: SPC (2014).

Link: http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=623&Itemid=148

Title: The Moana Declaration: An outcome statement for Pacific parliamentarians for population and development.

Author: UNFPA Pacific (2013).

Link: <http://countryoffice.unfpa.org/pacific/?reports=7673>

Title: Post-2015 made simple: Shaping the future of sexual and reproductive health and rights.

Author: International Planned Parenthood Federation.

Link: <http://www.ippf.org/resource/Post-2015-made-simple-Shaping-future-sexual-and-reproductive-health-and-rights>

Title: Pacific Brief: UN Women's position on the post 2015 stand-alone goal on achieving gender equality.

Author: UN Women Mutli Country Office.

Link: http://www.pacificwomen.org/wp-content/uploads/UN-Women-Pacific_Stand-Alone-Goal-1.pdf

Title: Sexual and reproductive health and rights in the Post-2015 Agenda: Taking their rightful place.

Author: Asian-Pacific Resource and Research Centre for Women (ARROW) (2014).

Link: <http://arrow.org.my/download/Advocacy%20Brief%20Food%20Security%20-%20website%2018072014.pdf>

Title: Beyond ICPD and MDGs: NGOs strategizing for sexual and reproductive health and rights in Asia-Pacific. Thematic papers presented at the regional meeting.

Author: Asian-Pacific Resource & Research Centre for Women (ARROW) (Ed.). (2012).

Link: http://www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

Recognise the role of civil society in advancing sexual and reproductive health and rights

Laws and policies that guide SRHR will be effective only if they reflect the changing context and values of the society that created them, are implemented as intended and are consistently monitored for effectiveness. Civil society organisations (CSOs) have a critical role to play in the process of developing, implementing and monitoring laws and policies.

CSOs include non-government organisations (NGOs), advocacy groups, charities, youth groups, faith-based organisations, women's organisations and community groups. They provide a voice for the people and hold governments accountable for implementing the laws and policies they make.

In the Pacific, CSOs play a critical role in ensuring that laws and policies relating to SRHR reflect the changing context, values and needs of the communities they represent, and are implemented as intended with adequate resourcing. They do this in a number of ways, including:

- ◆ assisting legislators, policy-makers, UN and regional inter-governmental agencies to better understand and address community needs;
- ◆ providing technical expertise to legislators and policy-makers;
- ◆ using the UN Treaty System to lobby the government for law reform; and
- ◆ raising community awareness and mobilising the community to lobby and advocate for law and policy reform.

Over the last decade, a number of Pacific CSOs have pursued legislative and policy reform as a key activity. The following is a selection of case studies that demonstrate the ways that CSOs are working together, with governments, and with the UN and regional inter-governmental agencies to affect change to their country's SRHR legal and policy framework in order to advance SRHR.

CASE STUDY:

Building partnerships to address discriminatory sexual assault legislation in Solomon Islands¹⁹

Building partnerships between civil society and key government bodies can be an important strategy when lobbying for changes in the law. In this way, lobbyists can maximise the sphere of influence and draw on varied expertise and experience.

In Solomon Islands, a successful partnership between the Ministry of Women, the Solomon Island Law Reform Commission (LRC), the Women's Law Association of Solomon Islands (WILASI), MPs, NGOs, SPC Regional Rights Resource Team (RRRT) as well as UN agencies such as UNIFEM, eventually led to the enactment of the Evidence Act 2009.

The Evidence Act 2009 removed three practices that discriminated against women. Firstly, it removed the common law practice known as the 'corroboration rule'. This meant that the court would remind ('warn') itself that it should not convict a defendant on the basis of uncorroborated evidence provided by the victim. This practice is based on a belief that women often lie about being raped or sexually assaulted. After training provided by RRRT, the Law Reform Commission examined the origin of the rule and found that it reflected norms in England from around 1944. They made a submission to the Evidence Bill Committee, arguing that there was a need for new, up-to-date legislation to fit the unique circumstances of Solomon Islands.

The second discriminatory practice was judging the credibility of a victim's evidence on the basis of their past sexual history. This meant that the accused's lawyers could ask irrelevant and humiliating questions of the victim in court. The Evidence Act 2009 states that 'no evidence can be given and no question can be put to a witness relating directly or indirectly to the sexual experience of the complainant with any person other than the accused, except with the permission of the court'.

The third discriminatory practice was that of questioning the reliability of evidence that has been reported some time after the event was alleged to have taken place. There are a number of perfectly valid reasons why victims of sexual assault may not report what has happened to them immediately, including fear of humiliation or not being believed, dependence (financial or emotional) on the person who committed the attack, and fear of retaliation.

It is hoped that the enactment of the Evidence Act 2009 will pave the way for even more progressive legislation that will make it illegal for courts to extract evidence from victims of sexual violence in a way that is unfair or discriminatory. Solomon Islands has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and therefore has an international obligation to ensure that its laws and policies do not discriminate negatively against women. The Ministry of Women, UNIFEM, and women's NGOs in Solomon Islands have been vigilant in reminding the government of these commitments.

CASE STUDY:

Development of the Yogyakarta Principles

In 2006, in response to well-documented patterns of abuse of LGBTIQ persons around the world, a distinguished group of international human rights experts met in Yogyakarta, Indonesia, to outline a set of international principles relating to sexual orientation and gender identity. The resulting document, known as The Yogyakarta Principles, is a universal guide to human rights that reaffirms existing international human rights standards in relation to sexual orientation and gender identity.

The 29 principles have already become a fixture in proceedings of the UN Human Rights Council and have influenced decisions of a number of United Nations agencies and human rights rapporteurs. They have also been used by regional human rights bodies, incorporated into foreign and domestic policies of some countries, and cited by national courts in overturning discriminatory laws.²⁰

In September 2012 a constitutional submission was developed, prepared and submitted by an intergenerational group of fifty Fijian lesbian, bisexual women and trans*people, facilitated by a local LBT network, Diverse Voices and Action for Equality. The submission utilised the Yogyakarta Principles to raise issues of state and community violence and torture, access to justice, privacy, non-discrimination, rights to freedom of expression and assembly, employment, health, education, public participation, and a variety of other rights. The submission is listed in the resources list at the end of this chapter.

CASE STUDY:

The Pacific Feminist SRHR Coalition

The Pacific Feminist SRHR Coalition aims to hold the line on SRHR commitments, and to advance the agenda in new and transformative ways in the Pacific.

The coalition is co-convened by five CSOs: the Pacific Youth Council, the Fiji Women's Rights Movement, Diverse Voices and Action for Equality, Punanga Tauturu and Development Alternatives with Women for a New Era (DAWN). There are over 40 CSO members from across the Pacific, including Chuuk (Federated States of Micronesia), Cook Islands, Fiji, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.

In the period 2015-2016, the group will formalise their arrangements with an MOU, and carry out regional and global shared work.

Increasingly, the coalition is incorporating SRHR into wider gender equality, social justice and development advocacy, and lobbying, including at regional and global multilateral negotiations such as the Pacific Plan Review, the Revised Pacific Platform for Action on Advancement of Women and Gender Equality 2005–2015, Beijing+20, the 12th Triennial Conference of Pacific Women, Cairo @20/ICPD Beyond 2014, and the post–2015 development agenda processes.

Pacific Feminist SRHR Coalition urgently calls for:^{iv}

- ◆ rights to legal and safe abortion for all Pacific women and girls;
- ◆ addressing the alarming levels of sexually transmitted infections (STIs) amongst Pacific women and girls;
- ◆ recognition that lesbian, bisexual and trans* rights are women's rights and human rights, and fulfilment of those rights;
- ◆ repealing all laws and policies in Pacific Island states that criminalise same sex relationships, and recognising all people with non-heteronormative sexual orientation and gender identity as full and equal rights-holders;
- ◆ decriminalisation of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers;
- ◆ the immediate ratification of CEDAW by Palau and Tonga; and
- ◆ regional leaders to prioritise an immediate end to small arms trade and trafficking and the militarisation of states that serve to perpetuate and reinforce patriarchal forms of power and control.²¹

^{iv} The original document (Pacific feminists and activists: Re-framing, re-articulating and re-energizing sexual and reproductive health and rights! 2013) calls for Papua New Guinea (PNG) to repeal the Sorcery Act. It was repealed in May 2013. However, extrajudicial killings in PNG and the region continue to be an urgent concern of the coalition.

CASE STUDY:

The Pacific Disability Forum

The Pacific Disability Forum (PDF) is the sole regional NGO entity that focuses on the area of disability. The PDF was established in 2002 and works towards inclusive, barrier-free, socially just and gender equitable societies that recognise the human rights, citizenship, contribution and potential of people with disabilities in Pacific countries and territories.

The Pacific Disability Forum (PDF) is a regional peak body that works in partnership with disabled persons organisations in the Pacific region. It aims to build the capacity of these organisations and improve the lives of persons with disabilities in the Pacific through advocacy. PDF carries out advocacy and awareness raising – sharing resources, experiences and expertise; capacity building and training; and promoting the equal participation of women.

In 2011, PDF convened a Pacific Regional Forum on Women with Disabilities. The following is a summary of the calls made during the Forum.

- ◆ A representative from the PDF should participate in the Regional Working Group of UN Women.
- ◆ Links with the gender officers from the Pacific Islands Forum Secretariat and the Secretariat of the Pacific Community need to be strengthened.
- ◆ Disabled persons organisations (DPOs) should be supported to incorporate the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Elimination of Discrimination Against Women (CEDAW), Biwako Millennium Framework (BMF), Millennium Development Goals (MDGs) and the Pacific Regional Strategy on Disability in strategic plans, programmes, activities, funding proposals and reporting.
- ◆ Pacific governments that have not already done so, should ratify CEDAW and CRPD and their respective Optional Protocols.
- ◆ Pacific governments should include specific policies, programmes and measures to address the rights of women and girls with disabilities in all relevant portfolios.
- ◆ Pacific governments should adopt and implement the 28 recommendations directed at government that are contained within the UNDP report, Pacific sisters with disabilities: at the intersection of discrimination.
- ◆ DPOs are to be supported to act and report on implementation of the eight recommendations directed at DPOs contained in the Pacific sisters report.



For successful lobbying make sure to follow these steps:^v



^v For more lobbying tips, see Changing laws: A legislative lobbying toolkit by FWRM and SPC RRRT available at <http://www.spc.int/rrrt/publications-media/publications/item/60-changing-laws>

Useful resources

Title: Changing laws: A legislative lobbying toolkit.

Author: Fiji Women's Rights Movement (FWRM) and Pacific Regional Rights Resource Team of the Secretariat of the Pacific Community (2010).

Link: <http://www.spc.int/rrrt/publications-media/publications/item/60-changing-lawsf>

Title: Pacific feminists and activists: Reframing, rearticulating and re-energizing sexual and reproductive health and rights!

Author: Outcome document of the first meeting of the Pacific Feminist SRHR Coalition, 2013. Organised by co-convenors Diverse Voices and Action for Equality, Fiji Women's Rights Movement, Pacific Youth Council and Punanga Tauturu, with Development Alternatives with Women for a New Era (DAWN). (2013).

Link: <http://www.pacificwomen.org/wp-content/uploads/Pacific-SRHR-2013-Outcome-Doc.pdf>

Title: The Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity (2007).

Link: http://www.yogyakartaprinciples.org/principles_en.pdf

Title: Submission to the Constitution Review Commission of Fiji.

Author: Diverse Voices and Action for Equality, (DIVA) Collective (2012).

Link: http://fjiconstitution.weebly.com/uploads/1/2/4/6/12466522/diva_fjjsubmission_final.pdf

Identify sexual and reproductive health and rights issues in the Pacific context

The Pacific region is home to a diverse and dispersed population of over 10 million people, who speak more than 800 indigenous languages. With this diversity comes a wide range of SRHR issues, which are experienced differently by different people.

Pacific Island countries are historically dynamic and resilient. Characterised by small economies, growing populations and fragile ecosystems, they face a number of challenges, including urbanisation, migration, food sustainability, and the impact of climate change and natural disasters. To address these, Pacific Islanders have developed technologies, knowledge and cultural practices to sustain viable communities over many centuries.

Despite this resilience, the Pacific region and its people face considerable difficulties in the realisation of sexual and reproductive health and sustainable population growth. Of particular concern in the Pacific region are: an increase in the number of reported HIV cases; high rates of STIs, gender-based violence and adolescent pregnancy; and low contraceptive prevalence.

In this section of the manual we'll further examine some of the unique aspects of the Pacific region and how they impact on the realisation of SRHR, as well as some of the critical sexual and reproductive health challenges facing the region.



Sexual and reproductive health and rights in the Pacific context

There are multiple factors, including cultural, religious, financial, logistical, institutional, legal and policy, that play a role in determining people's access to sexual and reproductive health services in the Pacific region.

High population growth

While fertility rates in the region have declined over the past several decades, in many Pacific Island countries, population rates are still too high to ensure viable, sustainable futures, and slow economic development has not kept pace with population growth.²² Related to high population growth is the presence of a 'youth bulge' across most of the region. While adolescent fertility rates have declined in some countries, rates of adolescent births continue to be well over 50 per 1000 births in others, including the Melanesian countries of Papua New Guinea, Solomon Islands and Vanuatu.²³ Improving sexual and reproductive health, particularly family planning services, is essential in achieving sustainable population growth in the Pacific region.



**REFLECT
& DISCUSS**

Estimates suggest that young people aged 15–30 years make up over a quarter of the Pacific region's population.²⁴

What are some of the specific challenges that young people face in realising their sexual and reproductive health and rights?

Urban migration

Migration has been a way of life for Pacific Islanders for thousands of years. To this day, migration affects the growth and distribution of Pacific populations, both between and within countries. Within countries, 'urban drift', or movement of people from the outer islands or rural areas to the towns and cities, has seen high percentages of Pacific Islanders living in overcrowded urban areas. Between countries, international migration provides vital opportunities for work and education, with an estimated 16,000 Pacific Islanders leaving their countries annually.²⁵



**REFLECT
& DISCUSS**

It has been said that migration has a gendered impact on Pacific Island communities, as it is mainly men who migrate for employment, leaving behind women-headed households.²⁶

What are some of the ways that migration might affect the sexual and reproductive health of men and women differently?

Geographical isolation

The Pacific Ocean covers 34 per cent of the Earth's surface, with only two per cent comprising land. The 25 nations and territories that comprise the Pacific Islands are spread over more than 25,000 islands and islets of the western and central Pacific Ocean.

This vast geographical dispersion compounds other barriers to sexual and reproductive health in the Pacific by increasing the cost of providing essential services to remote rural populations. The cost of transport is a key factor and can often make the cost of servicing small populations in remote and rural areas prohibitively expensive. Maintaining a skilled workforce in remote areas is also a challenge, with many professionals choosing better pay and conditions in urban centres.



REFLECT & DISCUSS

Privacy is one of our most basic human rights. Lack of privacy and confidentiality can be a significant barrier to people accessing sexual and reproductive health services, especially in rural communities where everyone knows each other.

What other barriers does geographical isolation pose to the realisation of sexual and reproductive health and rights in the Pacific?

Gender inequality

A number of complex and interrelated factors continue to fuel widespread gender inequality in the Pacific region, including patriarchal cultural norms; low levels of political representation at all levels of decision making; restrictive legislative frameworks; barriers to women's economic participation; and poor access to health care. One of the most pronounced impacts of gender inequality in the Pacific is violence against women. National prevalence studies have placed rates of physical and sexual violence by a partner or non-partner among Pacific Island women as high as 68 per cent in Kiribati²⁷ and 64 per cent in the Solomon Islands.²⁸ Not only does violence against women reinforce gender inequality and women's disempowerment, it prevents the free expression of women's sexuality and exacerbates reproductive health problems, including unwanted pregnancies, unsafe abortions and STIs, including HIV.



REFLECT & DISCUSS

Violence against women (including threats of violence) can make it difficult for women to have autonomy over their bodies and negotiate safe sex, including contraceptive and condom use.

What are some of the other ways that violence against women could impact access to sexual and reproductive health and rights?

Cultural and religious norms

Cultural practices and religious expression are diverse across the Pacific region, but they rarely enable the free expression of sexuality and fulfillment of sexual and reproductive health and rights. Traditional patriarchal cultures, embedded within contemporary religious practices (most commonly conservative Christianity), are a key factor in shaping and constraining access to sexual and reproductive health services.

In some cases, harmful cultural practices in the Pacific region have implications for sexual and reproductive health. These include bride price practices in Melanesia, compensation and forgiveness rituals, rape as punishment, dry sexual intercourse (Kiribati), virginity tests, sorcery and witchcraft (Papua New Guinea), and early, arranged or forced marriages. These practices, many which are forms of violence in themselves, are often related to controlling women's sexuality and can have detrimental mental, physical and reproductive health effects.

On the other hand, strong family, clan or tribal ties in rural and remote areas form effective social safety nets, which in some cases can enable good sexual and reproductive health. However, strict social control and lack of privacy may also affect opportunities to access sexual and reproductive health services and commodities, particularly by women and girls.



**REFLECT
& DISCUSS**

Across the Pacific, large families are the norm. This creates an important social safety net, where everyone is responsible for looking out for each other.

How might the cultural expectation for women to have many children affect the realisation of their sexual and reproductive health and rights?

Inadequate laws and policies

Despite some progress, there remains a need to improve legal and policy frameworks with respect to the protection of rights, ensuring that vulnerable groups, especially persons with disabilities, have access to sexual and reproductive health services.²⁹ The recent 20 year review of progress towards ICPD goals in Pacific Island countries found that the level of sexual and reproductive health integration into primary health care could also be strengthened to give those who live on outer islands and in remote rural communities greater access to information and services.³⁰ In recent years, an increasing number of Pacific Island countries have developed national population policies; but updating and raising the profile of these policies and ensuring that they reflect ICPD and MDG priorities is a priority.³¹



**REFLECT
& DISCUSS**

Locate your country's national policy document that covers the provision of sexual and reproductive health services.

Discuss three ways that the policy document could be enhanced to adopt a more rights-based approach to SRHR.

Lack of funding, resources and political will

Most Pacific Island countries spend a relatively small amount of their total budgets on health, with only a small fraction of that amount being spent on sexual and reproductive health.

The WHO Health Financing Strategy for the Asia-Pacific Region (2010–2015) urges member countries in the region to raise health expenditure per country to at least four or five per cent of GDP to ensure that sufficient resources are raised to address the health needs of their citizens.³² The health expenditure of Pacific Island countries varies greatly, with some countries, such as Fiji and Papua New Guinea, spending less than five per cent and some small island states such as Kiribati spending more than 10 per cent.³³

When government expenditure on health care is insufficient, the obligation to fund essential health services falls to either citizens, in the form of direct 'out-of-pocket' expenses, or, in the case of the Pacific region, foreign aid donors. While the contribution of donor funding towards sexual reproductive health programmes is inevitable, an over-reliance on donor funding is an unsustainable solution. Increasing government expenditure on health will require political 'champions' (key supporters) who are able to influence policy and budget decisions in favour of a rights-based approach to sexual and reproductive health.



REFLECT & DISCUSS

In August 2013, parliamentarians from across the Pacific gathered in Fiji to develop and endorse a rights-based strategy to address the unique sexual and reproductive health needs of the Pacific region. This document, known as The Moana Declaration, demonstrates what is possible when political champions form coalitions in support of SRHR.

What could be done in your country to develop 'political champions' capable of influencing policy and budget decisions in favour of SRHR?

Sexual and reproductive health issues in the Pacific

This section discusses some of the most significant sexual and reproductive health issues in the Pacific region. It is not an exhaustive list; the key issues affecting certain population sub-groups can be found in Module 2 of this manual. It is important to remember that these issues do not occur in isolation; they are experienced differently by different people and are related to each other in complex ways.

Gender-based violence

Gender-based violence, including family violence and sexual violence, is endemic in the Pacific, with young women and women with disabilities experiencing the highest risk. Violence against women and girls increases their risk of contracting STIs, including HIV, and can make it more difficult for them to negotiate safe sex and access sexual and reproductive health care.

The nature of the gender-based violence epidemic in the Pacific and its impact on the sexual and reproductive health and rights of women is discussed in detail in Module 2 in the section on women.

HIV

High rates of STIs other than HIV in most Pacific Island countries mean that the threat of HIV is ever present. The prevalence of HIV, however, varies greatly across the Pacific region. The estimated prevalence amongst adults aged 15 to 49 years in the 17 countries is less than 0.1 per cent, but the prevalence for Papua New Guinea is significantly higher at around 0.5 per cent.³⁴ The main path of transmission of HIV is through heterosexual contact, with over half of all cases transmitted this way. This is followed by male-to-male sex, through which 27 per cent of cases are transmitted.³⁵

Sexually transmitted infections

Sexually transmitted infections are hyper-endemic in the region. On average, one in four sexually active young people in the Pacific have an STI and in some countries the figure is as high as 40 per cent.³⁶ The most common STI in the Pacific region is chlamydia, with gonorrhoea and syphilis also present. STIs can have adverse effects on fertility and births and increase the risk of HIV transmission. High STI rates are indicative of low condom use. Although condom use has increased in many PICTs, consistent condom use is low across the Pacific.³⁷

Access to health services and contraception

Everybody has the same right to appropriate, affordable and good quality sexual and reproductive health care, information and related services. Unfortunately, however, stigmatisation, discrimination and a lack of confidentiality in many health services in the Pacific prevents vulnerable and marginalised groups from accessing sexual and reproductive health care and information. The specific barriers faced by women, young people, people living with HIV and AIDS, persons with a disability and LGBTQI persons are explored further in Module 2.

Contraceptive prevalence rates (CPR) have remained below 50 per cent, with the lowest rates (around 22 per cent) in the small island countries of Niue, Tuvalu, Palau and Kiribati. There are a number of likely reasons for low CPR in the region: weak health systems, limited access to contraception, lack of education regarding contraceptive choices, gender roles that prevent women from being able to make a decision about contraception use, and religious beliefs.

Teenage pregnancy

Teenage pregnancy is common in the Pacific, and while rates are declining, Marshall Islands, Nauru, Solomon Islands, Vanuatu and Papua New Guinea exceed the global average of children born to young women aged 15–19 years.³⁸ Young women are physiologically less ready for pregnancy, and they are less likely to have access to information and to antenatal and postnatal care compared to older women, which increases health risks and affects on their overall wellbeing. High rates of teenage pregnancy are an indication that sexual health education, services and commodities are not reaching young people.

Reproductive cancers

Human Papillomavirus (HPV), which can lead to reproductive cancers, is becoming an emerging area of concern. There is little data on the extent of HPV transmission, although a study in Fiji found that an average of 97 women a year are diagnosed with cancer of the cervix with an 80 per cent mortality rate.³⁹ HPV vaccination programmes for school-aged girls are under way in Kiribati, Vanuatu and Solomon Islands,⁴⁰ but these programmes are limited in scope, and girls in rural and remote areas often miss out.

Useful resources

Title: Populations and development profiles: Pacific Island countries.

Author: UNFPA (2014).

Link: <http://countryoffice.unfpa.org/pacific/?publications=9683>

Title: Reclaiming and re-defining rights. ICPD 20+: Status of sexual and reproductive health and rights in Asia Pacific.

Author: ARROW (2013).

Link: www.arrow.org.my/publications/icpd+20/icpd+20_arrow_ap.pdf

Title: Review of the Implementation of the International Conference on Population and Development Programme of Action Beyond 2014.

Author: UNFPA Pacific (2013).

Link: <http://countryoffice.unfpa.org/pacific/?reports=7583>

Title: Pacific Shared Health and Well-Being Shared Agenda 2015–2019

Author: Secretariat of the Pacific Community (2014).

Link: http://www.spc.int/hiv/index2.php?option=com_docman&task=doc_view&gid=623&Itemid=148

Title: Keeping it under the mat: The struggle for reproductive rights in the Pacific Island region in DAWN Regional Advocacy Tools for Cairo@20.

Author: Tara Chetty and Rachel Faleatua.

Link: <http://www.dawnnet.org>



MODULE 1

QUIZ

1. What is the difference between sexual health and reproductive health?

2. According to the 1986 Ottawa Charter for Health Promotion, what are the eight fundamental conditions and resources required to achieve good health? (Also known as the social determinants of health).

3. How do the terms sex and sexuality differ in meaning?

4. What are the four essential elements of a rights-based approach to SRHR?

5. Which UN human rights treaty specifically addresses the sexual and reproductive rights of women?

6. What significant event took place in 2014 to mark the twentieth anniversary of the International Conference on Population and Development?

7. The Pacific Conference of Parliamentarians for Advocacy on ICPD Beyond 2014, held in Suva, Fiji, produced which important declaration on SRHR?

8. Name some of the harmful cultural practices in the Pacific region that may negatively impact on people's sexual and reproductive health and rights?

9. Rates of HIV are low in most Pacific Island countries except Papua New Guinea. What is the major risk factor that could lead to increased rates of HIV in other parts of the Pacific region?

10. In which Pacific Island countries are contraceptive prevalence rates below 50 per cent?

Answers: The Answers to these questions can be found on the following pages of the Manual:

1. Page 13, **2.** Page 11, **3.** Page 14, **4.** Page 18, **5.** Page 24, **6.** Page 27, **7.** Page 36, **8.** Page 54, **9.** Page 56, **10.** Page 57

Module 2

Analysis

In Module 2 you will apply the principles, concepts and frameworks that you learned about in Module 1 to the needs of key marginalised and vulnerable groups who can face significant barriers to claiming their human rights.

Formulating legislative, policy and programme solutions that are inclusive of all members of society, particularly those who are vulnerable and marginalised, is an essential component of a rights-based approach to sexual and reproductive health.

Learning objectives:

Gain a deeper understanding of the specific enablers and barriers to the realisation of the sexual and reproductive health and rights of the following marginalised and vulnerable groups:

- ◆ women
- ◆ young people
- ◆ persons with disabilities
- ◆ LGBTQI persons
- ◆ people living with HIV



INTERSECTION

A NOTE ON INTERSECTIONS:

It is important to remember that inequality intersects in complex ways that can compound and exacerbate vulnerability. People who identify with more than one of the groups above (e.g. a young woman with a disability or a gay man living with HIV) will likely experience multiple forms of discrimination, which will act to undermine their human rights and increase their risk of poor sexual and reproductive health outcomes.

2

Women

Pacific Island women are more likely to experience poorer sexual and reproductive health outcomes than their male counterparts. A 2009 report by Family Planning International New Zealand⁴¹ found that women were at the highest risk of poor sexual and reproductive health outcomes in Papua New Guinea and Kiribati, which were characterised by very high maternal and infant mortality, more restrictive abortion laws, the lowest levels of skilled care at birth, low contraceptive use, low numbers of girls in secondary school, early age at marriage and high adolescent fertility rates. A further eight Pacific Island countries were in the 'high risk' category when it came to women's sexual and reproductive health. In order of highest to lowest risk in the 'high risk category', these were: Nauru, Vanuatu, Marshall Islands, Tuvalu, Solomon Islands, Federated States of Micronesia, Tonga and American Samoa.⁴² Overall, it is estimated that 650,000 women have an unmet need for family planning in the Pacific.⁴³

At the root of women's poor sexual and reproductive health is persistent gender inequality. Manifestations of this can include arranged marriages (in some cases of children); the modern-day commodification of women through bride price practices; the social acceptance of unquestioned male authority (often in relation to sexual activity, the use of contraception and health); and prevalence and acceptance of gender-based violence. Gendered norms and expectations, grounded in tradition, culture, religion and social constructs of masculinity, mean that women are often deprived of the power to make decisions about their sexual and reproductive health (such as the number and spacing of their children). A lack of women in leadership and decision-making positions also means that issues affecting women's health are rarely a high priority on political agendas.



INTERSECTION

RURAL WOMEN

The Pacific region is characterised by relatively small and geographically dispersed populations, with an estimated 77 per cent of people living in rural and remote areas.⁴⁴ Delivery of services of any kind in these environments can be extremely challenging, particularly when it comes to sensitive issues such as sexual and reproductive health. Women living in remote areas may face journeys of several hours or more to get to a health facility with trained health workers. When they arrive, the service may be out of stock of essential commodities or lack suitably skilled staff. There may also be a real or perceived belief that privacy and confidentiality will not be upheld.

Research points to a higher unmet need for contraception among women living in rural areas in most Pacific Island countries.⁴⁵ Unsurprisingly, adolescent fertility rates are significantly higher for young women in rural areas. For example, in the Marshall Islands, the rate of adolescent fertility is high in urban areas at 80:1000 births (to women aged 15–19 years old), but even higher on the outer islands, at 100:1000 births. Similarly, in the Solomon Islands and Vanuatu, rural adolescent fertility rates are a high, at 70:1000 and 77:1000 respectively, while only 34:1000 and 40:1000 in urban areas. This highlights a need for stronger focus on adolescent sexual and reproductive health information and services, especially in rural areas.

Sexual and reproductive health and rights issues for women

Access to safe abortion

In most Pacific Island countries, abortion is legal only when performed under strict conditions, which generally fall into one or all of these categories:

- ◆ to save a woman's life;
- ◆ to protect the physical and mental health of a woman; or
- ◆ to prevent foetal impairment.

Policy and legislation play a key role in either enabling or hindering women's rights. This is especially the case when the interpretation and implementation of a law or policy is strongly influenced by the opinions of politicians and community leaders, especially on issues that are culturally or religiously sensitive. For example, while the Fiji Crimes Decree 2009 permits abortion under limited circumstances, such as rape, anecdotal evidence suggests that it is being conservatively interpreted on the ground, making legal abortion, even in these limited circumstances, difficult to access.

When safe abortion is criminalised, the prevalence of unsafe abortions increases, which can increase the risk of maternal and/or infant mortality and disability.⁴⁶ These risks are highest among adolescents, as they may be slower to recognise or admit to pregnancy, are least able to afford appropriate care, and are most vulnerable to stigma and discrimination in the health care system, which can lead to poor quality care and use of dangerous termination methods. In the Pacific there is very little research available regarding the consequences of restrictive abortion laws on women, which makes it difficult to gain a full picture of the extent and consequences of unsafe abortion. Reform of laws relating to abortion has begun, but progress is slow. This can be attributed to the fact that laws are heavily influenced by social and religious beliefs and attitudes towards women and their role in society.



REFLECT & DISCUSS

When advocating for freedom from violence, youth-friendly sexual reproductive health information and services, and access to legally available safe abortion, people often speak of bodily integrity.

What human rights conventions and international consensus documents protect a person's right to bodily integrity?

Gender-based violence

Gender-based violence in the Pacific is widespread and there is limited access to justice and support services for survivors. Family Health and Safety Studies in Samoa, Solomon Islands and Kiribati have revealed that 46 per cent, 64 per cent and 68 per cent respectively of ever partnered women aged 15–49 have experienced either emotional, physical or sexual violence by an intimate partner.⁴⁷ Rates of violence against women are particularly high in Papua New Guinea. A recent multi-country study revealed that 61 per cent of men in Bougainville, Papua New Guinea, admitted to raping a woman (41 per cent of men reported raping a non-partner and 59 per cent to raping a partner).⁴⁸ Even more shocking was the fact that 14 per cent of men reported committing multiple-perpetrator rape and 25 per cent of men who reported committing rape were aged 15 years or younger when they committed their first rape.⁴⁹

Another significant issue in the Pacific is the existence of cultural practices in the region that amount to gender-based violence. These include bride price practices (Melanesia), traditional forgiveness practices, the burning of mainly female witches for alleged sorcery (Melanesia), early, arranged or forced marriages, punishment rape, exchange of brides as part of dispute settlements (Melanesia), dry sexual intercourse and virginity tests (Micronesia). These cultural practices are gendered in the sense that they are often either overtly sexual in nature or are related to women's sexuality and have detrimental mental, physical and reproductive health effects on women.⁵⁰

Violence against women and girls can result in many negative sexual and reproductive health outcomes, including:

- ❖ Preventing women from having bodily autonomy, including their ability to negotiate safe sex through contraceptive or condom use. This may result in a number of poor health outcomes, including unwanted pregnancies, abortion (including unsafe abortion) and STIs (including HIV).
- ❖ Restricting women's access to health care, including sexual and reproductive health services. For example, research in Fiji revealed that two out of five ever-partnered women surveyed needed to ask permission from their husband/partner before they could access health care for themselves.⁵¹
- ❖ Increased risk of contracting STIs, including HIV. Research has consistently shown that men who are violent towards their partners are more likely to have multiple sexual partners.⁵²
- ❖ Birth complications as a result of violence during pregnancy. For example, the Solomon Islands Family Health Safety Study revealed that 11 per cent of women who have ever been pregnant reported being beaten during pregnancy.⁵³ These women were more likely to report miscarriages, abortions or having had a child who died (although this correlation was not statistically significant).

Women in leadership and decision making

Article 7 of CEDAW states that countries should take all appropriate measures to eliminate discrimination against women in the political and public life of a country. Yet despite large numbers of women who are capable and willing to lead in the political, public, private and community sectors, and a recent significant investment by donors in women's leadership programming, women remain severely under-represented in leadership in the Pacific.

It is well known that women's representation in Pacific parliaments is the lowest in the world, with women occupying roughly four per cent of seats in national parliaments across the region.⁵⁴ While women are occupying more leadership and decision making positions in areas outside national politics, including provincial and local government and public service, progress is painfully slow.

Without women in leadership and decision-making positions, sensitive issues affecting their sexual and reproductive health and rights are unlikely to take a high priority on political agendas. However, neither is the presence of women in parliament a cure-all when it comes to placing women's sexual and reproductive health and rights on the political agenda. For example, during her 2010 campaign in Tonga, candidate Linda Ma'u expressed her concern that if Tonga became a signatory to CEDAW, it might mean legalising abortion and same-sex-marriage, two practices that she opposed.⁵⁵

Regardless of the status of women in political leadership in the Pacific, a concerted and sustained advocacy effort is required to ensure that women's sexual and reproductive health and rights remain on the political agenda.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

CEDAW is the core UN treaty that enshrines the SRHR of women and girls in international law. It sets the standards in international law for achieving gender equality and eliminating discrimination against women and girls. CEDAW was adopted by the United Nations General Assembly in 1979 and has achieved near-universal endorsement, with 187 countries ratifying the Convention.

The implementation of CEDAW is monitored by a group of 23 independent experts, known as the CEDAW Committee, who are elected for a two-year term. The committee meets annually to receive and respond to government reports on progress made towards the implementation of the convention (known as a periodic report). They also receive and respond to communications and enquiries, and formulate general recommendations, which are specific issues that the CEDAW Committee believes require further attention by State Parties.

Which CEDAW articles relate to SRHR?

The main CEDAW articles that relate to SRHR are given below.

- Article 10:** states that countries shall take all appropriate measures to eliminate discrimination against women in order to ensure equal rights with men in the field of education. This includes access to specific educational information to help to ensure the health and wellbeing of families, including information and advice on family planning.
- Article 12:** states that countries shall take appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
- Article 14:** states that countries shall take all appropriate measures to eliminate discrimination against women in rural areas. This includes access to adequate health care facilities, including information, counselling and services in family planning.
- Article 16:** states that countries shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations. This includes: the same right to enter into marriage; the same right to freely choose a spouse and to enter into marriage only with their free and full consent; the same rights to decide freely and responsibly on the number and spacing of their children; and have access to the information, education and means to exercise these rights.



While these are the main CEDAW articles that relate specifically to SRHR, it is important to remember that all of the articles of the treaty work together to ensure that women can realise their SRHR.

Which Pacific Island countries have ratified CEDAW?

At the time of writing, all Pacific Island countries, with the exception of Palau, had ratified CEDAW. Cook Islands, Vanuatu and Solomon Islands have also ratified the CEDAW Optional Protocol (OP), which gives additional powers to the CEDAW Committee to investigate violations of the convention.

Just because a country ratifies CEDAW doesn't necessarily mean that women's human rights will be protected. Many Pacific Island countries that have ratified CEDAW have yet to submit a periodic report, or do so irregularly. Sometimes, civil society organisations come together and prepare their own report of their government's progress. This is known as a 'shadow report'.

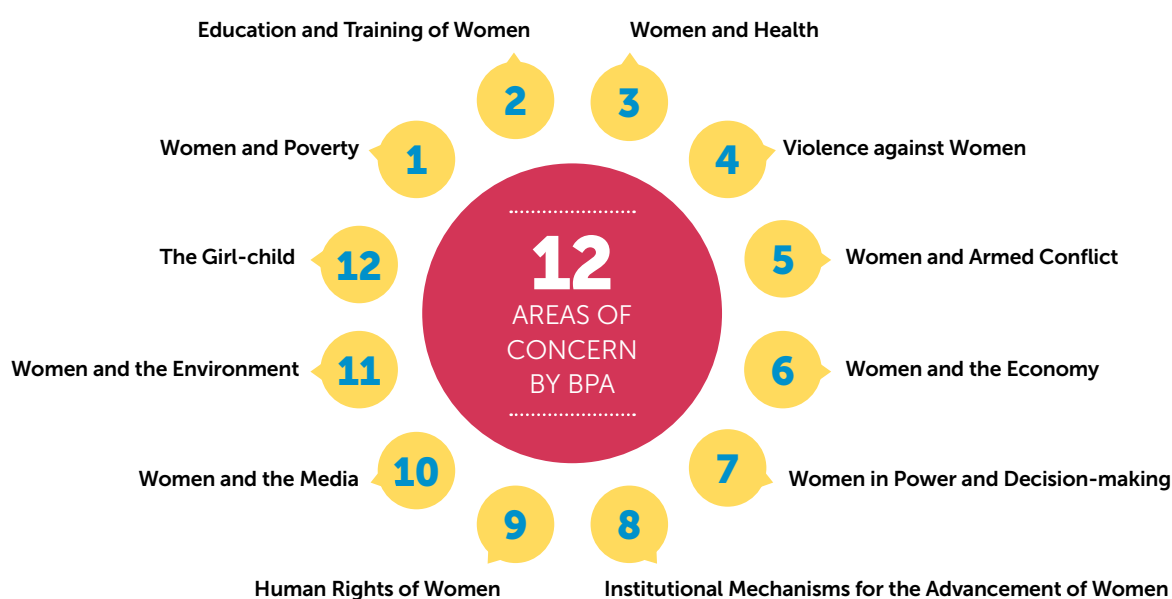
The following table outlines the status of CEDAW ratification and reporting in the Pacific:⁵⁶

Country	CEDAW ratification	CEDAW OP ratification	CEDAW report status	CEDAW shadow report status
Cook Islands	2006	2007	Initial report submitted 2006. Periodic report due since 2011.	Yes
Fiji	1995	-	2002, 2009 (next report due 2014).	Yes
Kiribati	2004	-	Initial report due since 2005.	No
Marshall Islands	2006	-	Initial report due since 2007.	No
Federated States of Micronesia	2004	-	Initial report due since 2005.	No
Nauru	2011	-	Initial report due since 2012.	No
Palau	signed in 2011 but yet to ratify	-	-	-
PNG	1995	-	Initial report due since 1996.	No
Samoa	1992	-	2005, 2010 (next report due 2016).	Yes
Solomon Islands	2002	2002	2013 (next report due 2018.)	Yes
Tonga	2015	-	-	-
Tuvalu	1999	-	2008, 2012 (next report due 2018).	Yes
Vanuatu	1995	2007	2005. Periodic report due since 2012.	Yes

Beijing Platform for Action (1995)

The Beijing Platform for Action (BPA) was the outcomes document of the Fourth World Conference on Women, held in Beijing in 1995. It was the largest gathering of government and NGO representatives ever held, with 17,000 in attendance, including representatives of 189 governments.⁵⁷ It also brought together over 30,000 activists from across the world. The BPA aims to promote the advancement of women and remove barriers to their participation in all aspects of public and private life by empowering women. The BPA is unique because it lists strategic objectives and actions to address a range of continuing barriers to women's equality.

The BPA includes 12 critical areas of concern:



While all of these areas are relevant to women's SRHR, the issue is discussed most thoroughly in Critical Concern 3: Women and Health. To address this area, the BPA includes five strategic objectives to improve women's health.

1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.
2. Strengthen preventive programmes that promote women's health.
3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV, AIDS, and sexual and reproductive health issues.
4. Promote research and disseminate information on women's health.
5. Increase resources and monitor follow-up for women's health.

Strategic Objective 3 lists 12 specific actions that governments, international bodies (including relevant United Nations organisations), bilateral and multilateral donors and non-governmental organisations must take to advance SRHR.

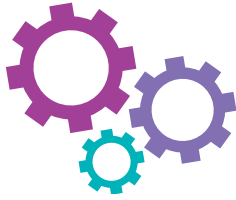
The Revised Pacific Platform for Action on the Advancement of Women and Gender Equality (2005–2015)

The Revised Pacific Platform for Action is a regional charter developed and agreed on by representatives from all PICTs. The document was initially developed and endorsed in 1994 and formed the basis of the Pacific region's contribution to the Beijing Platform for Action the following year. The document was then revised and re-affirmed in 2004.

The Pacific Platform for Action offers targets and indicators on women's rights and gender equality, and is a reference for developing national gender equality policies and supporting the integration of gender concerns in a broad range of sectors.

One of the strategic themes of the document is 'women's access to services', which makes a number of recommendations regarding SRHR, including improving the quality of and access to affordable sexual and reproductive health services, improving the provision of sexual and reproductive health information, and reviewing all aspects of legislation relevant to reproductive health.

The development of a further revision of the Pacific Platform for Action is currently under way.



ACTIVITY

Access to contraception – a human right

Time

30 minutes

Materials

Module 1

Overview

Women's ability to exercise their human rights is hindered when they are not able to make free and informed decisions about contraception use and they are not given access to appropriate, good quality, affordable family planning services, information and commodities.

This activity will help you gain a deeper understanding of access to contraception as a human right.

Instructions

1. Review the human rights conventions and international consensus documents discussed in Module 1.
2. Discuss which conventions and international consensus documents protect a woman's right to appropriate, good quality, affordable family planning services, information and commodities, and her right to decide on the use of contraception.
3. How does having the right to health contribute to women realising their human rights?

Useful resources

Title: A measure of the future: Women's sexual and reproductive health risk index for the Pacific.

Author: Family Planning International New Zealand (2009).

Link: <http://www.familyplanning.org.nz/media/124178/research-a-measure-of-the-future-2009.pdf>

Title: Mapping of existing legislation, programs and other mechanisms to support women's leadership in the Pacific.

Author: DFAT Pacific Women Shaping Pacific Development initiative (2014).

Link: <http://www.pacificwomen.org/wp-content/uploads/Mapping-of-existing-legislation.pdf>

Title: Ending violence against women and girls: Evidence, data and knowledge in Pacific Island countries.

Author: UN Women Pacific (2011).

Link: <http://asiapacific.unwomen.org/en/publications/2011/7/ending-violence-against-women-and-girls>

Title: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Author: United Nations (1979).

Link: <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>

Title: A guide to using CEDAW for NGOs.

Author: International Women's Rights Action Watch Asia Pacific (2015).

Link: <http://www.iwraw-ap.org/cedaw/using-cedaw/for-ngos/>

Title: Reclaiming and redefining rights: Guidance Series: Analysing sexual and reproductive health and rights under CEDAW.

Author: Asia Pacific Research and Resource Centre for Women (ARROW)(2012).

Link: http://www.arrow.org.my/publications/ICPD+15/R&R_GuidanceSeries.pdf

Title: Revised Pacific Platform for Action on the Advancement of Women and Gender Equality.

Author: Secretariat of the Pacific Community (SPC) (2005).

Link: <http://www.pacificwomen.org/resources/reports/revised-pacific-platform>

Title: Beijing Platform for Action (BPA).

Author: United Nations (1995).

Link: <http://www.un.org/womenwatch/daw/beijing/platform>

Title: Zazi: A participatory programme on sexual and reproductive health for women and girls: A toolkit for facilitators.

Author: Emma Durden and Mpume Gumede (n.d.).

Link: http://heids.org.za/site/assets/files/1225/zazi_toolkit.pdf

Title: Keeping it under the mat: The struggle for reproductive rights in the Pacific Island region in DAWN Regional Advocacy Tools for Cairo@20.

Author: Tara Chetty and Rachel Faleatua.

Link: <http://www.dawnnet.org>

Young people

The Pacific population has a 'youth bulge', meaning that there is a disproportionately large number of young people between the ages of 15 and 24 years. It has been estimated that these young people make up almost a quarter of the Pacific population.⁵⁸ As a result, across the region, there is a large group of people entering or already in their reproductive years who need to be aware of their SRHR, but this is not the case. For example, a 2006 study of young people aged 15–24 years in Samoa, Solomon Islands and Vanuatu (of whom two-thirds were sexually active, with the median age at first sex being 16 years) found that fewer than 20 per cent of the girls aged 15–19 and less than half the boys had ever used a modern method of contraception (including condoms). This is lower than most developing countries.⁵⁹

Over the last decade, the fertility rates of young women aged 15–19 years have declined in eight countries. However, in five countries (Marshall Islands, Nauru, Papua New Guinea, Solomon Islands and Vanuatu), rates have remained high, with more than 50 out of every 1,000 births to women 15–19 years old.⁶⁰ The consequences of early motherhood are varied. While some young women choose to have children at a young age, teenage pregnancy can heighten risks of complications such as severe bleeding, infections, high blood pressure, and unsafe abortions. Teenage pregnancy can also hinder young women's access to education and socio-economic independence.

These SRHR challenges directly contribute to a wide range of negative short and long-term consequences for the health and wellbeing of Pacific adolescents, their families and communities. It is also increasingly contributing to broader social and economic challenges that significantly hinder the development of PICTs.



How the government defines 'young person' or 'youth' determines who is targeted for a policy or project and therefore is important information for policy-makers, advocates and programme implementers.

Make sure you are aware of the government's definition and have a clear definition of 'young person' or 'youth' in the materials you use for lobbying or advocacy.



YOUNG WOMEN

Across the Pacific, young women bear a double burden of prejudice, discrimination and inequality as a result of their age and gender. Young women with a disability, living with HIV or AIDS, or who identify as LGBTQI can experience heightened vulnerability and are often extremely marginalised. Young women experience the poorest sexual and reproductive health and rights outcomes of any population group in the Pacific, including high rates of teenage pregnancy and STIs (including HIV), which is now described as a feminised epidemic. Young women are also the group most at risk of experiencing physical and sexual violence.

Patriarchal cultural and religious expectations continue to restrict young women's access to sexual and reproductive health services and commodities necessary to protect themselves, such as condoms and contraceptives. Young women are particularly vulnerable to some harmful cultural practices listed elsewhere, including early marriage, early sexual intercourse, bride price and compensation ceremonies, which can all violate young women's sexual and reproductive health and rights.

Sexual and reproductive health and rights issues for young people

Access to information

Access to SRHR information is crucial if young people are to make informed decisions about their health and sexual relationships. However, evidence suggests that there is not enough information provided to young people, especially young women, on the health, economic, and family pressures related to pregnancy.⁶¹ Even when information does exist, young people's access can be stifled by religious and cultural norms, which view adolescent sexuality as taboo.⁶² This discourages young people from seeking out the information they need to practice safe and healthy relationships.

Comprehensive sexuality education (CSE) is a recognised strategy designed to meet the challenges of providing relevant and accurate information about sexual and reproductive health to young people. WHO suggests that information about the following is essential to CSE:

- ◆ Prevention of STIs, contraception, and fertility and reproduction.
- ◆ Gender norms, differences and inequalities.
- ◆ The importance of responsibility and joint decision making, communication and negotiation skills.
- ◆ The role of pleasure.
- ◆ Sexual and gender identity and sexual choice.⁶³

Research has shown that CSE can help young people to abstain from, or delay, their first sexual experience, reduce the frequency of unprotected sexual activity, reduce their number of sexual partners and increase the use of protection against unintended pregnancy and STIs during sexual intercourse.⁶⁴

Sexuality education in the Pacific has long been taught from a conservative and often religious perspective, with abstinence emphasised over safe sexual practices. However, this is slowly changing. A 2013 study of eight PICTs (Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Tonga, Tuvalu and Vanuatu) showed that all were at some stage of implementing a CSE curriculum into schools. In order for CSE to be effective and sustainable, it must be supported by an overarching national policy framework. At the time of writing, only Fiji, Kiribati and Vanuatu had a national policy framework to support CSE, with Nauru and Tuvalu in the process of developing such policies. Federated States of Micronesia, Marshall Islands and Tonga had no overarching national policy framework to support CSE programming.



Comprehensive sexuality education is also referred to as family life education (FLE) in the Pacific region.



YOUNG PEOPLE WITH DISABILITIES

All people have the right to access education and information that can help them to make safe and healthy choices about their bodies and relationships. Persons with disabilities, however, often do not have equal access to information and education. This can be for a number of reasons, including physical barriers to accessing classrooms, varied learning needs and the values and attitudes of others and their decisions about what education or information to provide.⁶⁵

Information on sexuality and relationships is essential for young persons with disabilities. They are vulnerable to sexual abuse and exploitation and may require direct instruction to learn positive and protective skills. Research consistently shows that sexuality and relationships education is important for young persons with disabilities and can be successful in contributing to knowledge and skill acquisition, as well as influencing the development of positive behaviours.⁶⁶

Access to youth-friendly services

In order for young people to access sexual and reproductive information and services, they must be confident that their privacy will be protected, that staff will be respectful and non-judgmental, and that services are affordable and operate at convenient hours and locations.⁶⁷ These services are referred to as 'youth-friendly' sexual and reproductive health services and are crucial to the realisation of young people's sexual and reproductive health and rights. 'Youth-friendly' services do not need to be provided separately; the characteristics of youth-friendly service should be incorporated into all sexual and reproductive health services.

Key elements of a youth-friendly health service⁶⁸

Staff should:

- ◆ be specially trained in working with young people
- ◆ show respect for adolescents and young people
- ◆ consider the best interests of the young person and take into account their capacity
- ◆ ensure privacy and confidentiality
- ◆ allow adequate time for client–provider interaction.

Clinics should:

- ◆ have separate space or special times set aside for consultations with young people
- ◆ be in an easy-to-reach location and be open at times convenient to young people.

Programmes should:

- ◆ be designed with involvement of young people
- ◆ ensure that drop-in clients are welcome and appointments are arranged rapidly
- ◆ be welcoming to both boys and young men, and girls and young women
- ◆ provide a wide range of services and referrals, including peer counselling.

Unfortunately, youth-friendly sexual and reproductive health services are rare in the Pacific, with many falling short of acceptable standards. A 2010 study of so called 'youth-friendly' sexual and reproductive health services in Tonga, Solomon Islands, Vanuatu, Kiribati, Cook Islands and Tuvalu, found that the majority of these clinics were in fact not youth-friendly at all.⁶⁹

Violence

Sexual violence amongst young people is a troubling trend in the Pacific, with young women experiencing the highest risk. A 2007 survey in the Marshall Islands found that a quarter of female high school students had experienced 'dating violence' and a third had been physically forced to have sexual intercourse. The same survey showed that 26 per cent of female high school students experienced physically forced sexual intercourse in American Samoa; 19 per cent in Palau; 18 per cent in Northern Marianas; and 17 per cent in Guam.⁷⁰ Another study, conducted by UNICEF in Solomon Islands, Vanuatu and Kiribati, found that between 38 and 45 per cent of sexually active youth had experienced forced sex, with approximately 20 per cent reporting that their first sexual encounter was forced.⁷¹

Family health and safety studies in the Pacific have consistently shown a correlation between age of first sexual activity and instance of sexual violence, with women who reported losing their virginity at a young age more likely to report that the experience was forced or coerced.⁷² Research shows that sexual assault during childhood and adolescence has been linked to earlier sexual debut, sex with multiple partners, unprotected sex, transmission of STIs and early pregnancy,⁷³ creating a cycle of negative sexual and reproductive health outcomes throughout the lifespan.

Bullying is also a rising concern in PICTs. Bullying can be both physical and emotional, and is increasingly conducted in cyber spaces such as social media sites. Young LGBTQI persons are particularly susceptible to bullying. This can often take the form of physical abuse, but a more sinister form is the public 'shaming' of young LGBTQI persons, either verbally or through posts on social media sites or abusive text messages. Many young people do not report either types of violence for fear that they will not be believed, or that they will be somehow blamed for the violence perpetrated against them.

Key legislative and policy frameworks

The Pacific Youth Development Framework (2014–2023)

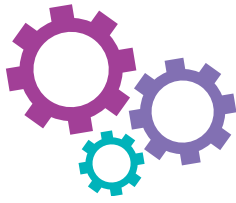
The Pacific Youth Development Framework (PYDF) 2014–2023 succeeds previous Pacific youth strategies (the 2000–2005 and 2005–2010 strategies) as the coordinated approach to youth-centered development in the Pacific region. It consists of a set of priorities and strategies that have been determined by young people, government officials and development partners to mainstream youth issues into regional and national development agendas. The framework seeks to achieve a coordinated approach that addresses barriers to implementation, maximises available resources, mobilises new resources, and achieves clear and lasting improvements in development outcomes for young Pacific Islanders.

The PYDF works towards a common vision of 'a sustainable Pacific where all young people are safe, respected, empowered and resilient'. To achieve this, it has four development outcomes.

1. More young people secure decent employment.
2. Young people's health status is improved.
3. Governance structures empower young people to increase their influence in decision-making.
4. More young people participate in environmental action.

To achieve these outcomes, five key strategies are required to ensure that implementation of the PYDF makes positive changes in young people's lives.

5. Partnerships for youth
6. Delivering youth-focused services
7. Strengthening local capacity
8. Increasing commitment and resources for youth outcomes
9. Strengthening youth statistics.



ACTIVITY
Case study

Time

30 minutes

Materials

Activity
Resource 3:
Case Study on
page 133.

Overview

This activity will help you gain a deeper understanding of the critical importance of incorporating characteristics of a youth-friendly service into all sexual and reproductive health services.

Instructions

Consider the case study on page 133 and answer the following questions:

1. How do you think this experience would have felt for Emily? What are the potential risks to her sexual and reproductive health as a result of this experience?
2. Were staff acting in a way that is consistent with a youth-friendly service? If not, what specifically is inconsistent with the key elements of a youth-friendly health service?
3. What could staff have done differently to make their service youth friendly?
4. How could the hospital prevent this type of incident from occurring in the future?

Useful resources

Title: State of Pacific Youth 2011: Obstacles and opportunities.

Author: UNICEF and SPC (2011).

Link: http://www.unicef.org/eapro/State_of_the_Pacific_Youth_Report_web.pdf

Title: Pacific young people's sexual and reproductive health and rights fact sheet.

Author: ARROW (2014).

Link: <http://www.pacificwomen.org/resources/research/pacific-young-peoples-srhr-factsheet/>

Title: Pacific young women's leadership strategy.

Author: World YWCA and AusAID PLP (2011).

Link: <http://www.pacificwomen.org/resources/policy/pacific-young-womens-leadership-strategy/>

Title: Pacific young women's leadership alliance: Summary of online dialogues.

Author: Pacific Young Women's Leadership Alliance (2013).

Link: <http://www.pacificwomen.org/wp-content/uploads/PYWLA-Dialogues-Summary1.pdf>

Title: I am not a lost cause! Young women's empowerment and teenage pregnancy in the Pacific.

Author: UNFPA (2013).

Link: <http://countryoffice.unfpa.org/pacific/?publications=8338>

Title: Pacific youth. Their rights: our future.

Author: New Zealand Parliamentarians' Group on Population and Development (2012).

Link: <http://countryoffice.unfpa.org/pacific/?reports=7584>

Title: Love, sex and young people: How to be a youth centered organisation.

Author: International Planned Parenthood Federation (2013).

Link: <http://www.ippf.org/resource/Love-sex-and-young-people-how-be-youth-centred-organization>

Title: Youth friendly services: A manual for service providers.

Author: EngenderHealth (2002).

Link: <http://www.engenderhealth.org/pubs/gender/youth-friendly-services.php>

Title: Mobilising communities on young people's health and rights: An advocacy training guide.

Author: Family Care International(2008).

Link: <http://www.familycareintl.org/en/resources/publications/66>

Title: Sexual and reproductive health training manual for young people.

Author: DSW and Youth 2 Youth Initiative (2010).

Link: <http://youth-to-youth.org/resources/training-manuals>

Title: Act 2015! Advocacy strategy toolkit.

Author: UNAIDS (2014).

Link: http://www.unaids.org/sites/default/files/media_asset/advocacy_toolkit_en_0.pdf

Persons with disabilities

The sexual reproductive health and rights of persons with disabilities are frequently overlooked, not only by mainstream organisations but by disability organisations as well. As a result, people with disabilities are among the most underserved communities when it comes to their sexual and reproductive health. Although one in every 10 people worldwide has a disability, they are often 'invisible' to policy-makers and service providers, who often greatly underestimate the number of persons with disabilities and assign them low priority among groups needing attention.

It is often incorrectly assumed that people with disabilities are not sexually active and therefore do not need sexual and reproductive health services. In fact, people with disabilities have the same sexual needs and desires as able bodied people and therefore require the same level of information, education and access to services. In some cases, people with disabilities have a greater need for SRHR information and education due to their unique needs and increased vulnerability to exploitation and abuse. These unique needs are often not caused by the person's disability itself, but by the stigma and discrimination they experience because of it.

In a rights-based approach, people with disabilities must not be treated as passive recipients of services. Rather they must be acknowledged as a significant stakeholder group and be given a place at the table when decisions about their sexual and reproductive health are being made.



INTERSECTION

WOMEN WITH DISABILITIES

Systematic prejudice and discrimination against women with disabilities continues to result in multiple and extreme violations of their sexual and reproductive rights, through practices such as forced and/or coerced sterilisation, forced contraception and/or limited or no contraceptive choices, a focus on menstrual and sexual suppression, poorly managed pregnancy and birth, forced or coerced abortion, termination of parental rights, denial of/forced marriage, and other forms of torture and violence, including gender-based violence.

Women with disabilities also experience systemic exclusion from sexual and reproductive health care services. These practices and violations are a result of entrenched disability-based and gender-based stereotypes that view women with disabilities as undesirable, unworthy and incapable of love and sexual expression.

When seeking reproductive health care and services, they often face abusive treatment at the hands of health care providers who do not understand their needs and circumstances and make negative assumptions about their capacity, choices and rights.

Forced sterilisation and contraception

Women and girls with disabilities are at particular risk of forced and coerced sterilisation, often performed under the auspices of legitimate medical care at the consent of others in their name. Women with disabilities (particularly those with intellectual disabilities) are more likely to be sterilised or to be prescribed long-acting, injected/implanted forms of contraceptives as opposed to oral contraceptives. In addition, women with disabilities are much less likely to be involved in decision-making around the type of contraception they use.

A study of the experiences of women with disabilities in Kiribati, Solomon Islands and Tonga found that in all three countries, involuntary sterilisation or contraceptive use was a common experience for women with an intellectual disability or mental illness.⁷⁴ This was most often carried out on the instigation of families or medical professionals because of a genuine dilemma: women were repeatedly raped and becoming pregnant, and their families or medical professionals wanted to help them but felt unable to prevent rape and assumed the woman could not manage her own fertility. For example, in an interview with a staff member of a psychiatric unit in Kiribati, it was stated that women were given the contraceptive injection, Depo-Provera, as a way of preventing pregnancy, and that even though some women 'don't want to', 'they have it in the end'.⁷⁵

Regardless of good intentions, forced sterilisation is an act of violence and a gross violation of multiple human rights, although perpetrators are seldom held accountable and victims are rarely, if ever, able to obtain justice. Pacific Island countries need to develop rights-based legislation that promotes and protects the rights of the woman. Education of families and health professionals might assist in identification of solutions that do not violate the rights of women, and improve the system of gaining informed consent. The rape of women is a gross human rights violation in and of itself, and much greater action is necessary to prevent this.



**REFLECT
& DISCUSS**

What human rights are violated with the forced sterilisation of women and girls? (Hint: refer to the CRPD for more information)

Gender-based violence

Compared to non-disabled women, women with disabilities experience significantly higher levels of all forms of violence and are subjected to this violence by a greater number of perpetrators. For example, a woman may be denied medication or medical devices, have their care needs neglected or be physically or sexually abused. Likely perpetrators of violence against women with disabilities include their partners, family members and carers. Much of the violence against women with disabilities is perpetrated or condoned by institutions.

Many women with disabilities are unable to speak out against violence because they are financially and physically dependent on the person who is committing the violence. As a result, crimes of violence committed against women with disabilities often go unreported. Even when crimes against women with disabilities are reported, police and legal practitioners are often unwilling or ill equipped to address the issue, so the crimes are inadequately investigated and prosecuted.

Studies show that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than women with no disabilities,⁷⁶ Unfortunately, there is almost an almost total absence of data on the prevalence of violence against women with disabilities in the Pacific.

One study was undertaken. Between 2010 and 2011, UNFPA Pacific Sub-Regional Office undertook a situation analysis in Kiribati, Solomon Islands and Tonga to assess the sexual and reproductive health situation and needs of women and girls with disabilities, including their vulnerability to violence, particularly sexual violence; identify critical issues and concerns which need to be addressed; and identify and document examples of good practice.

The situation analysis included qualitative interviews with 20 women with disabilities from Kiribati, 39 from Solomon Islands and seven from Tonga. Women reported a range of experiences of violence, including violence at the hands of intimate partners and caregivers and rape by strangers or acquaintances. Nearly half of the women interviewed were coerced or forced into their first sexual experience.

Access to information and services

For people with disabilities, a lack of adequate information on education, health care and sexual and reproductive rights contributes to their vulnerability and prevents them from participating in and contributing to their own development and the development of their families. Additionally, people with disabilities experience a range of additional barriers when accessing sexual and reproductive health services. These include: stigma and discrimination by their peers, partners and families; negative attitudes and discrimination by service providers; and physical barriers, such as the absence of wheelchair ramps and hearing loops.

Important information about SRHR may not be provided to people with disabilities based on an incorrect belief that they are not sexually active. When information is provided, it is rarely made available in formats accessible to people with disabilities, such as large print, braille or sign language. Financial constraints may prevent people with disabilities from purchasing information and communications technology equipment and/or adaptive technology that would allow them to be independently informed of issues relating to SRHR.

One of the most significant barriers to women with disabilities accessing sexual and reproductive health services is uninformed staff. A 2013 study of the experiences of women with disabilities in Solomon Islands, Kiribati and Tonga found that, in general, health professionals and other social service staff appeared to have a poor understanding of disability.⁷⁷ It recommended the provision of training, mentoring and coaching on disability and issues for people with disabilities for those working in the social sector in order to improve their services. Additionally, assisting social sector professionals by providing a range of information, education and communication materials that are accessible to people with disabilities will also likely improve the quality of services provided to women with disabilities.

Key legislative and policy frameworks

The Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) is the core international agreement that enshrines the sexual and reproductive rights of people with disabilities. The convention and its optional protocol were endorsed by the UN General Assembly in December 2006 and came into force in May 2007. The purpose of the convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Article 1 of the convention states that persons with disabilities include:

➤ *those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.*

The CRPD Committee is a body of 18 independent experts who monitor implementation of the convention. Committee members are elected from a list of persons nominated by the States at the Conference of the State Parties for a four-year term with a possibility of being re-elected once.

Which Pacific Island countries have ratified CRPD?

At the time of writing, all Pacific Island countries, except for Republic of the Marshall Islands, have either signed or ratified CRPD. Signing the convention means that a state gives preliminary endorsement to the convention, but does not commit to ratification. States that sign the convention must refrain from acts that would defeat or undermine the treaty's objectives and purpose. Ratification means that the state agrees to be legally bound by the terms of the convention.

Cook Islands, Fiji, Palau and Solomon Islands have also either signed or ratified the CRPD Optional Protocol (OP), which gives the CRPD Committee the right to receive complaints and make inquiries into violations of the treaty. Cook Islands is the only Pacific Island country that has submitted a periodic report to the CRPD Committee.

The following table outlines the status of CRPD signature and/or ratification and reporting in the Pacific:⁷⁸

Country	CRPD signed	CRPD ratified	CRPD OP signed	CRPD OP ratified	Last CRPD report submitted
Cook Islands	-	2009	-	2009	2013
Fiji	2010	-	2010	-	-
Kiribati	-	-	2013	-	-
Marshall Islands	-	-	-	-	-
Federated States of Micronesia	2011	-	-	-	-
Nauru	2012	-	-	-	-
Palau	2011	2013	-	2013	-
PNG	2011	2013	-	-	-
Samoa	2014	-	-	-	-
Solomon Islands	2008	-	2009	-	-
Tonga	2007	-	-	-	-
Tuvalu	-	2013	-	-	-
Vanuatu	2007	2008	-	-	-

Which CRPD articles relate to SRHR?

The main CRPD articles that relate to SRHR are:

- Article 6:** recognises that women and girls with disabilities are subject to multiple discrimination, and calls on State Parties to take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
- Article 9:** calls for accessibility, including access to medical facilities and information.
- Article 16:** requires State Parties to take measures to protect persons with disabilities from violence and abuse, including gender-based violence.
- Article 22:** asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information.
- Article 23:** requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life.
- Article 25:** requires that states ensure equal access to health services for persons with disabilities, with specific mention of sexual and reproductive health and population based public health programs.



While these are the main CRPD articles that relate specifically to SRHR, it is important to remember that all of the articles of the treaty work together to ensure that women can realise their sexual and reproductive health and rights.

Biwako Millennium Framework for Action (and Biwako Plus Five)

In 2002, Asia and Pacific governments adopted a set of guidelines and actions to support disability-inclusive policy implementation. It is entitled the Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights-based Society for Persons with Disabilities in Asia and the Pacific (BMF), 2002–2012. In 2007, Biwako Plus Five: Further Efforts Towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific was adopted. Unfortunately there were no explicit action areas in the BMF or BMF +5 that specifically focused on addressing the rights of persons with disabilities to sexual and reproductive health.

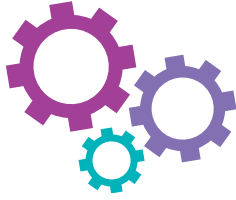
Incheon Strategy to ‘Make the Right Real’ for Persons with Disabilities in Asia and the Pacific

The Incheon Strategy was launched in 2012 at the Economic and Social Commission for Asia and the Pacific (ESCAP). The Incheon Strategy builds on the CRPD, through focusing action on a set of priority goals and targets from 2013 to 2022. The Incheon Strategy makes a robust contribution to improving the regional policy framework for the sexual and reproductive health of people with disabilities. It has specific targets on reproductive health and violence against women, including:

- ◆ Target 6.C: Ensure that all girls and women with disabilities have access to sexual and reproductive health services on an equitable basis with girls and women without disabilities.
- ◆ Target 6.D: Increase measures to protect girls and women with disabilities from all forms of violence and abuse.

Pacific Regional Strategy on Disability 2010–2015

Pacific Island leaders adopted the Pacific Regional Strategy on Disability 2010–2015 (PRSD) in 2009. The PRSD recognises women’s extra discriminatory burdens and specifically mentions the need for including disability issues in all programmes on gender, youth and other disadvantaged and vulnerable groups and to address the specific needs of young people, women, girls and children with disabilities. Unfortunately, the PRSD does not discuss improving health information and services for people with disabilities.



ACTIVITY

SRHR in the Pacific Regional Strategy on Disability

Time

One hour

Materials

Useful resource on page 88:
The Pacific Regional Strategy on Disability 2010 -2015

Overview

This activity will help you to identify the most critical SRHR issues for persons with disabilities.

Instructions

It has been said that one of the shortcomings of the Pacific Regional Strategy on Disability 2010–2015 is that it fails to acknowledge and address the SRHR of people with disabilities, especially women.

Imagine that you are preparing to lobby Pacific governments to include SRHR in future strategies and frameworks. List five priority areas for action that you would focus on.

For example: Educating health professionals on the sexual and reproductive health needs of persons with disabilities.

Useful resources

Title: UN Convention on the Rights of Persons with Disabilities (CRPD).

Author: United Nations (2008).

Link: <http://www.un.org/disabilities/convention/conventionfull.shtml>

Title: Incheon Strategy to 'Make the Right Real' for Persons with Disabilities in Asia and the Pacific.

Author: UNESCAP (2012).

Link: <http://www.unescapsdd.org/publications/incheon-strategy>

Title: A deeper silence: The unheard experiences of women with disabilities – sexual and reproductive health and violence against women in Kiribati, Solomon Islands and Tonga.

Author: UNFPA (2013).

Link: <http://countryoffice.unfpa.org/pacific/drive/ADEEPERSILENCE.pdf>

Title: Pacific sisters with disabilities: At the intersection of discrimination.

Author: UNDP Pacific Centre (2009).

Link: <http://www.pacificwomen.org/resources/policy/pacific-sisters-with-disabilities>

Title: Promoting sexual and reproductive health for persons with disabilities.

Author: WHO/UNFPA (2009).

Link: <http://www.unfpa.org/publications/promoting-sexual-and-reproductive-health-persons-disabilities>

Title: The Pacific Regional Strategy on Disability 2010 -2015.

Author: Pacific Islands Forum Secretariat.

Link: <http://www.forumsec.org/resources/uploads/attachments/documents/Pacific%20Regional%20Strategy%20on%20Disability.pdf>

Lesbian, gay, bi-sexual, transgender, queer, intersex (LGBTQI) persons

We all have the same human rights, regardless of our sexual orientation and gender identity. Sadly, lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) persons in many regions of the world still face death, imprisonment, torture, violence, discrimination and neglect because of their real or perceived sexual orientation, gender identity and gender expression.

Despite the traditional recognition of the social role of transgendered people in several Pacific societies, people of diverse sexualities experience persistent stigma and discrimination, which in many cases, restricts their access to sexual and reproductive health services.

Challenges and barriers faced by LGBTQI persons in the Pacific region include:

- ◆ stigma, discrimination and violence by their peers, partners and families;
- ◆ negative attitudes, discrimination or denial of service by health care providers;
- ◆ laws that criminalise same sex conduct or that are used to unfairly target people on the basis of their sexual orientation and gender identity; and
- ◆ exclusion from decision making and data collection on sexual and reproductive health issues.

Protection, recognition and respect for the sexual and reproductive health and rights of LGBTQI persons is long overdue in the Pacific region. This will require an immediate end to the violence and discrimination that impedes LGBTQI persons' enjoyment of their human rights, including the criminalisation of same sex conduct.

Important Terminology^{vi}

Sex

A person's biological make-up (their body and chromosomes), defined usually as either 'male' or 'female' and including indeterminate sex.

Gender

The social and cultural construction of what it means to be a man or a woman, including roles, expectations and behaviour.

Gender identity

A person's internal, deeply felt sense of being male or female (or something other or in between). A person's gender identity may or may not correspond with their sex. Gender identity and its expression vary greatly. There is no universally accepted umbrella term that adequately conveys the rich diversity of gender identities. People are free to define their own gender identity and not all people fit neatly into categories.

Gender expression

How someone expresses their sense of masculinity and/or femininity externally.

Gender reassignment services

The full range of medical services that trans people may require in order to medically transition, including counselling, psychotherapy, hormone treatment, electrolysis, initial surgeries such as a mastectomy, hysterectomy or orchidectomy, and a range of genital reconstruction surgeries.

Genderqueer

People who do not conform to traditional gender norms and express a non-standard gender identity. Some may not change their physical sex or cross dress, but identify as genderqueer, gender neutral or androgynous.

Transgender (Trans)

A man or woman whose gender identity is different from their physical sex at birth. A person who is taking steps to live their desired gender identity, including undergoing medical treatment such as hormone therapy or gender reassignment surgery, may be referred to as 'transitioning'.

Across the Pacific region, transgender persons use many different terms to describe themselves, including: fa'afafine (Samoa, American Samoa and Tokelau), fakaleiti or leiti (Tonga), fakafifine (Niue), akava'ine (Cook Islands), mahu (Tahiti and Hawaii), vakasalewalewa (Fiji), palopa (Papua New Guinea), whakawahine, hinehi, hinehua, tangata ira tane, takatāpui (some of a number of Māori terms describing someone with a gender identity different to their sex at birth).

^{vi} Glossary adapted from the NZ High Commission, Fact Sheet H: RESOURCES: Terminology

Transsexual

A person who has changed, or is in the process of changing, their physical sex to align with to their gender identity.

Sexual orientation

Sexual orientation refers to who someone is attracted to or chooses as a sexual or romantic partner. Trans people may be heterosexual/straight, lesbian, gay or bisexual – just like non-trans people.

Lesbian

Used exclusively in relation to homosexual/same-sex attracted women.

Gay

Can refer to homosexual/same-sex attracted women and men, but is more often used in relation to males.

Bisexual

Used to describe a man or a woman who is sexually attracted to both men and women.

Intersex

A general term used for a variety of conditions in which a person is born with reproductive or sexual anatomy that does not match the typical biological definitions of female or male. Most people who are intersex identify simply as male or female and are not trans. Most trans people are not born with intersex medical conditions.

Queer

Has been used as a derogatory term for gay and lesbian people but is increasingly reclaimed as a positive term, particularly by young people. It is sometimes used as a broader term to also include trans people.

Heterosexual

Used exclusively in relation to heterosexual/differently-sex attracted women and men.

Sexual and reproductive health and rights issues for LGBTQI persons

Access to services

LGBTQI persons around the world today often live in a culture of silence, non-recognition and disrespect. Discrimination against LGBTQI persons takes many forms and exists on different societal levels. It occurs in direct and indirect ways and can be perpetrated and condoned by individuals, the church and the State.

Stigma and discrimination are key factors in preventing LGBTQI persons from realising their sexual and reproductive health and rights. For example:

- ◆ same-sex couples may be denied services afforded to heterosexual couples and;
- ◆ LGBTQI persons may avoid seeking medical care or fail to disclose important details about their health for fear of stigma, discrimination or disclosure of their sexuality to others.

There has been some progress with raising issues relating to sexual orientation and gender identity as part of the discourse on regional and national efforts to prevent HIV, but this has been both a blessing and a curse. When interviewed on 21 May 2013, Noelene Nabulivou of Diverse Voices and Action for Equality stressed that, while beneficial in some instances, the large amounts of money that flowed into the region to address HIV helped raise the profile and increase the mobilisation of some groups (such as sex workers and men who have sex with men), but risked further submerging the needs of others (such as lesbians, bisexual women and trans* masculine people). Only addressing LGBTQI issues in the context of HIV is highly problematic because it leads to the assumption that their SRHR issues are limited only to HIV, leading to further stigma and discrimination.

Criminalisation

At the time of writing there are still nine PICTs that criminalise people based on their sexual orientation and gender identity. These are highlighted on the map below.



Most of these countries were either British colonies or inherited criminal laws from the colonial era. They criminalise sodomy, indecency or 'unnatural sex', which in effect criminalises consensual non-heterosexual sexual conduct. Although many of these laws can in theory be applied against females as well as males, the existence of these offences has primarily been of concern to men who have sex with men (only Solomon Islands actively criminalises sexual conduct between females).

Many LGBTQI persons fear that these offences can be used as a basis for harassment or police abuses. The existence of such offences compounds the stigma associated with homosexuality and can act as a deterrent to young LGBTQI persons from accessing sexual and reproductive health services, particularly if they fear arrest or breach of privacy and disclosure of their sexuality or gender identity to their family and community. In addition to sodomy and 'unnatural sex' offences, other criminal offences such as vagrancy and public order are sometimes selectively enforced by police against LGBTQI persons.

Fiji's new Constitution (2013) is the only one in the Pacific to specify protection from discrimination on grounds of sexual orientation, and gender identity or expression. However, it limits this right in the case of marriage, adoption and inheritance, thus violating the principle of non-discrimination.

Violence and abuse

LGBTQI persons face many kinds of abuse, violence and discrimination because of the sexual orientation or gender identity, including:

- ◆ domestic violence from current or ex partners;
- ◆ arbitrary arrest, imprisonment, targeting, beatings and other forms of abuse by police and other officials;
- ◆ violence by families and kinship networks, including religious and traditional leaders;
- ◆ so called 'correctional' rape and other forms of abuse because of real or perceived sexual orientation;
- ◆ exclusion from (include expulsion and denial of entry) and bullying in schools;
- ◆ violence in public places from strangers;
- ◆ bullying and harassment in the workplace; and
- ◆ forced separation from same-sex partners and or loss of custody of children.

Domestic violence in same-sex relationships is an under-researched area in the Pacific, resulting in little data to inform policies and service provision. There is, however, some evidence from other regions of the world that suggests that domestic violence between same-sex couples is not only equally or more prevalent than it is between heterosexual couples, but that it is vastly underreported.⁷⁹ In addition to the normal risks associated with reporting domestic violence, same-sex couples face the real or perceived fear that service providers will not take their complaint seriously, will deny them access to services or will disclose their sexual orientation to their colleagues, friends and family.

Key legislative and policy frameworks

The Yogyakarta Principles

The Yogyakarta Principles address a broad range of human rights standards and their application to issues of sexual orientation and gender identity. The 29 Principles are available at http://www.yogyakartaprinciples.org/principles_en.htm.

Moana Declaration

Pacific Parliamentarians of the 11 nations represented at the Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, affirmed in the Moana Declaration that they will advocate to:

Ensure access to sexual and reproductive health and rights (SRHR) for all our peoples, without discrimination.

Asian and Pacific Ministerial Declaration on Population and Development

The Economic and Social Commission for Asia and the Pacific (ESCAP), in cooperation with the United Nations Population Fund, convened the Sixth Asian and Pacific Population Conference (APPC) in Bangkok in September 2013. The conference aimed to set the population and development agenda for the region over the next decade and inform the International Conference on Population and Development (ICPD) beyond 2014.

The outcomes document — the Asian and Pacific Ministerial Declaration on Population and Development — includes the following statements concerning the sexual and reproductive health and rights of LGBTQI persons.

Paragraph 7

Reaffirming the importance of the Universal Declaration of Human Rights and the Vienna Declaration and its Programme of Action as well as other international instruments relating to all human rights ... and emphasizing the responsibilities of all States, in conformity with the Charter, to respect, protect and promote human rights and fundamental freedoms for all without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.

Paragraph 8

Expressing grave concern at acts of violence and discrimination committed against individuals on the grounds of their sexual orientation and gender identity.

Paragraph 25

Recognizing the importance of considering the impact, in terms of potential marginalization of the status of individuals in society and on public health, of laws and practices on consensual adult sexual behaviours and relationships.

Paragraph 43

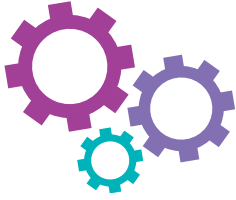
Recognizing that discrimination based on gender is inextricably linked to other factors, such as race, ethnicity, religion or belief, health, disability, age, class, caste, or all other status, and that these multiple and intersecting forms of discrimination can compound women's and girls' experience of injustice, social marginalization and inequality.

Paragraph 84

Work to reduce vulnerability and eliminate discrimination based on sex, gender, age, race, caste, class, migrant status, disability, HIV status and sexual orientation and gender identity, or other status.

Human Rights Council Resolution 17/19

In 2011, the Human Rights Council adopted the first United Nations resolution on sexual orientation and gender identity, expressing 'grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity'.⁸⁰ This resolution paved the way for the first official United Nations report on the issue, prepared by the Office of the High Commissioner for Human Rights: Born Free and Equal (see 'useful resources' on page 97).



ACTIVITY

Situating the Yogyakarta Principles within human rights treaties**Time**

One hour

Materials

Activity
Resource 4:
Yogyakarta
Principles and
Human Rights
Worksheet on
page 134.

Overview

The Yogyakarta Principles are not a distinct set of rights for LGBTQI people; rather they detail the application of international human rights law in relation to sexual orientation and gender identity.

The Principles already exist in binding international legal standards, however, unfortunately, people in every region of the world still face death, imprisonment, torture, violence, discrimination and neglect because of their real or perceived sexual orientation, gender identity and gender expression.

This activity will help you gain a deeper understanding of how the Yogyakarta Principles build on existing human rights treaties to affirm these rights for LGBTQI persons.

Instructions

Complete the worksheet by identifying which human rights treaties complement the Yogyakarta Principles.

Useful resources

Title: The Yogyakarta Principles: Principles on the application of international human rights law in relations to sexual orientation and gender identity.

Author: Independent Publication (2007).

Link: http://www.yogyakartaprinciples.org/principles_en.pdf

Title: Born free and equal.

Author: New Zealand Human Rights Commission (n.d.).

Link: http://www.hrc.co.nz/wp-content/uploads/2013/02/BornFreeEqual_for_Web.pdf

Title: Creating safe space for LGBTQ youth: A toolkit.

Author: Girl's Best Friend Foundation and Advocates for Youth (2005).

Link: <http://www.advocatesforyouth.org/storage/advfy/documents/safespace.pdf>

Title: Born free and equal.

Author: Office of the High Commissioner for Human Rights (OCHCHR) (2012).

Link: <http://www.ohchr.org/EN/Issues/Discrimination/Pages/BornFreeEqualBooklet.aspx>

Title: The Moana Declaration: An outcome statement for Pacific parliamentarians for population and development.

Author: UNFPA Pacific (2013).

Link: <http://countryoffice.unfpa.org/pacific/?reports=7673>

Title: Report of the Sixth Asian Pacific Population Conference.

Author: Economic and Social Commission for Asia and the Pacific.

Link: <http://www.unescapsdd.org/files/documents/Report%20of%20the%20Sixth%20APPC.pdf>

Title: 17/19 Human rights, sexual orientation and gender identity.

Author: United Nations General Assembly.

Link: https://iglhrc.org/sites/default/files/Resolution_17%3A19_2011_%20HRC_HRSOGI.pdf

People living with HIV and AIDS

Excluding Papua New Guinea, the Pacific is experiencing a low-level HIV epidemic, meaning that HIV prevalence has consistently not exceeded one per cent in the general population nationally, nor five per cent in any sub-population. From 1984 to 2012, a cumulative total of 1,737 HIV cases were reported in the region, excluding Papua New Guinea.⁸¹ The estimated prevalence amongst adults aged 15 to 49 years in the 17 countries with HIV cases in the Pacific is less than 0.1 per cent.⁸² In contrast, the prevalence of HIV in Papua New Guinea is estimated to be 0.65 per cent, which dropped by over 50 per cent between 2001 and 2012.⁸³ While the HIV infection rate of increase in the Pacific has slowed, the infection is becoming more feminised as the percentage of women with HIV continues to increase in some countries.

A 2011 academic review of the HIV epidemic in Papua New Guinea found that there has been real progress in recent years. It found the formation of a National AIDS Council; a clamp-down on HIV-based discrimination; the introduction of AIDS control committees in every province; education and promotion of safe sex strategies, such as condom use; participation of churches; and increases in antiretroviral medication coverage have all helped decrease transmission.⁸⁴

Despite the low prevalence of HIV in the remainder of the Pacific region, numerous risk factors exist that increase the potential for a rapid spread of HIV across the Pacific. These include:

- ◆ high levels of sexual and gender-based violence;
- ◆ homophobia;
- ◆ gender inequality;
- ◆ high rates of other STIs;
- ◆ a high proportion of young people reporting unsafe sex practices;
- ◆ stigmatisation and discrimination against people living with HIV;
- ◆ cultural taboos and religious beliefs around sex;
- ◆ limited access to health services; and
- ◆ weak economies with limited economic opportunities.⁸⁵



These risk factors are interconnected, which is why a comprehensive, holistic approach to SRHR is critical.

Stigma and discrimination

Globally, people living with HIV and AIDS have reported experiencing stigma and discrimination from friends, family, employers, health service providers and the wider community. Within the Pacific, a lack of confidentiality, stigmatisation and discrimination within health services are reported as key issues faced by people living with HIV.⁸⁶

A Papua New Guinea study of 80 men, women and transpeople living with HIV revealed that they experienced a significant amount of stigma and discrimination because of their HIV status:

- ◆ 85 per cent said they had been verbally insulted, harassed or threatened;
- ◆ 70 per cent said they had been physically insulted, harassed or threatened;
- ◆ 60 per cent said they had been denied services;
- ◆ 56 per cent said they had been excluded from social gatherings; and
- ◆ all but one said they had experienced gossip relating to their HIV status.⁸⁷

Access to treatment

Globally, stigma, discrimination, gender inequality and the lack of protection of human rights have been identified as among the major obstacles to achieving universal access to HIV prevention, treatment, care and support.

At home, in the Pacific, there has been a dramatic improvement in access to treatment, including in recent years a substantial increase in the number of HIV testing sites in Papua New Guinea. This has improved access to testing and treatment. In 2005 there were only 17 HIV testing sites; by 2013 this had increased to 329.⁸⁸ In 2013, there were 90 locations across the country, trained to dispense antiretroviral therapy (ART).⁸⁹ Despite this, current estimates suggest that only 84 per cent of adults and 39 per cent of children living with HIV are currently accessing ART in Papua New Guinea.⁹⁰

Violence

For women, violence is both a cause and an effect of HIV, with a growing body of data suggesting that violence against women and girls is linked to an increase in HIV risk.⁹¹ Women experiencing violence may be less able to negotiate safe sex or fear questioning their partner about their sexual activities. Additionally, forced sex poses a direct biological risk of contracting HIV and other STIs by tearing and lacerating the genitals, thereby increasing the likelihood of HIV infecting the bloodstream. This risk is even higher for young women and girls, because their vaginal tracts are immature and more easily torn during sexual intercourse.⁹² This is particularly worrying, given that data from violence against women studies undertaken in Kiribati, Samoa, Solomon Islands and Vanuatu reveal that between three to eight per cent of women had their first sexual experience before the age of 15, and of those young women 23 to 50 per cent reported that their first sexual experience was forced.⁹³

Just as violence against women and girls can increase the risk of HIV transmission, HIV positive women face various forms of violence because of their HIV status, including physical, psychological and economic abuse. This includes: being shunned or rejected

by family and the community; eviction from home and loss of assets; denied access to their children; ill-treatment by service providers; loss of livelihoods and denial of work opportunities; and abuse by police, including extortion.⁹⁴ A study conducted in four countries in the Asia-Pacific region found that HIV positive women are significantly more likely than men to experience discrimination, violence and be forcefully removed from their homes.⁹⁵ Around the world many women have reported experiencing different forms of violence following the disclosure of their HIV status, or even after disclosing that they have gone for HIV testing.⁹⁶ Fear of these repercussions can prevent women from being tested, revealing their status and/or seeking treatment, care and support.

Key legislative and policy frameworks

ESCAP Resolution 57/1: Regional call for action to fight the human immunodeficiency virus/acquired immunodeficiency syndrome in Asia and the Pacific

Resolution 57/1, adopted by the 57th Session of the Economic and Social Commission for Asia and the Pacific in Bangkok in 2001, recognises that HIV has generated a global pandemic that far exceeds what was predicted a decade ago, threatening the human security of the Asian and Pacific region. The resolution calls upon Member States to secure a regional commitment to enhancing effective measures to prevent the spread of HIV and address the social and economic impact of the epidemic.

Declaration of Commitment on HIV/AIDS: Global Crisis – Global Action

Between 25–27 June 2001, Member States attended the United Nations General Assembly Special Session (UNGASS) dedicated to HIV/AIDS. The special session was convened to address the problem of HIV/AIDS in all its aspects and to secure a global commitment to combat it in a comprehensive manner.

The declaration states what Member States have pledged to do to reverse the HIV epidemic. Unlike treaties and resolutions of the United Nations, the declaration is not legally binding. However, it is a clear statement by governments of their commitment to take action to reverse the HIV epidemic, and this can be a powerful tool for CSOs to keep governments accountable.

Pacific Sexual Health and Well-being Shared Agenda 2015–2019

The regional framework for addressing HIV in the Pacific region is the Pacific Sexual Health and Well-Being Shared Agenda (2015–2019). The Shared Agenda succeeded the Pacific Regional Strategy on HIV and other STIs, which expired at the end of 2013 and, replaces the medical approach to sexuality and sexual health with a comprehensive, rights-based approach.

More information about the Shared Agenda can be found on page 35.



ACTIVITY

Turning commitment into action

Time

One hour

Materials

Useful resource on page 102:

Declaration of Commitment on HIV/AIDS : Global Crisis—Global Action.

Activity

Resource 5: Turning commitment into action worksheet on page 136.

Overview

This activity will help you gain a deeper understanding of whether your government is acting on its commitment to address the HIV crisis as stated in the Declaration of Commitment on HIV/AIDS.

Instructions

Review the Declaration of Commitment on HIV/AIDS, looking at the specific actions under each Area of Commitment.

Complete the worksheet by researching and listing actions your government has taken under each Area of Commitment to address the HIV/AIDS crisis.

Useful resources

Title: Ensuring the sexual and reproductive health of people living with HIV: Policies, programmes and health services.

Author: WHO (2007).

Link: <http://www.who.int/reproductivehealth/publications/rtis/rhmatters/en/>

Title: Sexual and reproductive health for HIV-positive women and adolescent girls: A manual for trainers and programme managers.

Author: EngenderHealth (2006).

Link: <http://www.engenderhealth.org/pubs/hiv-aids-sti/srh-hiv-positive-women-girls.php>

Title: Sexual and reproductive health for women and adolescent girls living with HIV: Guidance for health managers, health workers and activists.

Author: EngenderHealth (2008).

Link: <http://www.engenderhealth.org/files/pubs/hiv-aids-stis/english-srh-guidance-final.pdf>

Title: Advancing the sexual and reproductive health and human rights of people living with HIV: A guidance package.

Author: The Global Network of People Living with HIV/AIDS (2009).

Link: http://www.who.int/reproductivehealth/topics/linkages/guidance_package.pdf

Title: Healthy, happy and hot. A young person's guide to their rights, sexuality and living with HIV.

Author: International Planned Parenthood Federation (IPPF).

Link: <http://www.ippf.org/resource/Healthy-Happy-and-Hot-young-peoples-guide-rights>

Title: 16 ideas for addressing violence against women in the context of the HIV epidemic.

Author: WHO (2013).

Link: http://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic

Title: SASA! Activist toolkit for preventing violence against women and HIV.

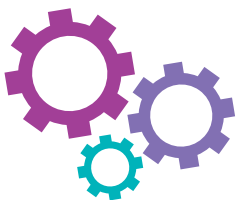
Author: Raising Voices (n.d.).

Link: <http://raisingvoices.org/sasa/>

Title: Declaration of Commitment on HIV/AIDS : Global Crisis—Global Action.

Author: United Nations General Assembly.

Link: <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>



ACTIVITY

A step forward**Time**

45 minutes

Materials**Activity****Resource 6:**

Sexual and reproductive rights on page 137.

Activity**Resource 7:**

Activity cards on page 138.

For this activity you'll need an open space where you can move around.

Overview

This activity will help you gain a deeper understanding of some of our sexual and reproductive rights and how different inequalities (and the way they intersect) can influence whether we are able to realise these rights.

Instructions

- ◆ Give each member of the group an activity card. Give everyone 10 minutes to pretend that they are the person shown on their card. Encourage them to use their imagination to think about what their life might be like if they were that person.
 - ◆ Ask everyone to stand in a straight line at one end of the room. This activity can also be done outside. Tell group members that they should not show or discuss their card with anyone else.
 - ◆ Explain to the group that you will now read out a list of some basic sexual and reproductive rights. Imagining they are the character shown on their card, tell group members to take a step forward if they believe they are able to claim this right, and stay standing where they are if they are not able to claim this right, or if they are unsure.
 - ◆ Read out the list of sexual and reproductive rights on Activity Resource 6, one by one, pausing in between each to give group members time to consider whether they are able to claim that right. When you have finished, declare the person at the front of the group the 'winner'.
 - ◆ Ask group members to reveal their characters. Use the following questions to engage the group in a discussion about how various characteristics, such as gender, sexuality, ability and age can influence whether we are able to realise our sexual and reproductive rights.
- Q How did it feel, imagining the lived experience of another person?
 - Q Were you surprised to know the identity of the people at the front/back of the group?
 - Q What kinds of things can act as a barrier to people claiming their sexual and reproductive rights?
 - Q How can these inequalities intersect/compound to disadvantage and marginalise certain groups?

**MODULE 2
QUIZ**

1. Describe some of the ways that violence against women and sexual and reproductive health are interlinked.

2. What are the main articles of CEDAW that relate to women's sexual and reproductive health and rights?

3. What are some of the consequences of teenage pregnancy for young women?

4. Name at least three elements of a youth-friendly sexual and reproductive health service.

5. What is the status of comprehensive sexuality education (CSE) in the Pacific region?

6. Why are women with disabilities at greater risk of experiencing violence than non-disabled women?

7. Name at least three ways that a service can improve its accessibility to people with disabilities.

8. Which Pacific Island countries still criminalise people based on their sexual orientation and gender identity?

9. What are the Yogyakarta Principles and why are they important?

10. HIV in Papua New Guinea has been described as a 'feminised epidemic'. Why?

Answers: The Answers to these questions can be found on the following pages of the Manual:

1. Page 64, 2. Page 65, 3. Page 72, 4. Page 75, 5. Page 73, 6. Page 82, 7. Page 83, 8. Page 92, 9. Page 94, 10. Page 98.

Module 3

Action

In Module 3 you will learn how to apply all the information you have learned in Modules 1 and 2 to develop practical strategies to advance SRHR across five key domains.

Learning objectives

Develop practical strategies for action across the following domains:

- 1 laws and policies
- 2 education
- 3 society and culture
- 4 economics
- 5 health systems



WORKING GROUP TIP

Model 3 is adapted from the WHO resource *Developing sexual health programmes: A framework for action*.

For more information on these five domains you can download the framework from: http://www.who.int/reproductivehealth/publications/sexual_health/rhr_hrp_10_22/en/

3

Five domains of change to advance sexual and reproductive health and rights

Actions to realise SRHR can take place within a range of settings. They include delivering clinical health services, education programmes, advocacy campaigns and influencing policy and legislation. While all of these activities are equally important, it is unrealistic to expect a single actor to implement all of them at once. Rather, a collaborative, coordinated and multi-sectoral approach is required.

In 2010, WHO published a comprehensive framework for action to improve sexual and reproductive health.⁹⁷ This framework highlights the importance of a rights-based approach across five key domains:



In this module we will explore these five domains of change and provide a range of practical tools and resources to help you implement a rights-based approach to sexual and reproductive health in your chosen area.

Domain 1: Law and policies

Countries can use laws, policies and other regulatory mechanisms to guarantee the promotion, protection and provision of sexual health information and services, including to vulnerable and marginalised groups. They can also use laws and policies to impose sanctions against health service providers who are unwilling to uphold the human rights of those seeking these services, such as refusal to offer a certain service to someone because of the gender, sexuality, age, ability or marital status. Laws and policies can also protect against discrimination and stigma related to sexuality and sexual health status.

When laws and policies adopt the norms, standards and principles of international human rights agreements, they can be a powerful enabler for SRHR. On the other hand, laws and policies that are heavily influenced by restrictive cultural or religious norms can pose a significant barrier to the realisation of SRHR.

Rights-based approaches to influencing legislation and policy include developing, implementing and monitoring laws and policies that:

- ◆ ensure the provision of sexual and reproductive health services, including to vulnerable and marginalised individuals and groups;
- ◆ protect vulnerable and marginalised individuals and groups from discrimination and exploitation;
- ◆ ensure the provision of comprehensive information relating to their sexual health and sexuality;
- ◆ recognise the right to bodily integrity, including the right to have a choice over the number and spacing of children;
- ◆ protect the rights of people in same-sex or transgender relationships to access services and live free from violence and discrimination;
- ◆ ensure equal access to sexual reproductive health services, including for those living with a disability or HIV; and
- ◆ address the issue of gender-based violence, including ensuring access to justice for survivors of violence.



It is important to recognise that the existence of a law or policy does not necessarily mean it will be implemented effectively. Ensuring that governments are held accountable for the full implementation of their laws and policies is equally as important as developing new legislation and policies to support SRHR.

Critical questions

Ask yourself the following critical questions to assess whether the SRHR legal and policy framework in your country is rights-based.

-
- Q** Are there any discriminatory laws and policies that hinder the promotion and achievement of sexual and reproductive health? For example, laws and policies that:
- ◆ restrict access to services for certain people (e.g. on the basis of marital status, age, parental consent);
 - ◆ criminalise certain actions (e.g. same-sex activity or sex outside of marriage); or
 - ◆ fail to criminalise certain actions (e.g. marital rape, early marriage).
- Q** Do mechanisms exist to achieve justice, including compensation, for violations of SRHR? If so, is there evidence that these mechanisms are being accessed?
-
- Q** To what extent do citizens have access to free or affordable legal advice (e.g. through community-based legal aid organisations)?
-
- Q** Do government legislation and policies display a commitment to international human rights standards?
-
- Q** Is there justice for women who have experienced physical or sexual violence? Is legal reform needed in this area? Does the existing legislation need to be implemented more strongly?
-
- Q** How well trained in gender and rights issues are police and other relevant officials, including those within the judicial system?
-

Once you have identified the strengths and weaknesses of the policy and legislative environment, consider how it could be improved to advance SRHR. For example:

-
- Q** What new legislation or policy could be introduced?
-
- Q** How could existing legislation and policy be amended to better adopt a rights-based approach?
-
- Q** How can the implementation of existing legislation and policy be strengthened (e.g. through training for police, judiciary and teachers in gender and rights issues in relation to SRHR)?
-

Suggested strategies

Here are some practical ways you can influence laws and policies to advance SRHR.

-  Advocate for, or participate in, the development of new legislation or policy that adopts a rights-based approach to sexual and reproductive health and/or gender-based violence.
-  Demand the review or repeal of legislation or policy that perpetuates or fails to adequately address discrimination and inequality in the area of SRHR.
-  Monitor the implementation of laws and policies that affect SRHR and ensure that duty bearers are held accountable.
-  Create political support and coalitions for SRHR and publicise the efforts of leaders who work to promote sexual and reproductive health.
-  Influence the ratification or implementation of key international and regional human rights agreements relating to sexual and reproductive health, by:
 -  participating in the development of a periodic report (either a government report or a shadow/alternative report) on an international human rights treaty (e.g. CEDAW, CRPD); and/or
 -  taking part in an official delegation to a regional or international consultative forum (e.g. Beijing +20, ICPD +20, Commission on the Status of Women [CSW])
-  Monitor the domestic application of international human rights standards to sexual and reproductive health, by using the media to draw attention to legislation and policies that breach human rights obligations, for example.
-  Conduct research and develop a strong evidence base to identify best practice in relation to SRHR and to inform legislation and policy development.
-  Use international human rights standards in SRHR advocacy.
-  Provide training and capacity building to different groups on international human rights processes and agreements.



For more information on how to develop an advocacy or lobbying strategy, see Restless Development's advocacy strategy toolkit which provides a user-friendly, step-by-step guide to creating an advocacy strategy. You can download it from http://www.unaids.org/sites/default/files/media_asset/advocacy_toolkit_en_0.pdf

Useful resources

The following resources will provide you with more information on how to advance SRHR through influencing legislation and policy:

Title: Changing laws: A legislative lobbying toolkit.

Author: Fiji Women's Rights Movement (FWRM) and SPC Regional Rights Resource Team (RRT) (2010).

Link: <http://www.rrrt.org/publications-media/publications/item/60-changing-laws>

Title: Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services.

Author: UNESCO, UNAIDS, UNFPA, UNDP, Youth Lead (2013).

Link: <http://unesdoc.unesco.org/images/0022/002247/224782E.pdf>

Title: Sexual rights and the Universal Periodic Review: A toolkit for advocates.

Author: International Planned Parenthood Federation and the Sexual Rights Initiative (2011).

Link: http://www.ippf.org/sites/default/files/upr_toolkit_2012_compressed.pdf

Title: ACT! 2015 Advocacy strategy toolkit.

Author: Restless Development (2014).

Link: http://www.unaids.org/sites/default/files/media_asset/advocacy_toolkit_en_0.pdf

Domain 2: Education

One of the most effective ways to improve sexual and reproductive health in the long term is to ensure that children and young people are sufficiently educated to make healthy decisions about their sexuality. Comprehensive sexuality education should be available to all young people in the form of accurate, evidence-based, appropriate sexual health information and counselling that is free of discrimination, gender bias and stigma (e.g. associated with disability or sexuality). Such education can be provided by teachers, employers, health professionals and by community and religious leaders.

Anyone involved in providing sex and relationships education, from teachers and community and religious leaders to health-care providers, should receive training and continuing education to ensure that the information and counselling they give are accurate, evidence-based, appropriate, and free from discrimination, gender bias and stigma. The curricula of teachers and health-care providers should be regularly reviewed and updated, and new training materials should be added where required.

A number of entry points for promoting sexual health and healthy sexuality are identified within the domain of education. These include: providing comprehensive education on sex and relationships to young people in school; training in sexuality and sexual health for health workers, teachers, social workers, youth workers and other professionals; and targeted community-based strategies, such as outreach work and peer and media-based education, to meet the needs of young people who are not in school or who may be especially vulnerable.



INVESTIGATE

Do young people have access to comprehensive sexuality education in your community? If not, what are the barriers that prevent it?

If comprehensive sexuality education is available, is it based on accurate, evidence-based, appropriate sexual health information? Is it free from discrimination, gender bias and stigma? If not, what can be done to improve it?

Critical questions

Ask yourself the following critical questions to assess whether SRHR education and training in your country is using a rights-based approach.

-
- Q** Which groups are reached by existing efforts, and which are left out? Which groups have no access to education about sex and relationships?
-
- Q** To what extent is good-quality education about sex, sexuality and relationships being provided in schools?
-
- Q** Is education about sex and relationships provided to young people through youth centres' outreach activities or via peer education schemes?
-
- Q** To what extent are sexuality education programmes comprehensive in their approach?
-
- Q** How well do they provide information and access to services?
-
- Q** Are they age-appropriate?
-
- Q** Do they use participatory methods?
-
- Q** Are they skills-based?
-
- Q** Do they seek to address and transform social norms?
-
- Q** Do existing teacher-training curricula adequately prepare teachers to provide education on sex, sexuality and relationships? To what extent do existing curricula incorporate perspectives that promote rights, diversity and gender equality?
-
- Q** How are SRHR information and services made available to different groups?
-
- Q** Are programmes in place to work with parents to sensitise them to young people's needs and rights?
-
- Q** To what extent are interventions reaching especially vulnerable groups, such as sex workers, drug users, men who have sex with men, truck drivers and prisoners? Which methods are proving most successful (e.g. peer education or outreach work)?
-

Once you have identified the strengths and weaknesses of SRHR education and training in your country, consider how it could be improved to advance SRHR. For example:

- Q What new services or information campaigns could be introduced?

- Q How could existing programmes be amended to better adopt a rights-based approach?










- Q How could existing programmes be amended to reflect the core principles of comprehensive sexuality education: providing accurate, evidence-based, appropriate sexual health information and counselling that is free of discrimination, gender bias and stigma?

- Q How can the capacity of teachers and/or trainers to deliver such programmes be increased?

- Q How can the media be used more effectively to promote awareness of SRHR issues?

Suggested strategies

Here are some practical ways you can advance SRHR through education.

-  Design, deliver or support comprehensive sexuality education (CSE) in schools.
-  Design, deliver or support CSE for the most vulnerable, including young people who do not attend school.
-  Undertake initiatives that recognise and remove barriers to sexuality education, particularly for vulnerable and marginalised groups.
-  Incorporate promotion of human rights, diversity and gender equality into teacher-training curricula.
-  Deliver training in SRHR for health workers, teachers, social workers, youth workers and other professionals.
-  Promote gender equality within sexual relationships and challenge and condemn violence.
-  Deliver or support community-based work on gender equality, including transforming harmful gender stereotypes and negative constructions of masculinity.
-  Develop and distribute information on SRHR for the purposes of education, including research, learning manuals, toolkits and other education resources.
-  Use the media, arts and culture to promote awareness of SRHR.

Useful resources

The following resources will provide you with more information on advancing SRHR through education:

Title: From evidence to action: Advocating for comprehensive sexuality education.

Author: International Planned Parenthood Federation (IPPF).

Link: <http://www.ippf.org/resource/Evidence-Action-Advocating-comprehensive-sexuality-education>

Title: Sexuality and life skills: Participatory activities on sexual and reproductive health with young people.

Author: International HIV/AIDS Alliance (2008).

Link: <http://www.aidsalliance.org/resources/317-our-future-teaching-sexuality-and-lifeskills>

Title: Its All one curriculum.

Author: Population Council (2009).

Link: <http://www.popcouncil.org/research/its-all-one-curriculum-guidelines-and-activities-for-a-unified-approach-to->

Title: Sexual and reproductive health training facilitator's manual.

Author: DSW and Youth 2 Youth (2014).

Link: http://www.dsw.org/fileadmin/content/Docs/SRH_manual/merged_smallpdf.com___2_.pdf

Domain 3: Society and culture

Social and cultural factors can be significant in determining people's access to sexual and reproductive health services and information. The influence of traditional values, beliefs and norms must not be underestimated. They affect the family, the community and society, and play an important part in shaping people's sexual lives. While the socio-cultural determinants of sexual health outcomes vary in time and place, groups that have less power in a society experience poorer sexual health outcomes, often because they have poor access to information and services or legal redress.

For this reason, any intervention to improve the sexual and reproductive health of a population must be understood and accepted by the community, especially its leaders, who often act as 'gate keepers' to information and resources. Despite this, older members of the family and community are often confused and sometimes distressed about the pace of change in sexual behaviours, lifestyles and norms. They can have difficulty in understanding or accepting change, which can lead them to impose restrictions, particularly for young people, and reaffirm traditional values, beliefs, rites and rituals.

Promoting sexual health in diverse social and cultural domains requires sensitivity to social norms and an in-depth understanding of the diverse sexual and reproductive health needs of the population as a whole. Working within social, cultural and religious norms can be challenging, but this is necessary if public health goals related to sexual and reproductive health are to be achieved. Experience has shown that programmes and interventions that contradict traditional teachings and do not attempt to achieve some level of acceptance or consensus among power-holders in the community are likely to fail. Success is most likely when the community agrees and chooses to change its traditions itself.



INVESTIGATE

What are some social, cultural or religious norms in your community that may affect the realisation of SRHR?

Critical questions

Ask yourself the following critical questions to assess whether SRHR interventions in your country or particular setting are using a rights-based approach to address social-cultural factors.

-
- Q** Is the influence of socio-cultural factors on sexual health outcomes understood?
-
- Q** What is known about gender power relations and their impact on SRHR?
-
- Q** Are community members and stakeholders and a broad range of community organisations represented and consulted in the development of SRHR initiatives?
-
- Q** Have opportunities for engaging with community and religious leaders been fully explored?
-
- Q** Are there any local or regional examples of the promotion of SRHR by community and religious leaders?
-
- Q** Are there any groups of people who are unsupportive or openly hostile towards a rights-based approach to sexual and reproductive health?
-

Once you have identified the strengths and weaknesses of SRHR interventions in using a rights-based approach to address socio-cultural factors, consider how SRHR interventions could be improved to advance SRHR. For example:

-
- Q** Is more work needed to understand the influence of socio-cultural factors, including gender power relations, on sexual health outcomes?
-
- Q** Are there case studies from the region that demonstrate effective strategies for using a rights-based approach to address social cultural factors? Can they be collected and used to inform future programming?
-
- Q** How can unsupportive or hostile groups be better engaged or the risk they pose be mitigated?
-

Suggested strategies

Here are some practical ways that you can advance SRHR through initiatives that address socio-cultural norms:

-  Where appropriate, incorporate cultural and religious teachings into SRHR advocacy and programmes.
-  Publicly challenge discrimination on the basis of sexuality, gender, age, ability or any other grounds, particularly in relation to accessing sexual and reproductive health services.
-  Promote cultural practices that improve sexual health and, where appropriate, challenge and redefine cultural practices that harm sexual and reproductive health.
-  Encourage cultural and religious leaders to challenge HIV and AIDS-related stigma and social and gender issues that are harmful to health within communities.
-  Promote dialogue about sexual and reproductive health at all levels, from grass-roots to national leadership, including among religious and community leaders.
-  Build partnerships to implement culturally sensitive programmes aimed at promoting SRHR and preventing all forms of violence against women.
-  Engage men in dialogue about SRHR and recognise the positive role that men can play in improving women's health.

Useful resources

Title: Men are changing: Case study evidence on work with men and boys to promote gender equality and positive masculinities.

Author: International Planned Parenthood Federation (IPPF) (2010).

Link: <http://menengage.org/resources/men-changing-case-study-evidence-work-men-boys-promote-gender-equality-positive-masculinities/>

Title: One man can: Working with men and boys to reduce the spread and impact of HIV/AIDS.

Author: Sonke Gender Justice Network.

Link: http://test.aidsportal.org/atomicDocuments/AIDSPortalDocuments/onemancan_workshop_activ_manualdec08.pdf

Title: Engaging men and boys in gender transformation: The group education manual.

Author: The ACQUIRE Project/EngenderHealth and Promundo (2008).

Link: http://www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf

Title: Voices of hope: A guide to inspire dialogues on religion, faith, sexuality and young people.

Author: International Planned Parenthood Federation (IPPF) (2010).

Link: <http://www.ippf.org/resource/Voices-Hope>

Domain 4: Economic

One of the major barriers to the achievement of the ICPD PoA in the Asia-Pacific region is the large population living in poverty. Poverty and economic inequality are intrinsically linked to poor sexual and reproductive health outcomes. This relationship is one of 'cause and effect', in the sense that poor individuals and communities experience worse sexual and reproductive health outcomes than richer individuals and communities, and poor sexual and reproductive health can further exacerbate poverty.

Although specific data are not available for the Pacific region, several studies of socio-economic differences in health have clearly established that people living in poverty are more likely to have poorer health, including sexual and reproductive health, and are less likely to use health services.

Poverty can adversely affect a person's SRHR in numerous ways. Some are listed below.

- ❖ Financial constraints, including the cost of transport in rural areas, can prevent a person from accessing sexual and reproductive health services. This includes antenatal care, which is critical for preventing and managing complications related to pregnancy, and emergency obstetric care, which saves lives and prevents serious and debilitating long-term health consequences for both mother and child.
- ❖ Poor nutrition undermines the maternal health of women of child-bearing age and pregnant women. Good nutrition is critical to people living with HIV and AIDS, who have to deal with a compromised immune system.
- ❖ Poor women are less likely to be educated, and women with little or no education are found to have less access to modern contraception and sexual and reproductive health services.
- ❖ People living in poverty often have poor access to basic amenities such as toilets and drinking water. For women and girls, poor toilet facilities make management of menstruation difficult and contribute to the risk of reproductive tract infections.
- ❖ Poorer women are more likely to experience violence,⁹⁸ and women who experience violence face a higher risk of unwanted pregnancy, poor pregnancy outcomes: miscarriages, stillbirths, pre-term deliveries, reproductive tract infections, and STIs, including HIV.
- ❖ Although data are limited, studies have indicated that the vulnerability of low-income women to HIV is heightened because of the interaction between poverty, biology and gender-based disadvantages.⁹⁹



INTERSECTION

The majority of those living in extreme poverty are women. Poverty compounds and exacerbates gender inequalities, including in educational attainment, occupational status, access to cash income, and lack of decision-making power, which undermines the realisation of women's sexual and reproductive health and rights.



REFLECT & DISCUSS

What are some ways that poor sexual and reproductive health can exacerbate poverty?

Critical questions

Ask yourself the following critical questions to assess whether SRHR interventions in your country or particular setting are using a rights-based approach to address the intersection between poverty and poor sexual and reproductive health outcomes.







- Q How well is the relationship between poverty and sexual health outcomes understood?
- Q In what ways are SRHR interventions addressing the intersection between poverty and poor sexual and reproductive health outcomes?
- Q In what ways do strategies to promote economic empowerment and alternative livelihoods address SRHR?
- Q Are programmes addressing the intersection between poverty and SRHR being implemented for vulnerable groups, such as women, sex workers, young people who do not attend school, and migrants?

Once you have identified the strengths and weaknesses of SRHR interventions in using a rights-based approach to address the intersection between poverty and poor sexual and reproductive health outcomes, consider how the SRHR intervention could be improved to advance SRHR. For example:

- Q Is more work needed to understand the relationship between poverty and sexual and reproductive health?
- Q Are there opportunities to develop an evidence-base regarding the benefits of combining sexual health and economic interventions in communities?
- Q How could SRHR interventions, economic empowerment and alternative livelihood interventions be better integrated?

Suggested strategies

Here are some practical ways you can advance SRHR through economic empowerment.

-  Advocate for free SRHR information, services and commodities.
-  Make sure there are no hidden financial barriers to SRHR services, such as the cost of transport.
-  Recognise and emphasise the links between poverty, economic marginalisation and poor sexual and reproductive health outcomes.
-  Promote economic empowerment and alternative livelihood strategies for vulnerable groups (e.g. women, sex workers, young people, people with disabilities, migrants, and LGBTQI people).
-  Promote economic development that favours economic improvement and opportunity for women and girls.
-  Undertake or support research on the links between sexual and reproductive health and poverty.

Useful resources

Title: Knowledge gateway for women's economic empowerment.

Author: UN Women.

Link: <http://www.empowerwomen.org/>

Title: Beyond ICPD and MDGs: NGOs strategizing for sexual and reproductive health and rights in Asia-Pacific. Thematic papers presented at the regional meeting.

Author: Asian-Pacific Resource & Research Centre for Women (ARROW) (Ed.). (2012).

Link: http://www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

Title: Sexual and reproductive health and rights in the Post-2015 Agenda: Taking their rightful place.

Author: Asian-Pacific Resource & Research Centre for Women (ARROW) (2014).

Link: <http://arrow.org.my/download/Advocacy%20Brief%20Food%20Security%20-%20website%2018072014.pdf>

Domain 5: Health systems

Accessible, acceptable, affordable and good quality sexual health services are fundamental to achieving SRHR. Sexual and reproductive health services must be offered to people of all ages, throughout their lifespan, regardless of their marital status. It is also important to make particular efforts to target young people because of their social and biological vulnerability. Services should be easily accessible, confidential and non-discriminating. Health interventions should also move beyond a medical model and seek to understand the sexual behaviours, desires and aspirations of individuals and communities, acknowledging the role that sexual pleasure and wellbeing play in people's health status.

The list below details the main clinical services required to achieve good sexual and reproductive health.¹⁰⁰ While sexual and reproductive health services are ideally delivered in a way that is comprehensive and holistic, it is often not feasible for a clinic to deliver all of these services. Where possible, referral procedures should exist to ensure that patients receive the care, treatment and support they require, including:

- ◆ evidence-based comprehensive sexuality education (CSE) and life skills education that are consistent with evolving capacities and are age-appropriate, including for adolescents and young people, specifically on SRHR, human sexuality and reproductive health;
- ◆ access to a range of voluntary, safe and affordable contraceptive options;
- ◆ safe, effective, affordable and acceptable family planning methods;
- ◆ sexuality counselling for the client's sexual health concerns or needs, and their sexual reproductive and contraceptive preferences; prevention, care and treatment of STIs and HIV and AIDS, including voluntary counselling and follow-up;
- ◆ diagnosis and referral for sexual dysfunction;
- ◆ safe antenatal, obstetric, delivery and post-natal care;
- ◆ prevention and appropriate treatment of infertility;
- ◆ prevention of unsafe abortion and management of the consequences of unsafe abortion;
- ◆ where abortion is not against the law, trained and well-equipped health service providers to ensure that abortion is safe and accessible, including post-abortion care and support;
- ◆ diagnosis, screening, treatment and follow-up for reproductive tract infections, reproductive cancers and associated infertility;
- ◆ prevention and treatment of breast cancer, cervical cancers and other cancers of the reproductive system; and
- ◆ a comprehensive health system approach to identify and support victims of sexual and gender-based violence.



INVESTIGATE

Does your health system provide all of the above services? If not, which ones are missing?

Barriers and enablers to sexual and reproductive health in health systems

The table below shows the factors that are known barriers and enablers to the realisation of SRHR within health systems.

Issue	✗ Barriers	✓ Enablers
Access	<p>Access to sexual and reproductive health services are limited or non-existent outside urban areas.</p> <p>Existing services are inaccessible to certain groups, including people with disabilities, young people or LGBTQI people.</p>	<p>Access in rural areas is enhanced through outreach or integrated services.</p> <p>Services take specific actions to improve accessibility to vulnerable and marginalised groups.</p>
Quality	<p>Sexual and reproductive health services are poorly equipped, lacking necessary equipment or experiencing shortages of certain commodities.</p> <p>There are insufficient staff to cope with demand and/or staff receive inadequate training.</p>	<p>Sexual and reproductive health services are adequately equipped with functioning equipment and a stable supply of commodities.</p> <p>Policies and procedures are in place to attract and retain suitably qualified staff, who have access to ongoing professional development opportunities.</p>
Leadership	<p>Leaders in the political, faith, traditional and/or community spheres are reluctant to acknowledge sexual and reproductive health issues and hold beliefs and attitudes that are heavily influenced by cultural and religious norms.</p>	<p>Leaders in the political, faith, traditional and/or community spheres are engaged and empowered as advocates and champions to generate support, mobilise communities and drive change for the realisation of SRHR.</p>

Issue	✗ Barriers	✓ Enablers
Confidentiality	<p>Services lack the policies and procedures necessary to ensure patient confidentiality, including safe storage of files or private screening areas.</p> <p>Staff willingly breach confidentiality guidelines, or there is a perception that confidentiality will be breached (particularly in small communities).</p>	<p>Policies and procedures are in place to ensure patient privacy and confidentiality, and sanctions are imposed against non-compliant staff.</p>
Legislation and policies	<p>Legislation and policies necessary to prevent people being discriminated against when accessing services (e.g. due to marital status, age or sexuality) or to ensure the legal provision of some services (such as safe abortion) do not exist or are not implemented.</p>	<p>Legislation and policies enshrine the principles of international human rights agreements and ensure equal access to sexual and reproductive health services, regardless of age, gender, ability, sexuality or any other characteristics. Legislation and policies are implemented correctly to achieve their intended outcome.</p>
Health professionals	<p>Health professionals possess personal beliefs and attitudes that are not supportive of a rights-based approach or that are heavily influenced by cultural and religious norms.</p>	<p>Health professionals act as advocates for SRHR, willingly participate in training and capacity building and adopt new ways of thinking and working that enable a rights-based approach.</p>

Critical questions

Ask yourself the following critical questions to assess whether health services are adopting a rights-based approach to sexual and reproductive health.

- Q Are sexual and reproductive health services accessible to a wide variety of different groups, such as women, young people, people with disabilities, men who have sex with men, transgender people and sex workers? If not, what kinds of barriers restrict access by these groups to sexual and reproductive health services (e.g. location of centre, time of opening, staff attitudes, languages in which services are available)?

 - Q Are policies and procedures (including disciplinary procedures) in place to promote and protect the rights of people who are particularly likely to experience stigma and discrimination in healthcare settings, such as people living with HIV, unmarried adolescents, sex workers, and men who have sex with men?

 - Q Are community members able to participate in the development of sexual health programmes and services? Are they consulted in relation to needs assessment or the programme design?

 - Q Are sexual health services integrated into primary health care or reproductive health care services?

 - Q Are privacy and confidentiality maintained at all times?

 - Q To what extent are health providers trained to be youth-friendly or are youth-friendly services available?

 - Q What is the capacity of the health sector to deal with physical and sexual violence against women? Do guidelines, including clinical care protocols, exist? Are there appropriate referral mechanisms in place?

 - Q Do training programmes on gender equality and rights exist for health professionals?
-

Once you have identified the strengths and weaknesses of health services in employing a rights-based approach in the delivery of sexual and reproductive health services, consider how services could be improved to advance SRHR. Here are some examples.






- Q How can health services ensure that health professionals maintain a non-judgmental approach to clients and respect their rights?

 - Q How can sexual and reproductive health services be better integrated into the primary health care or reproductive health care services?

 - Q What measures can be taken to remove barriers to sexual and reproductive health services, especially for marginalised and vulnerable groups?
-

Suggested strategies

Here are some practical ways that health services can advance the quality of SRHR.

-  Establish new sexual and reproductive health services, especially for the most vulnerable and in areas where there is unmet need.
-  Eliminate barriers and increase access to existing sexual and reproductive health services, especially for the most vulnerable.
-  Improve the quality of sexual and reproductive health services by implementing rights-based approaches to service provision, including through the capacity building of healthcare professionals.
-  Enhance communication between providers and clients (e.g. by promoting counseling within sexual health services).
-  Promote greater integration of sexual and reproductive health services.

Useful resources

Title: Integration of gender and human rights in HIV and sexual and reproductive health services. Training for Health Care Providers Facilitators Manual.

Author: UN Women and PAHO (2013).

Link: http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&Itemid=270&gid=23827&lang=en

Title: Integrating HIV and sexual and reproductive health: A Pacific specific mapping.

Author: Population Action International and Family Planning International New Zealand (2010).

Link: <http://www.familyplanning.org.nz/media/124181/research-integrating-hiv-and-sexual-reproductive-health-2010.pdf>

Title: A handbook for integrating sexual and reproductive health and rights into HIV programmes.

Author: SAfAIDS and Alliance Zambia (2011).

Link: http://www.saf aids.net/files/SRHR_HandbookForHIVProgrammers.pdf

Title: Transforming Health Systems: Gender and Rights in Reproductive Health. A training curriculum for health programme managers.

Author: WHO (2001).

Link: http://www.who.int/reproductivehealth/publications/gender_rights/RHR_01_29

Title: Gender Mainstreaming for Health Managers: A Practical Approach.

Author: WHO (2011).

Link: http://www.who.int/gender/documents/health_managers_guide/en/



MODULE 3
QUIZ

1. What is one way that laws and policies can enable SRHR and one way that they can pose a barrier to SRHR?

2. Name one practical strategy to enhance SRHR through influencing legislation and policies.

3. Name one practical strategy to enhance SRHR through the provision of education.

4. Why is it important to engage traditional and faith leaders in dialogue about SRHR? What are some of the barriers to doing this?

5. Name one practical strategy to enhance SRHR through addressing socio-cultural norms.

6. How might poverty and economic inequality affect a person's sexual and reproductive health?

7. Name one practical strategy to enhance SRHR through economic empowerment.

8. Name at least three clinical services required to achieve good sexual and reproductive health.

9. How might the knowledge and skills of health professionals act as either a barrier or an enabler to SRHR?

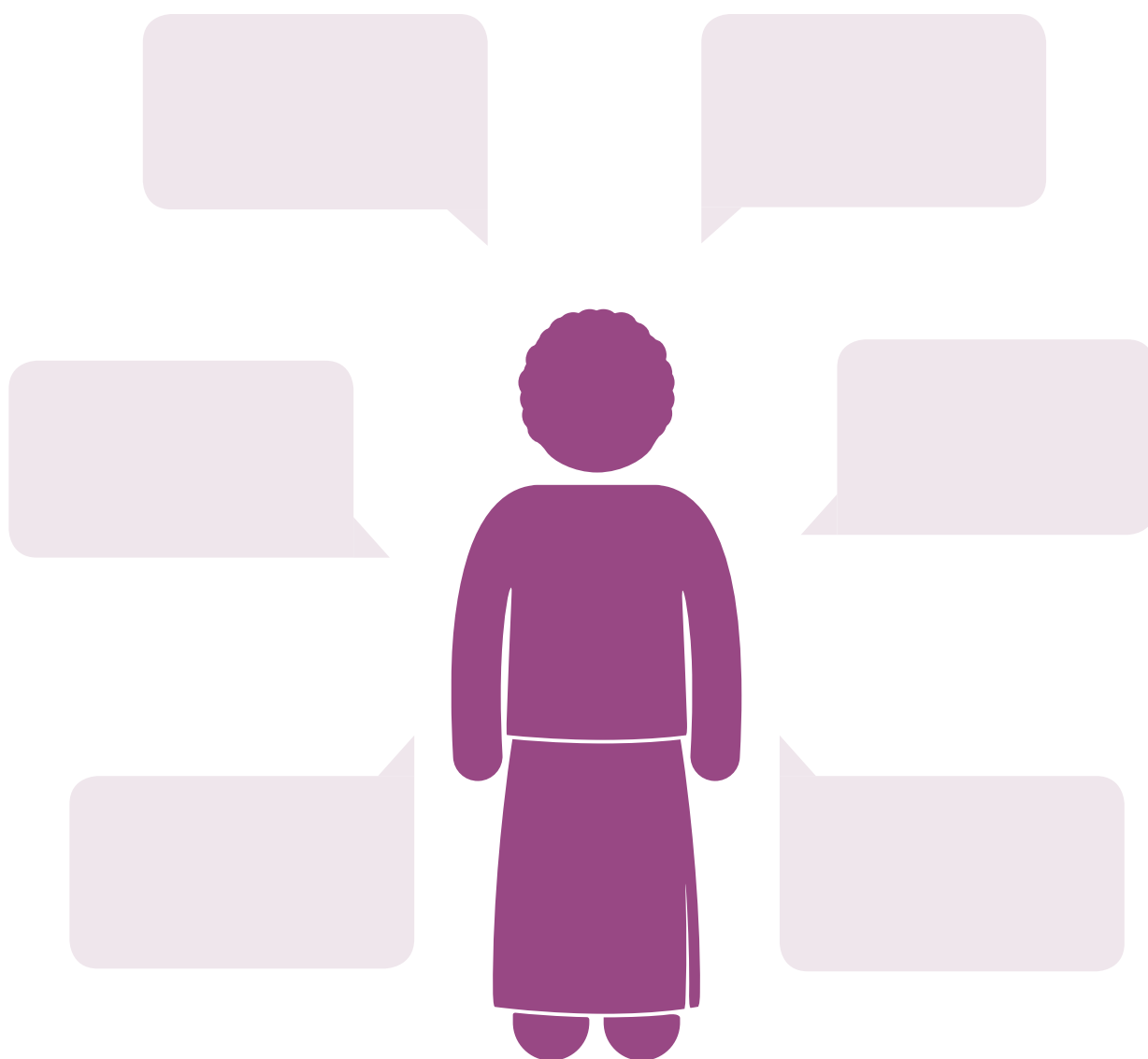
10. Name one practical strategy to enhance SRHR through strengthening health systems.

Answers: The Answers to these questions can be found on the following pages of the Manual:

1. Page 108, 2. Page 110, 3. Page 114, 4. Page 116, 5. Page 118, 6. Page 120, 7. Page 121, 8. Page 123, 9. Page 125, 10. Page 127

Activity resources

Activity Resource 1: My rights in a picture worksheet



Activity Resource 2: Legislative and policy scan worksheet

Country Name:

SRHR issue:	Relevant legislation	Relevant national policy
Access to safe abortion		
Age of consent to sex		
Age of consent to marriage		
Age of consent to access SRHR services and commodities		
Criminalisation of physical and sexual violence		

SRHR issue:	Relevant legislation	Relevant national policy
Access to family planning services		
Provision of antenatal care		
Criminalisation of people based on their sexual orientation and gender identity		
Access to comprehensive sexuality education		
Access to voluntary counselling and testing and antiretroviral treatment for people with HIV and AIDS		

Activity Resource 3: Case study

This case study is based on actual events. Identifying information, including the young person's name, has been changed to protect the people's privacy.

Emily, a 14-year-old girl, is admitted to hospital to await the birth of her child. She was brought in by her mother. It is clear that her mother disapproves of the pregnancy as she regularly gossips with the nurses about her daughter's stupidity and rebelliousness, often in front of other patients and Emily. Staff also witness the mother regularly reminding her daughter that she has brought shame on the family. Emily is regularly found to be sobbing quietly in her room.

Emily's mother tells the medical staff to let her daughter feel the pain of her pregnancy so that she knows that it is not easy to give birth and to bring up a child. She tells her daughter that pain is the consequence of having sex. The medical staff follow the mother's instructions.

Activity Resource 4: Yogyakarta Principles and human rights worksheet

Yogyakarta Principle	Human rights treaty
Principle 1. The right to the universal enjoyment of human rights	
Principle 2. The right to equality and non-discrimination	
Principle 3. The right to recognition before the law	
Principle 4. The right to life	
Principle 5. The right to security of the person	
Principle 6. The right to privacy	
Principle 7. The right to freedom from arbitrary deprivation of liberty	
Principle 8. The right to a fair trial	
Principle 9. The right to treatment with humanity while in detention	
Principle 10. The right to freedom from torture and cruel, inhuman or degrading treatment or punishment	
Principle 11. The right to protection from all forms of exploitation, sale and trafficking of human beings	
Principle 12. The right to work	
Principle 13. The right to social security and to other social protection measures	
Principle 14. The right to an adequate standard of living	

Yogyakarta Principle	Human rights treaty
Principle 15. The right to adequate housing	
Principle 16. The right to education	
Principle 17. The right to the highest attainable standard of health	
Principle 18. Protection from medical abuses	
Principle 19. The right to freedom of opinion and expression	
Principle 20. The right to freedom of peaceful assembly and association	
Principle 21. The right to freedom of thought, conscience and religion	
Principle 22. The right to freedom of movement	
Principle 23. The right to seek asylum	
Principle 24. The right to found a family	
Principle 25. The right to participate in public life	
Principle 26. The right to participate in cultural life	
Principle 27. The right to promote human rights	
Principle 28. The right to effective remedies and redress	
Principle 29. Accountability	

Activity Resource 5: Turning commitment into action worksheet

Area of commitment	Action(s) taken by your government
Leadership	
Prevention	
Care, support and treatment	
HIV/AIDS and human rights	
Reducing vulnerability	
Alleviating social and economic impact	
Research and development	
HIV/AIDS in conflict and disaster affected regions	
Resources	
Follow-up	

Activity Resource 6: Sexual and reproductive rights

- 1 I have the ability to negotiate the use of contraception (such as condoms or the birth control pill) in my relationship.
- 2 I am able to freely choose the number and spacing of my children, or to decide not to have children if I so choose.
- 3 I have access to essential reproductive health checks, such as a mammogram, cervical cancer test (pap smear) or prostate exam.
- 4 I am free to express my sexuality without fear of violence and discrimination.
- 5 I have sex only when I choose to and never against my will.
- 6 I have never experienced violence at the hands of my partner.
- 7 I know where I can go for a sexual health check if I need it.
- 8 I have all of the information I need to make good choices about my sexual and reproductive health.
- 9 I am able to start and conclude relationships freely, without pressure from others.
- 10 I am not worried about getting a sexually transmitted infection because I know how to protect myself.

You can add your own questions to this list.

- 11 _____
- 12 _____
- 13 _____
- 14 _____
- 15 _____
- 16 _____
- 17 _____
- 18 _____
- 19 _____
- 20 _____

Activity Resource 7: Activity cards

A grid of eight activity cards arranged in four rows and two columns. Each card is separated by a dashed line, and scissors are placed at the intersections of these lines to indicate where to cut. The cards contain the following text:

A PREGNANT 16-YEAR-OLD GIRL	A SINGLE MOTHER WITH FOUR CHILDREN
A FEMALE SEX WORKER	A YOUNG MAN
A MALE SEX WORKER	A WOMAN LIVING IN A RURAL VILLAGE
A MAN WITH A DISABILITY	A GAY MAN

A LESBIAN WOMAN	AN ELDERLY WOMAN
A UNIVERSITY-EDUCATED WOMAN	A MAN LIVING WITH HIV
A YOUNG WOMAN	A WOMAN WITH A DISABILITY
A WOMAN LIVING WITH HIV	A UNIVERSITY-EDUCATED MAN

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