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ARROWs For Change

Women's, Gender and Rights Perspectives in Health Policies and Programmes

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15 Years after Cairo:

Taking Stock, Moving Forward in Asia and the Pacific[1]

Fifteen years after Cairo, we need to be cognizant of the socio-political paradigms that influence the realisation of the sexual and reproductive health and rights (SRHR) of all human beings, especially of those who are poor and marginalised.

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In the last 15 years, the implementation of the International Conference on Population and Development Programme of Action (ICPD PoA) has been chequered: sidelined by the Millennium Development Goals (MDGs), hampered by the Global Gag Rule and hindered by hostility to several dimensions of SRHR in many countries. Although the PoA is considered to be a compromised document[2] in many ways, it is the one existing comprehensive document on SRHR which is internationally agreed upon. More concerning is the fact that many stakeholders are of the opinion that the document itself should not be re-opened and re-negotiated at 2015 simply because the language that will emerge will be more regressive than the present, compromised language. This in itself speaks volumes regarding achievements on our rights to autonomy over our bodies and our sexual and reproductive lives in the past 15 years.

It is also important to be mindful of developments that affect the implementation of the PoA, such as health sector reforms and the various forms of privatisation of health and their impact on women's SRHR; the new aid architecture and funding mechanisms for governments and how these affect the health sector; and the decentralisation of governments and its impact on health policy formulation, programme implementation and service provision. Women's empowerment is also a critical factor. Currently, standard measures of women's empowerment, such as the Gender-related Development Index (GDI) and the Gender Empowerment Measure (GEM), do not factor in aspects of sexual and reproductive rights that are so essential for women's autonomy and bodily integrity. Furthermore, factors and outcomes such as high maternal mortality ratios (MMRs), gender discrimination, health system failure and poverty of women need to be included and calculated within existing indicators of development. Gender dynamics and the intersections of poverty are critical to be accounted for while developing true measures of women's empowerment.

The recognition of SRHR as a defining socio-economic and political issue has not been mainstreamed in these 15 years. Governments were not required to periodically report progress on the implementation of the PoA, even during annual sessions of the Commission on Population and Development (CPD). This contributed to lagging momentum to the degree that the new cadre of policy-makers is unfamiliar with the document and what governments have agreed to. Moreover, reporting is currently driven by the MDG framework, which does not recognise rights as the basis of achievement of the limited targeted desirable developmental outcomes. Yet, the rights-based approach is crucial to the full realisation of SRH. Furthermore, the rights of many marginalised and vulnerable groups have been completely left out within the MDGs' target-driven approach to development. This is particularly pertinent to countries which are considered

to have already achieved the MDGs, but continue to demonstrate gaps among marginalised groups. With the shift in agenda from ICPD to MDGs, the push from donors to governments to adopt women's rights, reproductive rights and sexual rights is waning in strength.

But while there have been setbacks, there have been significant gains as well. It is important to recognise that, at the same time, a strong movement around sexual rights has come to the fore in the region. Sexual rights, although not explicitly stated within the ICPD PoA, is an essential paradigm to fulfilling the PoA.[3] The PoA itself recognises the right to a "safe and satisfying sex life,"[4] and calls upon governments to empower women to exercise decision-making on sexuality and reproduction[5] as well as to establish rights, where those rights may not currently exist, to enable these decision-making capacities.[6] In many Asia-Pacific countries, where the challenge of SRHR is precisely located in shifting the debate from reproduction to sexuality, the concept of sexual rights is an eminently valuable one and can help expand access of groups marginalised by mainstream policy-making and programme development, such as unmarried adolescents, sex workers, lesbians, gays, transgender people and other gender non-conforming people.

Advocating for and helping enable the realisation of SRHR of those who are in the periphery of development plans and agendas—the poor, the young, the unmarried, those with disabilities, those who live in conflict/disaster/remote and other marginalised areas, sex workers and people of diverse sexual orientation and gender identities, among others—is imperative to establish the universality of sexual and reproductive rights, the cornerstone of our agenda.

In such a scenario, wherein lies the way forward? Although progress in the region is uneven and slow with regards to SRHR, ARROW's ICPD+15 monitoring report[1] across 12 countries in Asia shows that political will of governments is crucial in ensuring SRHR outcomes. Reducing maternal deaths in Malaysia and Thailand; providing safe abortion services in China and Vietnam; addressing reproductive cancers in Malaysia; passing legislation to recognise same-sex sexual relationships and transgenderism in Nepal are concrete examples of political will towards SRHR. More generally in all countries, passing legislation on gender-based violence and providing voluntary counselling and testing (VCT) and anti-retroviral therapy (ART) are examples of governments acting in accordance to international standards, as acted upon by national and regional catalysts.

However, despite the above considerable successes, access to marginalised groups is a concern across all countries in Asia and the Pacific: women who are poor, less educated, younger, live in remote and/or rural areas, from ethnic and religious minorities, from lower castes, in sex work, with disabilities, and those who are detainees, internally displaced, migrants and refugees, among others, face greater difficulties in accessing services and realising autonomy of their bodies. This is regardless of whether the desired services are those of contraception, maternal health services, safe abortion services or prevention and treatment of STIs.

ARROW's review of 12 Asian countries shows that population policies in nine of the 12 countries view fertility as "too high," aim to lower fertility levels, and are demographically driven with the burden of contraception mostly falling on women.[7] In spite of significant declines in the fertility levels, women continue to have more children than they actually want,[8] pointing to high unmet need for contraception in the region. This is coupled with the lack of an enabling environment to exercise informed choice amongst the users, including lack of choice with regards to methods of contraception.

Sexual health, especially with the inflow of funds to the HIV arena, continues to be framed in the limited paradigm of disease prevention. Individuals who do not fall under the purview of "high risk" find it difficult to seek these services. Though it is widely acknowledged that the intersections and interconnections between HIV/AIDS and SRHR are profound, they continue to remain predominantly separate and parallel programmes not only from the angles of donors but also from national health systems' point of view.

Furthermore, discourses and policy prescriptions around sexuality continue to be limited to reproductive functions, and shifting the paradigm to include non-reproductive functions continues to be a challenge. This is most amply demonstrated by the lack of access to comprehensive sexuality education for adolescents; the still limited discussions around sexuality and pleasure as a right; and the lack of recognition to the concepts of marital rape and sexual harassment, the role of sex as work, as well as the sexual and reproductive rights of people of diverse sexual and gender identities.

After 15 years, we need to step up our efforts. Policy change that is underpinned by commitment to the ICPD PoA and recognises rights to the highest attainable standard of sexual and reproductive health and to sexual and reproductive autonomy of all human beings, whether

national or global citizens, is critically needed. This policy creation and review need to be done in secular spaces free from the influence of religious fundamentalisms and doctrines which restrict human rights. Moreover, we need to change norms of masculinity, and ensure that public policies address and challenge cultural definitions of traditional masculinity and femininity that impede gender equality, sexual rights of gender non-conforming people, and an end to gender-based violence.

Policy reforms must be backed by functional health systems, adequate budgets, trained human resources and updated training and curriculum.

Beyond policies, there is a critical need to ensure universal access to affordable, quality, gender-sensitive and comprehensive sexual and reproductive health services through functional and integrated health systems. These services should start from the primary health care level, and be available at all times, including during times of conflicts and disasters. Comprehensive SRH services should include the following: the full range of contraceptive methods (including condoms and emergency contraception), the full range of abortion services (including manual vacuum aspiration and medication abortion) and post-abortion care, skilled attendants at birth, Emergency Obstetric Services, services to address gender-based violence, services to treat STIs and HIV/AIDS, as well as counselling and information services. At all times, providers should give non-judgmental and gender-sensitive services, which includes affirming the rights of young people, sex workers and people of diverse sexual orientation and gender identities.

Governments (both national and local), donors and international and regional institutions need to ensure adequate and sustained investments in women's SRHR. An additional $24.4 billion is projected as a requirement by 2015, to provide universal access to sexual and reproductive health information and services as agreed in the ICPD, excluding HIV/AIDS and other components. Actual spending on SRH services at the national and local levels needs to be tracked through the creation of SRH sub-accounts. Funding mechanisms for SRH services, including HIV/AIDS, need to be integrated.

Furthermore, given that human rights and sexual and reproductive rights apply to all, stakeholders must work to improve access of adolescents, marginalised groups of women, and people of diverse sexual orientation and gender identities to SRH information and services.

The ICPD PoA set a deadline of 2014 to achieve full implementation. It is accurate to say that this deadline will not be met. Thus, there is a need for an international process which calls on governments to report on ICPD PoA implementation, hand-in-hand with NGO shadow reporting, to assess progress. Governments must be held accountable to what they have already signed on to before deciding whether to move ahead. At no point should governments and international agencies be left off the hook for the minimum standards set by the PoA 15 years ago.

We need to reposition the SRHR agenda within the global, regional and national political and economic frameworks, using the human rights, social justice and the public health approaches to facilitate rights to the highest attainable standard of sexual and reproductive health and to sexual and reproductive autonomy. We need to achieve universal access to fully-funded, quality, gender-sensitive, comprehensive sexual and reproductive health services through functional and integrated health systems starting from the primary health care level, and during times of crises, if we are to realise the highest attainable standard of sexual and reproductive health.

Finally, we need to be inclusive and broaden our constituency to set the agenda for the full realisation of SRHR for men, women and gender non-conforming people beyond 2015. Advocating for and helping enable the realisation of SRHR of those who are in the periphery of development plans and agendas—the poor, the young, the unmarried, those with disabilities, those who live in conflict/disaster/remote and other marginalised areas, sex workers and people of diverse sexual orientation and gender identities, among others—is imperative to establish the universality of sexual and reproductive rights, the cornerstone of our agenda.

Endnotes

1 *This editorial draws heavily from the following publication: Thanenthiran, S. & Racherla, S. 2009. Reclaiming and Redefining Rights- ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur, Malaysia: The Asian-Pacific Resource and Research Centre for Women (ARROW). http://arrow.org.my/home/index.php?option=com_content&view=article&id=51&Itemid=108 The countries covered are Bangladesh, Cambodia, China, India, Indonesia, Laos, Malaysia, Nepal, Pakistan, Philippines, Thailand and Vietnam.*

2 *Compromised as the ICPD PoA only recognises provision of abortion services, where legal; denotes that abortion should not be included as a family-planning method; and where illegal, advocates only for treatment of complications of unsafe abortion. Access to safe abortion services is not mentioned as a reproductive right. Although recognising the different forms of families, the document does not explicitly state sexual rights. Furthermore, it retains a mainstream model of development which hampers realisation of SRHR.*

3 *Indicators of sexual rights, such as legal age of marriage, existence of forced/arranged marriage, sexual violence against women, are closely intertwined with the realisation of women having autonomy over their reproductive lives and their health.*

4 *ICPD PoA para 7.2*

5 *ICPD PoA Para 7.34 and 7.36*

6 *ICPD PoA Para 4.4 (c)*

7 *The analysis is drawn from information provided by the United Nation World Population Policies 2007. The nine countries who view fertility as "too high" are Bangladesh, Cambodia, India, Indonesia, Laos, Pakistan, the Philippines and Vietnam. China, Malaysia and Thailand view fertility as "satisfactory."*

8 *As seen in Wanted Fertility Rates versus their Total Fertility Rates.*

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SPOTLIGHT

Privatisation in SRHR:
Glimpses from Some Countries of South and Southeast Asia[1]

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In Laos, rural women have to contend with distance to health care facilities, cost of transportation and user fees—all are contributors to the high number of women dying from pregnancy and childbirth.

Privatisation may be defined as the adoption of deliberate policies and mechanisms by national governments and/or international financial institutions and bilateral donors to expand the role of the private sector. Privatisation in social sectors can be in financing, in service provision or in both.

Privatisation in the health sector, as part of a larger process of privatisation of the economy, is happening in almost all countries of South and Southeast Asia, including erstwhile command economies. This paper explores privatisation in three diverse settings—Lao PDR, Pakistan and Thailand—and the positive and negative implications of privatisation for equitable access to sexual and reproductive health (SRH) services.

Of the three countries, Lao PDR and Pakistan have severely under-resourced health sectors (*see* Table 1). Lao PDR has a limited private sector presence, with only a small number of private clinics and pharmacies since its transition to a market economy. Pakistan has a large and powerful private sector in health. In contrast, Thailand has well-resourced public and private health sectors, and most of its health expenditure is from public sources.

Lao PDR. Privatisation in health in Lao PDR has been mainly through private financing of publicly run facilities, i.e. the introduction of user fees. User fees were first introduced in 1995 with charges for drugs (The Revolving Drug Fund), and were expanded in 2005 to cover all products and services offered in government facilities.

Exemptions from user fees to low-income groups and students, although in place, have failed in practice. Started in 2003, Health Equity Funds compensate health facilities in return for free services to the "poor." However, they cover only a small proportion of the poor and do not compensate for loss of wages and transportation costs—which can be large, given the mountainous terrain and sparse settlement pattern.

Availability of SRH services is constrained by the sparse distribution of health care facilities—both public and private. In rural areas without roads, 43% of the population live more than 10 km away from a health centre and 70% live more than 10 km away from a hospital.[2] However, women have to travel much farther for emergency obstetric care (EmOC), which is not available except in the small number of provincial hospitals.

User fees also constrain access to delivery care. In 2003, about 35% of women living in non-poor villages gave birth in hospitals as compared to only 15% of women in poor villages.[2] Costs of transportation for EmOC are prohibitive: ranging from US$100-US$700 in 2000, and even those within a reasonable distance to a provincial hospital are unable to seek EmOC.[3] These are clearly major contributors to the high maternal mortality ratio of 660 per 100,000 live births in 2005.

High cost of care is also responsible for widespread untreated sexual and reproductive morbidity. For example,

blood and urine tests in a public hospital were reported to cost about 100,000 kips (US$12), beyond the reach of many women. In another instance:

"In Luang Prabang, a young mother with a nine-month old baby and unemployed husband had been bleeding for three months. The family already borrowed 100,000 kips from a neighbour who charged 30,000 kips interest. They could no longer afford treatment."[4]

Pakistan. In Pakistan, legislations introduced between 1998 and 2002 led to increase in user fees in tertiary hospitals in the North West Frontier Province and in all health institutions in the public sector in the Punjab province. In 2003, public contracting for running all Basic Health Units (BHUs) was introduced in 12 districts of Punjab, through a contract between the government and the Punjab Rural Support Programme (PRSP), an NGO. Two major social franchising projects are in operation: Greenstar Marketing (GSM) and Key Social Marketing (KSM). There are also other public-private partnership involving international NGOs and the government, such as the Pakistan Initiative for Mothers and Newborn (PAIMAN), funded by the USAID. PAIMAN works to create demand for maternal and newborn health care and to strengthen public health facilities in 10 districts of four provinces.

The implications of privatisation for access to quality SRH services have been mixed, with some positive gains but many negative fall-outs.

In terms of access, user fees have made delivery care in tertiary care facilities unaffordable to the vast majority. Social franchising clinics are concentrated in urban areas, and do not cover the majority of women living in the country's rural areas; and according to one study, cater to relatively wealthier clients. PAIMAN's interventions are reported to have increased access to antenatal care services in government or franchised facilities, and an increase in admissions for delivery and in the number of C-sections in 31 health centres that the project had "strengthened"—a very small proportion of the country's population.

Availability of SRH services through GSM and KMS has been limited to contraceptive devices and antenatal care, and to a lesser extent, surgical contraceptive services and delivery care. BHUs run by the contracted NGO were reported to have difficulties in providing SRH services beyond basic antenatal care.

Evaluation reports of franchised clinics raise serious concerns about the quality of care. Providers in many franchised clinics appeared to prefer IUCDs rather than contraceptive pills, carried out little or no screening before dispensing pills, and adhered poorly to infection control practices. Here is a description by the evaluator of her observation on one particular day in one GSM facility during the *Clinic Sahoolat* held once in six months, where women from the health facility's target areas were invited to receive free family planning services from the trained provider:

Table 1.
Sources of health financing: Lao PDR, Pakistan and Thailand

Countries	Lao PDR (2005)	Pakistan (2006)	Thailand (2006)
Total health expenditure (PPP$)[5]	78	49	346
Total health expenditure as % of GDP	3.6	2.1	3.5
Public expenditure as % of total health expenditure[6]	20.6	17.5	63.9
External funding as % of total health expenditure	11.3	3.6	0.2
Private expenditure as % of total health expenditure	79.4	82.5	36.1

Source: World Health Organisation (WHO). 2008. *World Health Statistics 2008*. Geneva: WHO.

"The doctor was busy … (the paramedic) took the client for IUCD insertion. After examining the client it was found that there were no instruments on the trolley. ..(the paramedic) started searching for instruments in the cupboard with the gloves on her hands. Meanwhile the client was lying exposed on the couch and pulled her own shawl on her exposed body due to embarrassment. ….the instruments (which were eventually located) were soaked in tap water in a kidney dish. …While adjusting the size of the Multiload, the thread came out of the adjusting tube and the Multiload and thread were on her (paramedic) hands. When suggested to use a new Multiload, the suggestion was ignored and the same IUCD was inserted into the woman's uterus."[7]

Thailand. Thailand's economic boom during 1986-1996 was also a period of rapid privatisation of the economy, and of the health sector. During this period, there was a three-fold increase in the number of beds and doctors in the private sector. There was an internal brain drain from the rural public sector to the urban private sector.

It must be noted, however, that during the period of privatisation, and even through the economic crisis of 1997, Thailand's public expenditure in health grew steadily both in absolute terms and as a proportion of total health expenditure.

The economic crisis of 1997 severely affected demand for care in private hospitals. Many private hospitals responded by entering into contracts with the government for providing services to formal sector employees (and their dependents) insured under the Social Security Scheme. Other private hospitals, especially those with higher investments, turned to medical tourism.

Many factors helped the growth of medical tourism in Thailand. These include: low costs of major surgical procedures; growing demand from the Middle East after 11 September 2001 when US visas became difficult to obtain; accreditation of Thai hospitals to international standards such as ISO 900:2000; and policy support. The vast majority of medical tourists in Thailand are from Japan, neighbouring Southeast Asian countries and the Middle East (60%). The second largest group (30%) is expatriate residents in Thailand.[8]

Medical tourism has made private medical care unaffordable to the Thai middle-class who may not want to use the overstretched public sector facilities. The brain drain of highly qualified doctors and other health professionals from government-run hospitals to private hospitals has increased because of the much higher salaries and better working conditions offered by the large "five-star" private hospitals catering to foreign tourists.

The 1997 economic crisis also led to the adoption in Thailand of the principle of "sufficiency economy," which would find a balance between the "needs of society at the grassroots and the imperatives of the global economy."[9] Perhaps as a consequence of this, and also in response to pressures from civil society organisations, Thailand has sought to balance the growth of a thriving private sector in health with high levels of public investment, pursuing policies aimed at universal coverage and social protection for the poor.

Thailand's universal coverage policy introduced in 2001, ensures coverage of all uninsured persons; and those insured in schemes for the poor and schemes for the non-poor. A National Health Security Fund has been set up, financed by tax revenue, which reimburses health facilities for services provided to the poor. Services are provided by all public facilities and a small number of accredited private facilities.

Sexual and reproductive health services constitute a major part of the universal coverage package. The entire range of SRH services, ranging from sex education, family planning and counselling for women experiencing violence and screening for STIs and cancers to delivery care, including C-sections and treatment for reproductive cancers and gynaecological conditions, are covered. The only major lacuna is in the restrictions to provision of safe abortion services, for which a struggle is on for legislative change.[10]

Conclusions. The diverse trajectories of privatisation of these three countries offer some interesting lessons. The experience of Lao PDR confirms that privatising the financing of SRH services puts the most vulnerable groups at risk of being denied services when they need it most, contributing to avoidable deaths and burden of illness. In Pakistan, we see the classic case of a state taking diminished responsibility for health care, with low contribution to financing and handing over service provision to private parties. Both population coverage and the range of SRH services available are limited, and quality is compromised in many instances. Privatisation in settings with a poor health infrastructure and low level of public financing in health runs contrary to ICPD commitments, by denying universal access to essential SRH services.

Thailand offers a contrast, and appears to be maintaining a fine balance between equity and social justice on the one hand and profitability and economic survival on the other, challenging us to look beyond "public versus private" debates. For those advocating for universal access to comprehensive SRH services, Thailand's experiment in pursuing universal coverage without completely clamping down on privatisation is one worth keeping track of and drawing lessons from.

Privatisation in settings with a poor health infrastructure and low level of public financing in health runs contrary to ICPD commitments, by denying universal access to essential SRH services....Thailand offers a contrast [to Laos PDR and Pakistan], and appears to be maintaining a fine balance between equity and social justice on the one hand and profitability and economic survival on the other, challenging us to look beyond "public versus private" debates.

Endnotes

1 This article draws from the findings of the case studies on privatisation in SRHR prepared by the author for ARROW's ICPD+15 Monitoring, Research and Advocacy project. Not all citations have been included due to space limitations. For complete references, please refer to the papers, which can be accessed through arrow@arrow.org.my.

2 Gender Resource Information and Development Centre (GRID). 2005. Lao PDR Gender Profile. Vientiane, Laos: GRID.

3 Asian Development Bank (ADB). 2007. Proposed Asian Development Fund Grant: Lao People's Democratic Republic Health Systems Development Project. Manila: ADB.

4 Paphassarang C. et al. 2002. "Equity, privatisation and cost recovery in urban health care: The case of Lao PDR. Health Policy and Planning. Vol. 17 (Suppl 1), pp.72-84.

5 PPP stands for purchasing power parity, a criterion for an appropriate exchange rate between currencies. It is a rate such that a representative basket of goods in country A costs the same as in country B if the currencies are exchanged at that rate.

6 External funding to governments is counted as a part of the public expenditure.

7 Midterm assessment of social marketing program (2003-2008). 2006. Report submitted by Grant Thornton, Chartered Accountants to the United States Agency for International Development.

8 Harryono M., et al. 2006, May 5. "Microeconomics of competitiveness." Cambridge: Thailand Medical Tourism Cluster, Cambridge, Harvard Business School.

9 UNDP. 2007. Thailand Human Development Report 2007: Sufficiency economy and human development. Thailand: United Nations Development Programme.

10 Under Thai law, abortion is legal only when the pregnancy threatens the woman's physical or mental health or results from rape or incest. The struggle to reform the abortion law has been on since 1973 but has had limited success in the face of stiff political opposition. In early 2000s, a new advocacy network was formed to demand liberalisation of the abortion law.

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Bogor, Indonesia:
Decentralisation's Promises Unfulfilled

The 1994 International Conference on Population and Development Programme of Action (ICPD PoA) encouraged the decentralisation of government functions, in order "to create an enabling context for development" and to "promote much greater community participation in reproductive health services."[1] Proponents say it will enhance health system responsiveness to local needs, and thus improve health system performance. Fifteen years after ICPD, it is critical that women's groups examine the impact of decentralisation on women's rights and access to sexual and reproductive health (SRH) care and services. This article looks at the case of family planning (FP) decentralisation in Indonesia.

Between 1970 and 1998, the National Family Planning Coordinating Board (NFPCB) became a powerful bureaucracy with offices in all provinces, districts/cities and sub-districts of Indonesia, all tightly controlled from the central office in Jakarta. Beginning in 1999, however, Indonesia underwent a radical decentralisation, and in January 2004, NFPCB broke central control and delegated authority for setting policies and implementing FP programmes to the district and city governments. The decentralisation also shifted control of staff to the districts, including the salaried FP fieldworkers.

After five years, the purported aims of decentralisation have not been achieved: it has not improved the quality of family planning services, nor made the health system rights-based or more responsive to local needs, especially the needs of women who are from low-income groups or from rural areas (half of Bogor district remains rural). At least, these are the findings of the Women's Health Foundation in a study designed to examine the impact of decentralisation on access to contraception and the quality of services in Bogor District, West Java, Indonesia (population 4.3 million).[2]

The study revealed that after decentralisation, budget for family planning in Bogor district suffered cuts. Only 50% of the contraceptive supplies was provided by the NFPCB, while the other half was purchased by the local government. However, religious conservatism has had a negative impact on financing the FP programme. The newly installed policymakers, several of whom are religious conservatives who feel that the State should not provide modern contraceptives, influenced the district government's decision not to prioritise FP. Another issue is that the local government use current budgetary allocations to fund future contraceptive use. This puts contraceptives security at risk; if demand for contraceptives increases, there will be stock-outs and people will not have access to the basic supplies they need to prevent unwanted pregnancy.

The study also revealed that under decentralisation, the Bogor District policy on reproductive health (including FP) remains broadly based on the approach inherited from the old NFPCB. The authoritarian "population control" approach, both in policy and practice, still prevails in Bogor rather than the human rights approach promulgated in the ICPD. FP field workers are still forced to reach numeric targets. To do this, they resort to mass campaigns for inserting implants and IUDs and sterilisation (focused more on tubectomies than vasectomies), where about 300 clients are provided services by only four doctors in a day. These mass campaigns, which occur every three months using health facilities from the army, have serious implications on women's rights and compromises the quality of services. Health protocols are bent or broken; several women reported suffering complications and complained about the lack of adequate counselling and follow-up services.

Further, the full range of contraceptives was no longer offered at the public community health centres (*Puskesmas*). Outreach aside from the mass campaigns services virtually disappeared. The *Puskesmas* health providers did not approach women in their neighbourhood to provide FP services. Meanwhile, like in other local governments, after decentralisation, FP fieldworkers in Bogor were reassigned to other sectors, thus cutting the number assigned to FP to almost half, and leaving one worker to care for two to three villages. The FP fieldworkers were no longer equipped with contraceptive supplies and motorcycles to reach villages. They thus relied on health cadres or volunteers to recruit potential acceptors for sterilisation and implants in their mass sterilisation campaigns.

Yet mass FP campaigns, and the lack of the full range of contraceptives in the *Puskesmas*, are not only the most obvious examples of compromised quality. The *Puskesmas* are only open from 8am till 1pm, and midwives and physicians, while working at the *Puskesmas* in the mornings, are allowed to set up their own private practices in the afternoons and evenings. This leads to poorer service offered at the *Puskesmas* (offering better services in the private clinics mean more income for providers). It is no surprise that the statistics of the Bogor district shows that 43.5% of women who availed of family planning services went to private practices, and 56.5% went to the public facilities. This results in lack of access for those who need it most. Women from the lowest-income groups are unable to access services since they are at work when the *Puskesmas* is open, and they cannot afford the fees at the several private clinics which are open in the evenings. Middle-class women benefit the most from these services since they can afford the fees, have stronger social links with the providers, and sometimes are given privileged access to scarce supplies, drugs and attention.

The study revealed high unmet need in Bogor District: two-

fifths of the respondents (n=500) interviewed wanted no more children, while the other two-fifths wanted to delay having a child. Unmet need for modern contraceptives is concentrated in women from low-income groups and those that live far away from the *Puskesmas* due to prohibitive transportation costs, as well as the cost of the services (for example, even if the IUD device is free, there is a service fee for IUD insertion). Indeed, the study found that majority of the IUDs acceptors from the *Puskesmas* belong to high-income groups. The unmet need in the district is 9.1%, while the contraceptive prevalence rate (CPR) was reduced from 57.5% in 2004 to 56.5% in 2008.

Another finding of the study was the lack of integration of sexual and reproductive health services in the district. As there is no single institution responsible for SRH, including FP, in the district, there is a lack of clarity on how different bodies should cooperate to implement SRH and FP programmes. For example, the District Head Decree on Reducing High Maternal Mortality does not mention FP or contraception provision, even though this can enable spacing and limiting of births, prevent too frequent, too early or too late pregnancies, and reduce the need to resort to unsafe abortion, all of which help reduce the risks associated with maternal mortality.

The study highlights the need for stronger political commitment to sexual and reproductive health and rights, together with adequate and sustained resources to assure contraceptive supplies, outreach services by midwives and nurses to ensure access for those most in need, and a well-trained and sufficient work force. Contraceptive provision should be integrated into maternal and child health and HIV programmes. It also speaks of the need to ensure that religion is kept out of politics and decision-making processes, and to ensure the participation of women's groups and community women in planning and implementing programmes related to SRHR. As part of government accountability, public complaint mechanisms need to be put in place. Most importantly, FP and SRH services should be guaranteed through a rights-based and gender-sensitive framework.

Endnotes

1 *ICPD PoA, paragraphs 9.4 and 7.9*

2 *The study, titled Impact of Decentralisation on Access to Contraception in Bogor, Indonesia, was coordinated by the author. It was conducted as part of the ICPD+15 monitoring research and advocacy project coordinated by ARROW in 12 Asian countries. To access it, email arrow@arrow.org.my*

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Abortion in Malaysia:
Legal Yet Still Inaccessible

Despite the Cairo and Beijing conference agreements 15 years ago, women's access to safe legal abortion services was not widely recognised as a human right, reproductive right and public health issue in Malaysia until the Reproductive Rights Advocacy Alliance Malaysia (RRAAM) was set up in 2007. RRAAM believed that in spite of the 1989 liberalisation of Malaysia's Penal Code to allow abortion for physical and mental health reasons, the law was not widely known.

In 2007, RRAAM, a multi-sectoral alliance of women NGOs, the Federation of Reproductive Health Association of Malaysia (FRHAM), gynaecologists, specialists, lawyers and feminist researchers, began to collect evidence on barriers to abortion service accessibility from both within the health system and from women's experiences. The ARROW ICPD+15 monitoring and advocacy project allowed RRAAM and FRHAM to gather more evidence and to advocate with policy makers. This article discusses the main findings and recommendations from this monitoring study.[1]

The RRAAM-FRHAM study found that there is very restricted accessibility to legal abortion in most government hospitals. When abortions are provided in government hospitals, this is strictly based on medical reasons and not according to the full permissibility of the Penal Code.[2] Some women who have been raped and women with foetuses with congenital abnormalities have been reported to have been refused abortion and referred to other hospitals. In one Kuala Lumpur public hospital, an extreme reluctance to perform any kind of legal abortion was reported. Furthermore, experiences with women seeking help from women NGOs showed that some low-income, young, unmarried and disadvantaged women have been refused safe, legal and affordable abortion from government hospitals in Kuala Lumpur.

Meanwhile, abortion services were found to be available in the private sector, but services are costly, secretive and unregulated. The reported cost of an abortion can reach RM2,000 (US$588), when an average fee for an early abortion is estimated by RRAAM to be around RM300 (US$88), thus making the service inaccessible to poor, low-income, migrant and young women.

The study also found that the main barrier restricting access is the misconception by doctors, nurses, women, the media and the public that abortion is not legal. A RRAAM survey found that of 120 doctors and nurses, 43% responded incorrectly about the legalities of abortion. Similarly, a survey of reproductive health clients who had had a legal abortion in a private clinic, found that 41% did not know the correct legalities on abortion. Inaccurate statements on the legality of abortion were also found in some government publications and

NGO websites, in the Malaysian Medical Council Code of Ethics and in mass media articles.

Another barrier is the unsympathetic and judgemental attitudes of many government doctors and nurses. When asked the RRAAM survey question: "What do you think women who are pregnant due to rape should consider doing?" 38% of the 120 doctors and nurses responded that such women should continue the pregnancy and either look after the baby themselves or give it up for adoption rather than consider having an abortion. Other barriers are the misconception of service providers on Muslim *fatwas* on abortion and the prohibition of the Vatican on abortion. The *fatwa* in Malaysia,[3] as in many of the 57 Muslim countries globally, allow abortion for health and welfare reasons up to four months. However, this is also not widely known. Yet, irrespective of personal and religious beliefs, providers need to respect the civil law and women's choices. No guidance exists on these ethical issues.

Furthermore, there are no Ministry of Health (MOH) clinical practice guidelines on the provision of abortion services; thus, availability of abortion services was reported to vary according to the views of the Heads of the Obstetrics and Gynaecological Departments in government hospitals. Another problem found by the RRAAM-FRHAM study is that not all types of abortion services are offered in government hospitals. The main abortion method used in government hospitals is still dilation and curettage, which requires anaesthesia and hospitalisation and is costlier, carries comparatively more risks[4] and is less convenient for women, compared to the cheaper, safer and short out-patient manual vacuum aspiration (MVA) procedure. Medication abortion is also not offered even though mifepristone and misoprostol have been available globally for 15 years and have been recently included by WHO in the essential drugs list. Mifepristone has not yet been registered as a drug in Malaysia, while misoprostol has been registered for treatment of gastric ulcer and, hence, not used in hospitals for abortions.

The *fatwa* in Malaysia...allow[s] abortion for health and welfare reasons up to four months....Yet, irrespective of personal and religious beliefs, providers need to respect the civil law and women's choices.

Medical education curricula for undergraduates in three public universities, which are also teaching hospitals, are not up-to-date on the legality of abortion. Practical training on abortion is also not available for undergraduates due to the very few abortions being carried out in government hospitals.

The study points to Malaysian women's high need for better access to legal abortion, particularly due to several factors. Women have a high unmet need for contraceptives. Twenty-four percent of married women in 2004 did not want more children but were not using any kind of contraceptives, according to the most recent national population and family study.[5] Additionally, young people (who are not included in these surveys) are increasingly sexually active but their use of contraceptives is low. Indeed, the use of contraception in Malaysia has stagnated for 20 years at around 50% for married couples, which is an indication of low policy priority. Moreover, in 2004, only 32% used modern contraceptive methods. The need for abortion is known to be higher in countries with low use of contraceptives. Access to safe, legal abortion and to a wide-range of contraceptives are both necessary to ensure women's reproductive rights.

The combination of low contraceptive use and limited abortion access has several mortality and morbidity outcomes, including deaths due to unsafe abortions, suicide of young people and abandoning of babies. Morbidity includes psychological suffering due to having unwanted babies, abandoning babies and being forced to bear children as an outcome of rape and incest and children with congenital abnormalities. While morbidity has not yet been quantified, RRAAM has been gathering evidence for this.

Recommendations based on the evidence gathered from the study are already being acted upon. The Ministry of Health is now working on an abortion policy and guidelines. In 2009, the MOH joined RRAAM in a series of state-level seminars educating all private and public sector service providers on abortion law and rights-based women-centred abortion services. The Obstetrics and Gynaecological Association of Malaysia is also on-board and invited RRAAM in 2009 to present a first-ever symposium on abortion and reproductive rights at their annual congress. Meanwhile, RRAAM submitted updated content on abortion legality at the end of 2009 for the review of the Malaysian Medical Council Code of Ethics, as the legal inaccuracies confuse doctors.

Recommendations that still need to be addressed are obtaining high policy priority for increasing contraceptive use, updating the medical curriculum with accurate legal content on abortion and training on rights-based and ethical abortion services, and education of the media.

Endnotes

1 *Abdullah, Rashidah (with input from FRHAM). 2009. ICPD+15 NGO Country Monitoring Report. Malaysia: ARROW. [unpublished]. Email arrow@arrow.org.my for the copy.*

2 *"In Malaysia, abortion is permitted under the following circumstances according to the Penal Code 312 (Amendment) Act 1989 in Malaysia: a) to save the woman's life, b) to protect the woman's physical health, and c) to protect the woman's mental health." RRAAM. 2010. "Top 10 Myths about Abortion."*

3 *"In 2002, the national Fatwa Committee in Malaysia issued a fatwa (legal advisory under syariah law) declaring that an abortion after 120 days gestation is considered murder unless the mother's life is in danger or there is fetal impairment." RRAAM. 2010. "Top 10 Myths about Abortion."*

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5 *Lembaga Penduduk and Pembangunan Keluarga Negara (LPPKN). 2009. Laporan Kajian Penduduk Dan Keluarga Malaysia 2004. Malaysia: LPPKN, Kementarian Pembangunan Wanita & Keluarga dan Masyarakat. [National Population and Family Development Board (NPFDB). 2009. Malaysian Population and Family Study 2004. Malaysia: NPFDB, Ministry of Women, Family and Community.]*

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SPOTLIGHT

Photo by Indira Maya Ganesh

Raising the rainbow flag, signifying sexual and gender diversity, at the Bombay Pride 2009, India

Missing in Action:
Transgender People and Their Sexual and Reproductive Rights

The ICPD Programme of Action (PoA) marked significant progress for sexual health and reproductive rights. Yet this historic document overlooked one population that is often politically, socially, economically and sometimes culturally marginalised, even though they have very specific sexual and reproductive health needs—transgender[1] people.

With a few exceptions, state laws and policies often ignore the needs and rights of transgender people. Without law and policies protecting their rights, transgender people face violations of their basic rights to life, security, work, health, equality, non-discrimination,[2] freedom of expression, freedom from torture and founding a family, among others rights. For instance, in many Asian countries, a post-operative transsexual[3] person's change of sex is not legally recognised in identity documents, hindering access to education, employment, health, housing, marriage, parenting and others. Often, marriage laws allow marriage only between a man and a woman, thus leaving out transgender people, or people who want to marry a person of the same sex. Rape laws in most Asian countries do not recognise that transwomen can also be raped, thus leaving them without protection or legal recourse.

Some laws actively discriminate against transgender people, such as the *sharia* law in Malaysia against cross-dressing and sex-reassignment operations (although it is allowed for intersex[4] people). Laws in several Asian countries, including Bangladesh, Malaysia and Pakistan, criminalise sexual acts against the "order of nature," interpreted as all acts other than penile-vaginal intercourse. This includes anal and oral sex, thus including within their ambit transgender people. Further, for a variety of reasons, many transgender people take up sex work as an occupation. Laws against sex work in several countries, including Cambodia, China, Laos, Pakistan and Thailand, serve to criminalise their chief means of earning a livelihood.

A study conducted for ARROW's ICPD+15 monitoring project in 12 countries in[5]Asia found that social attitudes, reinforced by their invisibility in State mechanisms, give free rein to State personnel to violate transgender people's rights. Findings showed that law enforcement personnel, including the police and the army, subject transgender people to arbitrary arrests, verbal and physical abuse and torture, sexual harassment, rape and murder. Providers in public healthcare systems were found to routinely ridicule, humiliate and even refuse to treat transgender people.

> *In a medical emergency, when a transwoman is taken to a hospital, the hospital staff look at her face and body; they get confused and make fun of her rather than treating her.*
> - Bhoomika Sreshtha, Transwoman, Nepal

All people are equal before the law, and transgender people have rights equal to any other person's. Urgent as well as long-term sustainable action needs to be taken in order to protect, promote and fulfil transgender people's rights, as well as empower them to access these. These include the following:

States

- Take affirmative action to promote the rights of transgender people. Tamil Nadu in India set an example by reserving seats for third-gender[6] students in government-owned arts and sciences colleges and providing ration cards (identity documents) to third-gender people with the appropriate gender category.
- Reform laws that discriminate against and invisibilise transgender people, enact anti-discrimination laws and create laws that protect the rights of people regardless of their gender identity or sexual orientation. In Nepal, a 2008 Supreme Court ruling asserted that transgender and third-gender people have equal rights as other people; in Fiji, a 2005 High Court ruling declared the criminalisation of consensual adult sex in private unconstitutional; and in Delhi, a 2009 High Court ruling removed consensual adult sex in private from the ambit of "unnatural sex."
- Train and sensitise law enforcement personnel, healthcare providers and teachers on gender and sexuality, including on the needs and rights of gender non-conforming people.
- Research health needs, particularly sexual and reproductive health, of transgender people and the appropriate responses, and include these in the medical curricula.
- Provide comprehensive gender and sexuality education to all children and youth, within and outside formal education systems, which includes discussions on sexual and gender diversity and sexual rights.
- Engage transgender people in the formulation of laws and policies and in the planning, implementation and evaluation of programmes that impact them. For example, consult transgender people to make medical guidelines regarding gender identity disorder and sex reassignment more responsive to their needs and less stigmatising.

Civil society

- Build internal and social understanding on gender, sexualities, sexual rights, reproductive rights and the links with all human rights, including on transgender issues. This would include dispensing with binary thinking (such as man and woman as the only two genders) and sexual hierarchies (such as some sexual behaviours and relationships being more acceptable than others).
- Ensure that our own organisations, networks and partnerships have affirmative and non-discriminative policies, including for transgender people.
- Advocate for laws, policies and programmes that protect and promote transgender people's rights.
- Support mobilisation, organising and capacity building of transgender people for political purposes.
- Work in partnership with different social movements towards social justice and human rights for all.

Donor agencies

- Work in partnership with States and civil society to promote the rights of transgender people through organising, capacity building, advocacy and support services, research on health needs, public education, training and sensitisation of State personnel and others.
- Support building of inter-movement linkages and discourses, including with gender identity, sexual orientation and sexual rights movements.

Endnotes

1 *Transgender is the state where one's gender self-identification does not match one's socially assigned gender. Individuals whose appearance and behavior do not conform to the cultural norm for the gender assigned to them at birth are considered transgender.*

2 *Equality means equal entitlement to all rights. Non-discrimination means prohibition of active discrimination against a person on some basis.*

3 *Transsexual refers to a person who identifies with a physical sex different from the one with which they were born, and may undergo hormonal and/or surgical procedures to modify their primary and/or secondary sexual characteristics.*

4 *Intersex is a term used to describe a variety of conditions in which a person's sex chromosomes, genitalia and/or secondary sex characteristics are determined to be neither exclusively "male" nor "female."*

5 *Sood, Neha. 2009. "Transgender people's access to sexual health and rights: A study of law and policy in 12 Asian countries." ARROW. Unpublished paper. For a copy, email arrow@arrow.org.my. The countries covered are Bangladesh, Cambodia, China, India, Indonesia, Laos, Malaysia, Nepal, Pakistan, the Philippines, Thailand and Vietnam.*

6 *Third-gender refer to persons who consider themselves neither male, nor female; rather, in between. Examples include the hijras in India and Pakistan, and the kathoeys in Thailand. The term is not meant to indicate a gender hierarchy.*

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Photo courtesy of Green Map System via Flickr Creative Commons

Thai adolescents and youth receive sexuality education in school, but a lot remains to be done for it to be available across-the-board, comprehensive and rights-based. As well, a huge gap remain in reaching "vulnerable" groups of youth.

SPOTLIGHT

Sexuality Education in Thailand:
How Far Do We Need to Go?

Thailand and Its Youth. Thailand is a developing country in a stage of rapid economic, social and cultural change. Consumerism, materialism and mass media play a crucial role in reshaping norms and values. Adolescent sexual behaviours have changed quickly, and while adolescents tend to have sex at an earlier age, condom use is low, with 85% of males not using condoms and females relying on post-intercourse (emergency) contraception.[1] Adolescents who have already had sex include both those outside the educational system and those in schools, with a mean age of first sex at approximately 16 years.[2,3] Non-consensual sex is common among female teenagers at their sexual debut, as is frequent change of sexual partners among male teenagers.[4] The number of new HIV cases among youth has also been steadily increasing, especially among young women who lack access to sexuality education and sexual and reproductive health services.[5] The above data speaks of the urgent need for a comprehensive, rights-based sexuality education that is available across-the-board in Thailand.

Sexuality Education in Thailand. In Thailand, the first national policy on sexuality education in schools was announced in 1938, although sex education was not taught in schools until 1978. It was taught in only those schools that were receptive and that were ready to integrate sex education with other subjects, such as health education and sociology. Called "Life and Family Studies," its content consisted of issues related to the reproductive system and personal hygiene.[6]

Over the years, sexuality education has been revised and gradually accepted as a problem-solving tool for adolescent sexual and reproductive health issues. This has been a consequence of educational reform following the National Education Act B.E. 2542, increasing awareness of problems related to adolescents' sexual practices and the emergence of women's, sexuality and queer movements. In addition, ongoing campaigns for sexuality education by women's and AIDS organisations along with financial aid and technical support from international organisations, especially the Global Fund to Fight AIDS, Tuberculosis and Malaria, have also boosted the acceptance of sexuality education. These factors have led to the revision of the curricula and have expanded cooperation between government organisations (GOs) and non-government organisations (NGOs).

The most remarkable new approach in sexuality education curricula has been the Teenpath Project developed by the Program for Appropriate Technology in Health (PATH), an international non-government organisation based in Bangkok. PATH has succeeded in institutionalising sexuality education curricula into schools since 2003.[7] An enlarged content curriculum of sex education was proposed by PATH following the Sexuality Information and Education Council of the United States (SIECUS)'s concept of six dimensions (i.e., human development, relationships, personal skills, sexual behaviour, sexual health and society and culture). This curriculum also provides young people with crucial health information with respect to sexually transmitted infections (STIs), HIV/AIDS and unplanned pregnancies, in order to make young people be keenly aware of potential risks of unhealthy, unsafe and unprotected sexual activities.

PATH also proposed new methods for teaching sexuality education. Formerly, sexuality education was taught via lectures. Now, it involves a student-centred learning process, changing students' attitudes and raising consciousness related to positive sexuality, sexual health and rights in the form of games, group activities and case study analysis.

Remaining Gaps. Despite the above successes, the

situation is still far from perfect. Although Thailand has adopted a national policy on comprehensive sexuality education, several problems related to implementation remain.

Due to lack of political will for mandatory sexuality education in schools with a rights-based approach, there is no clear policy commitment at the Ministry and school levels. Thus, comprehensive sex education has not yet been taught in all schools nationwide. The numbers of schools teaching the new sexuality education curriculum and the new approach are a mere drop in the bucket. Although sexuality education is taught at various levels (from the primary school to universities), only 4% of all schools have adopted the sexuality education curriculum under the PATH project. Sexuality education is taught in 0.44%, 11.74%, 60%, 5.4% and 25% of elementary schools, middle schools, high schools, vocational schools and teaching colleges, respectively.[8] Meanwhile, the curricula of the Office of the Basic Education Commission (OBEC), which are composed of sex education curricula from various agencies and include comprehensive content covering all six dimensions of sexuality education, have been initiated in only 21 out of 76 provinces in Thailand, as pilot projects.[9]

Furthermore, sexuality education has never been established as a subject in its own right, except in vocational colleges, where statistics show that the rate of sex among vocational students is the highest compared to other adolescents of the same age, thus putting vocational students in a "higher risk" category.

Moreover, in practice, most sexuality education still lacks a focus on sexual and reproductive rights, in both content and pedagogy. They focus almost exclusively on controlling adolescent sexual behaviour or, at best, promoting safer sex to prevent unplanned pregnancy, abortion and STIs occurring among youngsters. None focuses on the sexual rights of adolescents. Issues that relate to the understanding of desire, pleasure and love and other positive aspects of sexuality are often overlooked. This reflects the mainstream perspective of Thai society that sex does not need to be taught and that sex is a distasteful and obscene matter. Issues regarding gender, sexual diversity, sexual fluidity and homosexuality are often neglected by teachers, including the sexual rights of LGBTI (lesbian, gay, bisexual, transgender, intersex) people. Teaching content and methods may even be discriminatory, particularly those adopting an abstinence-only approach, which regard homosexuality as abnormality. There is also gender bias in teaching, with teachers still emphasising that girls protect themselves from sexual attention, pregnancy and diseases, while giving little attention to the sexual responsibilities of men.

Additionally, the attitudinal adjustment process for teachers participating in the new approach to sexuality curricula is not always successful. Traditional sexual attitudes, socialisation and individual experiences prevent some teachers from opening their minds to the new curricula or to novel teaching approaches.[10] Some teachers avoid teaching sexuality education, teach it the traditional way without listening to their students' opinions, or teach it without supplementary activities.

Beyond sexuality education in schools, a huge gap remains in reaching "vulnerable" groups such as adolescents who are labourers, refugees or displaced, with disabilities, in orphanages, in prisons, in rehabilitation centres, living with HIV and others.

Recommendations. To address the gaps mentioned above, the Thai government should strongly enforce a policy that mandates standard, comprehensive sexuality education for students in all schools. The government also needs to ensure that sexuality education is a continuous learning process and that the subject is taught separately from other subjects, with content suitable for youth in different age groups. As well, teachers must increase their focus on teaching sexual rights, gender and sexual diversity and empower students to develop critical thinking skills. Strong teacher training programmes that will make teachers' conservative attitudes more sensitive and respectful of adolescents' sexual rights is also needed. Comprehensive sexuality education for vulnerable groups of young people as mentioned above needs to be implemented. Finally, we need to ensure the participation from all stakeholders, especially policy makers, parents, teachers, communities and students in supporting a standard, comprehensive sexuality education agenda that addresses the understanding and acceptance of gender and sexual diversity, including respect for women's and LGBT's human rights.

Endnotes

1 *Thai Rath. 2001, July 21.*

2 *Raks Thai Foundation. (Forthcoming). The Study of Societal and Individual Factors that Affect Condom Use among The Youth in Trat and Phatalung Provinces. Thailand: Raks Thai Foundation. [In Thai.]*

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8 *Teenpath. 2008. Kaoyang yangkaojai: Covera. January 13. Available at www.teenpath.net/ teenpath/ database/Map.asp. (in Thai). [Accessed on 10 October 2008]*

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International

On 2-4 September 2009, about 400 participants from around the globe gathered in Berlin at the *Global Partners in Action: NGO Forum on Sexual and Reproductive Health and Development—Invest in Rights, Health and Future*. Funded by UNFPA and the Government of Germany, the forum was the sole global meeting held in recognition of the 15th anniversary of the ICPD PoA, which was led by NGOs for NGOs, and which put an emphasis on ensuring significant participation from the global South and from young people.

ARROW played a key role in the NGO Forum, being one of the co-chairs of the Steering Group. During the forum, ARROW facilitated the Asia-Pacific meeting, which brought together all the participants from the region to discuss the critical input the region would want to see in the outcome documents of the meeting. ARROW also organised two satellite sessions prior to the forum, one focusing on religious fundamentalisms and another on advocacy for resource mobilisation on sexual and reproductive health and rights (SRHR) (co-organised with the Asia Pacific Alliance). ARROW also served as the co-facilitator of the drafting committee of the Berlin Call to Action, one of the outcome documents which is envisioned as an advocacy tool for NGOs to share with government and funders after the meeting. The Berlin Call to Action moves the ICPD agenda ahead by: a) shifting the SRHR agenda from a public health perspective to a human rights perspective; b) ensuring SRHR is underscored and recognised within the new aid architecture, and the range of SRHR services is provided for at all levels of the health care system; c) addressing the needs of young people; d) addressing the meaningful partnerships among NGOs, governments and funders; and e) addressing the importance of allocating funding for SRHR through both national governments and international agencies.

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Regional (The Pacific)

To mark the ICPD PoA's 15th anniversary, UNFPA and the University of the South Pacific co-organised a three-day *Pacific Regional Symposium on Population and Development* in Suva, Fiji on November 2009. Attended by government representatives, NGOs, regional organisations, international agencies, academics and a few women's rights organisations, the Symposium aimed to assess progress in the Pacific towards achieving the ICPD PoA, consolidate lessons learned, identify the remaining challenges and formulate policy recommendations for accelerating progress.

Although the Symposium had a variety of plenary thematic areas, it failed to focus on the gendered and multiple forms of discrimination that women, especially young women and girls, face in the Pacific. For feminists, the ICPD PoA was monumental because it legitimised the notion of sexual and reproductive rights (SRR), shifting the frame from population control to SRHR, while taking women's realities into account. It also made commitments for meeting those needs and acknowledged the central role of women and young people in the development process.

This can prove difficult in the Pacific region because of the geographical isolation of small island states and associated issues, such as lack of poor infrastructure and poor delivery of services. Additionally, the Pacific has a vast linguistic and cultural diversity. Traditional culture is centered on the extended family and, in many cases, the Christian church. In the Pacific societies, status is attained with age. As a young woman, growing up in the Pacific can be both a beautiful and a challenging experience. Culture places value on women—as child bearers and care givers—but this also restricts women because it defines women only by these roles. This is particularly so for young women, who are expected to be seen but not heard. Being young and a female is synonymous with having little power and no voice.

As such, a review of the ICPD PoA need to reflect women's multiple identities and reality in order for women to fully realise their sexual reproductive and health rights. This includes dealing with issues such as abortion and sexuality that are widely considered taboo and immoral in the Pacific, and providing services that are safe and affordable, while creating awareness and demystifying issues around these issues.

A Pacific Sub-Regional Review of the ICPD PoA implementation visibly indicates challenges,[1] such as universal access to RH remaining a long way from being achieved in the predominantly rural, village-based societies. Unmet need for FP and contraception for young people remain significant where contraceptive prevalence remains below 50% in most countries. Approximately 650,000 women have unmet need for FP in the Pacific. Adolescent SRR and sexuality remain culturally contested concepts in the Pacific, and adolescents and young people in rural areas have limited access to SRH information, counseling and services. Gender-based violence is persistent and pervasive in the Pacific. Sexual minorities remain marginalised and stigmatised without widespread support or access to SRH services, including for HIV and sexually transmitted infections.

Pacific feminists and women's rights organisations need to take an active role in pressuring their Governments to comply with the principles of the ICPD. Compliance needs to be focused on the four principles of equality, diversity, personhood and bodily integrity, but placed within a "larger frame that also includes adequate nutrition, housing, a job and social assistance."[2]

Source: Michelle Reddy, Fiji Women's Rights Movement. Emails: info@fwrm.org.fj, reddymich@gmail.com

Endnotes

1 *Hayes, George. 2009. UNFPA Pacific Sub-Regional Office, Suva.*

2 *Correa, Sonia. Sexual and Reproductive Rights – Historical Trends. www.dawnnet.org*

India

The ICPD PoA was one of the initial documents to specifically mention the need to engage and work with men to achieve gender equality, an idea that was reinforced by the 4th World Conference on Women at Beijing in 1995.

As part of the year long review process to understand its implementation in India, Gaps and Gains: ICPD+15, A Civil Society Review organised the *National Consultation on Where Are We on Men, Masculinities and Gender Equality* on 10 February 2010 in New Delhi. The meeting, which was done in partnership with the International Centre of Research on Women, the International Planned Parenthood Federation/ South Asia Regional Office and the Forum to Engage Men, brought together civil society organisations, policymakers, media, academicians, international organisations and women's groups.

Inaugurated by eminent feminist Kamla Bhasin, the consultation expressed concern that even though VAW, HIV/ AIDS and SRH are important policy concerns in India, the government response both in policy and programmes (health and other) is very limited. While being vigilant that resources necessary for working with women are not taken away, one needs to increase efforts to work with men and boys not only to prevent gender-based violence (GBV) in an instrumentalist way, but also to change patriarchal constructs of "masculinities."

Through sharing of research studies and experiences of working with men in India, it was highlighted that boys and men are aware that they can take actions to stop GBV and such work does lead to changes in aggressive male behaviour. It was brought to the fore that men are finding it difficult to adapt to rapidly changing social and economic realities, relationships and role requirements, and their frustrations get manifested in much of the violent patterns of male behaviour. Review of the policies related to men and gender equality showed that informed policymaking and policy review was essential and not mere tokenism.

The consultation arrived at a positive note that there is a growing urgency to work with men and boys by civil society as it does bring added value to gender equality work. While working with men and boys, addressing intersectionalities and diversities of class, caste, race, religious, linguistic minorities and other social exclusions is essential. Moreover, the concerns of women's movements on men's higher status and privileges in any social category, and the need to challenge this, must be addressed.

Source: Jayashree Velankar, Secretariat, Gaps and Gains: ICPD+15: A Civil Society Review. Email: jayavelankar@gmail.com

The Philippines

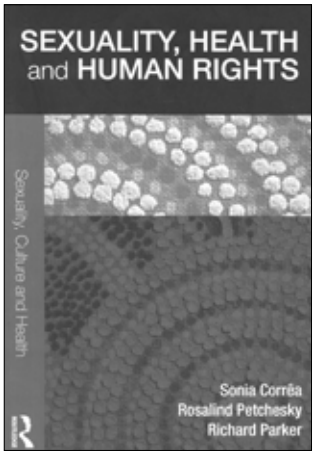
"Improving Policies to Enable Access by Poor Women and Youth to Safe Motherhood and Family Planning Services" was the theme of the roundtable discussion on the merits and implications of two separate action researches that Linangan ng Kababaihan (Likhaan) and the Reproductive Health, Rights and Ethics Center for Studies and Training (ReproCen) had undertaken in 2008 to assess the Philippines' progress in the implementation of reproductive health services as the ICPD PoA entered its 15-year review.

Likhaan's qualitative research focused on maternal survival by understanding why Filipino women from the poorest two quintiles are not more actively resorting to the three critical services that effectively avert maternal mortality: family planning, skilled birth attendance and emergency obstetric care (EmOC). The problem is graver among poor and marginalised women, such as the Manila women who have been deprived of public FP services since 2000, and the Basilan women, mainly Muslim, who are geographically and politically isolated. Based on the women's perspectives, social-cultural-economic factors—including the patient and the provider—acted as barriers to women's informed exercise of healthy reproductive behavior as well as their access to critical safe motherhood services.

ReproCen's study on the contraceptive use of young people between 12 to 21 years in five select urban poor communities in Metro Manila attributed the low level of use to lack of information, concern about side effects and cost of contraceptives. Young people's sources of contraceptives include the drugstore, community health clinic, convenience store or a club, government hospitals, community health workers, private doctors or NGOs. Most young people are using withdrawal as a method; however, the study indicates that only 10% would use withdrawal if they had a choice, if they had money to buy contraceptives and if they had the information to decide about contraceptives. The study concluded that the lack of effective access to FP information and services and the unmet need for contraception are due mainly to the absence of a government policy to provide contraceptives to all, including sexually active unmarried youth.

Approximately 45 people from government agencies, NGOs, universities and private and community health centers attended the discussion last 29 October 2009 in Quezon City. Because of the good selection and mix of panel reactors and audience, many different disciplines were represented, resulting in valuable insights on the many facets of the studies and on recommendations that hopefully would have implications to reproductive health policies and programmes in the Philippines.

Source: Likhaan, Quezon City, Philippines. Emails: office@likhaan.org, likhaan.mail@gmail.com



Correa, Sonia; Petchesky, Rosalind; & Parker, Richard. 2008. *Sexuality, Health and Human Rights.* New York: Routledge. 312p.

Hailed as a potential classic work, this book explores how rapid changes happening at the beginning of the 21st century in social, cultural, political and economic domains impact on sexuality, health and human rights. The book is divided into three sections: a) "Global 'sex' wars," which discusses the notion of sexualities, its political landscapes internationally, and the return of religious fervour and extremism; b) "Epistomological challenges and research agendas," which examines modern "scientific" understandings of sexuality, its history and the way in which HIV and AIDS has drawn attention to sexuality; and c) "The promise and limits of sexual rights," which discusses human rights approaches to sexuality, its strengths and limitations, and new ways of imagining erotic justice. The publication is useful to professionals, advocates and policy researchers, and is appropriate for a diverse range of courses including gender studies, human sexuality, public health and social policy.

DAWN. 2009. *DAWN Informs*: "ICPD+15 Supplement." 8p. Available at www.dawnnet.org/uploads/newsletters/2009-October.pdf

This supplement on ICPD+15 features articles from three DAWN feminists. Carol Ruiz Austria's "ICPD+15 at the crossroads: Health, rights and citizenship" reports on preliminary trends from DAWN's research on sexual and reprodictive health and rights (SRHR) and the Millenium Development Goals (MDGs), which explores the link between state policies on citizens' welfare and SRHR in India, Mexico and Nigeria. Angela Collet's "Advocating for full sexual and reproductive health and rights: Still an uphill battle" provides an update on the resolution resulting from the 42nd session of the Committee on Population and Development (CPD). Finally, Gita Sen's "Sexual and reproductive health and rights and global finance: Crisis or opportunity?" considers the potential impact of the global financial crisis on health financing, which in turn will impact on the SRHR agenda.

Family Planning International, with the Secretariat of the Pacific Community and Population Action International. 2009. *A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009.* New Zealand: Family Planning International. 27p. Available at www.fpi.org.nz/LinkClick.aspx?fileticket=eks3Ol1tHhg%3d&tabid=446

This regional report presents a Pacific Island women's sexual and reproductive risk index, which covers ten indicators measuring women's health status in these four stages—sex, pregnancy, childbirth and survival—in 21 Pacific island countries and territories. Its accompanying narrative outlines the SRHR issues that Pacific women continue to face—including contraception, unsafe abortion, STI and HIV, child and maternal mortality and gender-based violence—as well as contextualises these through a description of the Pacific, the social determinants of health and the health systems in the region. Some chapters also specifically focus on people with disabilities, young women, men and boys and women with HIV. The report is intended to provide Pacific policy makers and SRHR advocates with a tool for understanding and overcoming the barriers to Pacific Island women's good health, in order to reach the ICPD objectives and the MDGs.

Germain, Adrienne; Dixon-Mueller, Ruth & Sen, Gita. 2009. "Back to basics: HIV/AIDS belongs with sexual and reproductive health." *Bulletin of the World Health Organization.* Vol. 87, pp. 840–845.

Going beyond calling for "bridging the gap," "collaboration" or "strengthening linkages" between HIV/AIDS and SRHR, this article argues for utilising the comprehensive ICPD framework for achieving SRHR, which includes prevention and treatment of HIV/AIDS. The article traces the history that led to the separation these two programmes, which, it argues, does a disservices to the achievement of both sets of goals and objectives. It suggests five principles of priority setting to adress this fragmentation: a) institutional commitment to achieving the ICPD PoA; b) investment in health systems capacity building with priority attention to universally accessible comprehensive SRH services; c) prioritisation of prevention programmes in schools, communities and health systems; d) incorporating SRHR fully into national, district and local-level HIV programmes, and conversely, incorporating HIV prevention and treatment into all SRH information and services; and e) amendment of HIV/AIDS policies and budgets of bilateral and multilateral donors to invest in SRHR.

International Women's Health Coalition (IWHC). 2009. "2009 CPD resolution highlights and analysis." Available at www.iwhc.org/index.php?option=com_content&task=view&id=3579&Itemid=824

This document provides a helpful analysis of the resolution of the 42nd session of the CPD from an SRHR lens. IWHC notes that this is the first intergovermental statement that recognised that ICPD implementation is essential to achieving the MDGs and that recognised MDG target 5b (universal access to reproductive health). It also has an unprecedented emphasis on human rights, including sexuality. Other positive developments include making maternal health a matter of priority; prioritisation of SRH in health systems strengthening; and new commitment to "comprehensive

education on sexuality and gender equality," access to male and female condoms, and reproductive health services for adolescents without restrictive language on culture, religion or parental rights. However, the paper does not mention how the resolution fared in terms of social and economic development, financing for development and relevant issues such as migration. The UN resolution is available at www.un.org/esa/population/cpd/cpd2009/CPD42_Res2009-1.pdf

Roseman, Mindy Jane & Reichenbach, Laura. 2010. "International Conference on Population and Development at 15 Years: Achieving Sexual and Reproductive Health and Rights for All?" *American Journal of Public Health.* Vol. 100, No. 3, pp. 403-406.

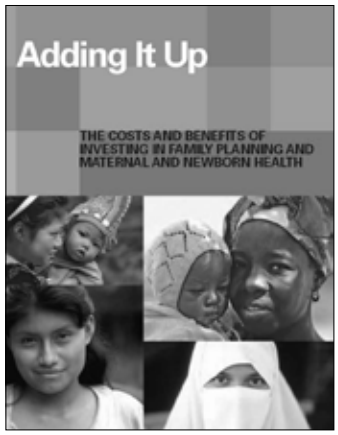
This article is a commentary on the findings of a group of scholars associated with the Group on Reproductive Health and Rights at the Harvard Center for Population and Development Studies who reviewed ICPD. Fifteen years post-ICPD, the article observes that ICPD remains relevant today and recommends several areas where advocates, practitioners and researchers can inform future progress for sexual and reproductive health. These include improving measurement and accountability related to the evidence base for SRH, indicators of programme success and the tracking of resource flows; creating and renewing alliances to strengthen advocacy; and employing new resource mobilisation strategies.

Serour, Gamal (Ed.). 2009. *International Journal of Gynaecology and Obstetrics.* Vol. 106, Issue 2: "World Report on Women's Health 2009—Reproductive and Sexual Health Rights: 15 years after the International Conference on Population and Development." Available at www.ijgo.org/issues/contents?issue_key=S0020-7292%2809%29X0008-1

The 2009 World Report on Women's Health, which fittingly focuses on women's SRHR 15 years after ICPD, provides the reader with a comprehensive overview of what has been achieved since 1994, unmet needs, obstacles and the feasible actions in the countdown to 2015. It aims to scale up SRH services as a human right of women around the world and underline that the poorest and underserved women in low- and middle-income countries have least access to the necessary or basic information and services. The report consists of five chapters with 23 articles covering reproductive and sexual rights, safe motherhood and newborn health, sexual health, fertility regulation and challenges to progress in achieving the ICPD goals and health-related MDGs.

Singh, Susheela, et al. 2009. *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health.* New York: Guttmacher Institute & UNFPA. 40p. Available at www.guttmacher.org/pubs/AddingItUp2009.pdf

This report presents an economic argument for investing in two key SRHR areas: contraceptive services and pregnancy-related



and newborn care. It found that doubling the world's current annual spending of US$12 billion on these two programmes in developing nations would have dramatic results—unwanted pregnancies would decline by 67%, unsafe abortions would be cut by 73%, maternal deaths would drop by 70% and newborn deaths would be reduced by 44%. Other health, societal and economic benefits would follow. The report notes that these improvements can only be achieved by simultaneously investing in family planning and maternal and newborn health care.

Regional findings are also available as stand-alone fact sheets. The fact sheet on investing in family planning and maternal and newborn health in South Central and Southeast Asia is available at www.unfpa.org/webdav/site/global/shared/documents/publications/2009/facts_aiu_asia.pdf

Thanenthiran, Sivananthi & Racherla, Sai Jyothirmai. 2009. *Reclaiming & Redefining Rights: ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* 162p. Available at www.arrow.org.my/index.php?option=com_content&task=view&id=51&Itemid=85 Tel.: Fax.:

ARROW's third ICPD PoA monitoring report, *Reclaiming & Redefining Rights* offers a comprehensive look at the status of SRHR in Asia, 15 years after the signing of the landmark agreement. This publication, which covers five key areas—women's empowerment, reproductive health, reproductive rights, sexual health and sexual rights—paints a picture of uneven progress across 12 countries. It makes four main recommendations to ensure that the ICPD and Millenium Development goals are met: a) policy changes that are underpinned by commitment to the ICPD PoA and are respectful of reproductive rights and sexual rights; b) ensuring universal access to affordable, quality gender-sensitive SRH services through functional and integrated health systems, starting from the primary health care level; c) continued and sustained investments in women's SRHR by both the government and the donors; and d) improvement of access to services of adolescents, marginalised groups of women and those with diverse sexual orientation and gender identities.

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Saeed, Hilda; Saeed, Rahal; & Khan, Saman. 2010. *ICPD+15, Investigating Barriers to Achieving Safe Motherhood: A Study in Selected Sites in Rural Sindh and Punjab.* Lahore, Pakistan: Shirkat Gah Women's Resource Centre. 49p. Available at www.arrow.org.my

Singh, Joyti Shankar. 2009 (2nd ed.). *Creating a New Consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women's Empowerment.* UK & USA: Earthscan.

Singh, Susheela, et al. 2009. *Abortion Worldwide: A Decade of Uneven Progress.* New York: Guttmacher Institute. Available at www.guttmacher.org/pubs/AWWfullreport.pdf

UN Economic and Social Council. 2009. "Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development Report of the Secretary-General." 42nd session, 30 March-3 April 2009. 20p. Available at www.unfpa.org/icpd/15/docs/financial_flows_cpd_report.pdf

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ARROW's Publications

Thanenthiran, Sivananthi & Racherla, Sai Jyothirmai. 2009. *Reclaiming & Redefining Rights: ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia.* 162p. US$10.00

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Definitions[1]

Reproductive Health (RH)

Reproductive health is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity"; it "addresses the reproductive processes, functions and system at all stages of life." It "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women [as well as gender non-conforming people] to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice 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."[2]

Reproductive Rights (RR)

Reproductive rights "recognise that the sexual and reproductive health of both women and men [as well as gender non-conforming people] requires more than scientific knowledge or biomedical intervention." Rather, they require "recognition and respect for the inherent dignity of the individual." They "refer to the composite of human rights that protect against the causes of ill health and promote sexual and reproductive wellbeing."[3] They "embrace certain human rights that are already recognised 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."[4] RR include the right to safe, legal and accessible abortion services.

Reproductive Justice

Reproductive justice (RJ)[5] places reproductive health and reproductive rights within a social justice framework. It is "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives." While the RH framework "emphasises the very necessary reproductive health services that women need," and the RR framework is "based on universal legal protections for women and sees these protections as rights," the RJ framework "stipulates that reproductive oppression is a result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights."

Sexual Health

"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it 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."[6] The purpose of sexual health care should be "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[7] "For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[6]

Sexual Rights

"Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. They include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, 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."[5] Sexual rights also include the "right to personhood (the right to make one's own choices), equality (between and among men, women and transgender people), and respect for diversity (in the context of culture, provided the first three principles are not violated)."[8] Moreover, "a human rights approach to sexuality and sexual policy implies the principle of indivisibility—meaning that sexual rights are inextricable from economic, social, cultural, and political rights. Freedom to express one's sexual or gender orientation or to be who one is as a sexual person, to experience erotic justice, is interdependent with a whole series of other rights, including health care, decent housing, food security, freedom from violence and intimidation, and to be in public space without shame."[9]

Endnotes

1 *Compiled by Maria Melinda Ando, Programme Officer, ARROW*
2 *Adapted, "Reproductive Health." World Health Organization. www.who.int/topics/reproductive_health/en/*
3 *Erdman, J.N. & Cook, R. 2008. "Reproductive rights." Elsevier Inc. pp. 532-538.*
4 *ICPD PoA, para 7.3 hwww.unfpa.org/icpd/icpd-programme.cfm#ch7*
5 *Asian Communities for Reproductive Justice (ACRJ). 2005. A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice. California, USA: ACRJ. www.reproductivejustice.org/reproductive.html*
6 *"Gender and Human Rights." World Health Organization. www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html*
7 *ICPD PoA, para 7.2*
8 *Chandiramani, Radhika. 2007. "Why affirm sexuality?" In ARROW's for Change, Vol. 13 No. 2, pp. 1-2.*
9 *Petchesky, Rosalind. 2006. "Introduction: Sexual rights policies across countries and cultures: Conceptual frameworks and minefields." In Parker, R.; Petchesky, R; and Sember, R. SexPolitics: Reports from the Front Lines. Sexuality Policy Watch. www.sxpolitics.org/frontlines/book/pdf/sexpolitics.pdf*

FACTFILE

Youth SRHR in the Pacific:

Deserving Urgent Attention[1]

Covering over 29 million square kilometres of ocean, the Pacific region is characterised by diversity. The region's 22 countries and territories speak over one-third of the world's languages. Its 9.6 million people live in vastly different environments: from tiny coral atolls to expansive, forested mountain interiors. Out of 182 countries, the 2009 UNDP *Human Development Report* rates several Pacific Island countries as experiencing medium levels of development. Papua New Guinea (PNG) is the lowest at 148, sitting alongside Haiti. The Solomon Islands is at 135, alongside the Congo. Samoa is the highest at 94 with Tonga at 99 and Fiji at 108. In general, women experience a lower status than men across Pacific countries, with the Pacific having the lowest number of female parliamentarians in the world. Pacific people are increasingly urbanised and predominantly young, with 56% of the population under the age of 24 years.[2]

It is these young people who are the future of our region, and who need improved sexual and reproductive health (SRH) services. We have made progress in meeting these needs. Access to antenatal care has improved, skilled attendance at births has increased, vaccination coverage[3] has expanded and in some countries, maternal deaths have reduced. Legislation affirming, promoting and protecting women's rights have been passed in some countries. Greater attention is being paid to some SRH issues, particularly HIV.

A good deal of work has been done to ensure that young people can visit youth-friendly information and services. The Adolescent Health and Development programme, across 10 Pacific Island Countries, has been working for several years to promote youth-friendly services. Similarly, provision of sexuality and relationships education in skills has been the subject of efforts across several Pacific Island governments, with support from various development agencies.

But to ensure our young people can enjoy safe and healthy sexual and reproductive lives, and make the most of life's opportunities, we need to do more. We know this because not only do young people tell us, but also because the statistics indicate this. A study of young people aged 15-24 years of age in Samoa, Vanuatu and the Solomon Islands showed that about two thirds of young people were sexually active, with the median age at first sex 16 years, with a range of 10 to 23 years.[4] However, this study showed that condom use is generally low, with one third of young people having used a condom with their casual partner in the last 12 months but only 12% using a condom consistently with their casual partners. Condom use at first sex ranges from 15% in the Solomon Islands to 24% in Samoa. The use of modern contraceptives amongst women aged between 15-48 years ranges from 18% in Kiribati to 24% in PNG to a high of 64% in the Northern Mariana Islands.[5]

Related to this situation of generally low contraceptive use, unintended teenage pregnancy across the Pacific is high, in some cases, amongst the highest in the world. In the Marshall Islands, the rate of births per 1,000 teenage women is 138. In Papua New Guinea it is 65, while in Tuvalu it is 42.[6] Similarly, sexually transmitted infections are high in young people: a 2005 study revealed a prevalence of chlamydia in under-25 year-old pregnant women of 40.7% in Samoa and 34% in Fiji.[4]

There are many reasons for these statistics. Attitudes and beliefs that young people should not be sexually active until married, and a lack of policy and legislative attention to young people's rights and gender inequality, contribute to underfunded and unsupported sexual and reproductive health services and information. Violence is also a major concern in relation to SRH. While boys in particular, and some men, experience sexual coercion and violence, it is by far women and girls who predominantly survive the trauma of violence. A study in Samoa (2007) found that 46% of women had experienced physical and/or sexual violence. Similar studies in the Solomon Islands (2009) found that the percentage of women who experience violence is 64%, while in Kiribati (2009) it is 68% of women.[7] This violence has severe impact on a girl's sexual and reproductive health and rights across her lifespan, and her ability to enjoy opportunities she would otherwise be able to.

All these statistics point to the need for quality, confidential, non-judgemental information and services for young people, including contraception and safe abortion. These activities need to be supported by comprehensive, evidence-based sexuality and relationships education. Parents, teachers, politicians and health care professionals need to recognise, and be supported to recognise, that adolescence is a time of transition for young people and that exploring sexuality and sexual intimacy is an important part of this transition.

We must draw inspiration and encouragement from the achievements we have already made, to garner us for the five years to 2015. Our progress proves to us that we are able to address challenging issues, so let us spare no effort to make expanded rights, choices and opportunities the legacy of the ICPD PoA in the Pacific and all across the globe. Our people are entitled to nothing less, especially our young people. Our future depends on it.

Endnotes

1 *More information can be found in A Measure of the Future at www.fpi.org.nz This study amalgamates primary data from DHS, Censuses and other sources. Not all Pacific Island Countries have the same data available, which is why this publication is generally referred to rather than primary data sources, so that data from across the region can be provided.*

2 *Secretariat of the Pacific Community. 2009. Pacific Island Populations: Estimates and Projections of Demographic Indicators for Selected Years. Noumea, New Caledonia.*

3 *UNFPA, UNICEF, WHO. 2009. Maternal Health in the Pacific. Wellington, NZ: UN Health Agencies' Submission to the NZ Parliamentarians' Group on Population and Development (NZPPD). p.1.*

4 *WHO. 2006. Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in Six Pacific Island Countries. Geneva, Switzerland: World Health Organisation. pp. 20-25.*

5 *Family Planning International, Secretariat of the Pacific Community, Population Action International. 2009. A Measure of the Future: Women's Sexual and Reproductive Risk Index for the Pacific 2009. Family Planning International. p 22. (Data from years 2000 – 2008.)*

6 *A Measure of the Future , p 22. (Data from years 1996-2007.)*

7 *A Measure of the Future, p 30.*

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