BRIDGING THE GAP

EIGHT PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE PACIFIC REGION

PRODUCED BY THE PACIFIC SRHR WORKING GROUP

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- Development Alternatives with Women for a New Era (DAWN)
- Diverse Voices and Action for Equality (DIVA for Equality)
- Fiji Women's Rights Movement (FWRM)
- International Planned Parenthood Federation (IPPF)
- Oceania Society for Sexual Health and HIV Medicine (OSSHHM)
- Pacific Islands Forum Secretariat (PIFS)
- Pacific Youth Council (PYC)
- SPC Human Development Programme
- SPC Public Health Division (PHD)
- SPC Regional Rights Resource Team (RRRT)
- United Nations Population Fund (UNFPA)

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ABOUT THE READER

This reader is the product of a long line of work by various State and non-State organisations working on SRHR, gender equality, women's human rights, and health and wellbeing in the region. In February 2013, the Secretariat of the Pacific Community (SPC) Regional Rights Resource Team (RRRT) called a meeting to convene a regional working group that would bring together these organisations and explore the idea of working in partnership to create a reader on sexual and reproductive health and rights (SRHR) for the Pacific.

While there is a growing body of literature on SRHR globally, there remains a significant gap in information and resources that are tailored specifically to the Pacific context. This reader, a compilation of eight distinct essays on key SRHR topics written by a range of experts and professionals from across the Pacific, aims to bridge that gap and contribute to building the body of knowledge on SRHR in the Pacific region.

The reader takes a rights-based approach to SRHR and explores the SRHR of vulnerable and marginalised groups, such as women, young people, persons with disabilities, people living with HIV and lesbian, gay, bisexual, trans*[1], queer and intersex (LGBTQI) persons.

Advocates from both government and non-government organisations have made great progress in advancing SRHR in the Pacific region, but there is much more to be achieved. This reader is intended to contribute to these efforts by providing a resource – tailored to the Pacific context – that can inform the work of governments, civil society and the not-for-profit sector, and academia.

[1] trans* includes transgender women and men, trans-diverse and transgender persons. For more information on the sexual and reproductive health and rights issues for persons with diverse sexualities, gender identities and expressions see Chapter Seven.

CHAPTER ONE:

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE PACIFIC

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and Maha Muna, UNFPA

> Our vision is...that every person has the right to sexual and reproductive health, every pregnancy is wanted, every birth is safe, every young person has the right to education and services to grow up healthy, every girl is treated with dignity and respect, and violence against women should and can end.
>
> Babatunde Osotimehin, Executive Director of UNFPA (ICPD GCC 2013)

This essay aims to set the scene for understanding sexual and reproductive health and rights (SRHR) in the Pacific. It will explore the key concepts of SRHR, including sexual health, sexuality, sexual rights, reproductive health and reproductive rights and what it means to take a rights-based approach to sexual and reproductive health. It will highlight the importance of ensuring that every individual is able to enjoy their sexual and reproductive health rights without discrimination and that everyone enjoys the highest standards of health, as mandated by international, regional and national laws and consensus documents.

Sexuality and reproduction lie at the heart of what it is to be human and alive, and at the foundation of families and communities. The concept of SRHR as we know it originated at the 1994 International Conference on Population and Development (ICPD). The conference saw the expansion of reproductive health to include sexual health and agreement among participating states that reproductive rights are human rights that are already recognised in domestic and international law. Additionally, ICPD called for the promotion of positive sexual health choices and wellbeing as crucial to achieving SRHR (United Nations 1994).

The ICPD Programme of Action (PoA) (United Nations 1994) offers the following definitions of reproductive health and rights:

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

Although reproductive health relates closely to reproduction, achieving good reproductive health requires that individuals also have good sexual health, including the freedom to express their sexuality. It is noted that sexual and reproductive health is reliant on 'lived' or 'expressed' sexuality. As such, sexuality and sexual relations are in many ways central to the realisation of sexual and reproductive health.

The World Health Organization (WHO) (2006) offers the following working definitions of sexual health and sexuality:[1]

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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.*

Sexuality is *a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.*

[1] These working definitions were developed through a consultative process with international experts and reflect an evolving understanding of the concepts as well as building on international consensus documents such as the ICPD Programme of Action and the Beijing Platform for Action. These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health, as with other areas of health, is influenced by a complex interplay of biological, psychological and social determinants (O'Rouke 2008). When viewed holistically and positively, sexual health:

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

At the foundation of this approach are the principles of non-discrimination, inclusion and equal participation in society. All members of the community, regardless of their age, ethnicity, religion, sexuality, ability or marital status, have the right to the highest standard of sexual and reproductive health.

Providing reproductive health services is an important commitment in the ICPD PoA (United Nations 1994). The PoA states that all countries should strive to make reproductive health care accessible through their primary health care system, including:

- family planning counselling, information, education, communication and services;
- education and services for prenatal care, safe delivery and post-natal care;
- prevention and appropriate treatment of infertility;
- abortion, including prevention of abortion and the management of the consequences of abortion;
- treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions;
- information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood;
- referral for family planning services;
- further diagnosis and treatment for complications of pregnancy, delivery and abortion; infertility; reproductive tract infections; breast cancer and cancers of the reproductive system; and sexually transmitted diseases, including HIV; and
- active discouragement of harmful practices, such as female genital mutilation.

There are multiple factors, including cultural, financial, logistical, institutional, geographical, religious, and legal and policy, that play a role in determining people's access to sexual and reproductive health services. Some of these factors include, but are not limited to:

- embarrassment about needing, wanting or asking for SRHR information and commodities;
- access to services (including the distance from services);
- the cost of servicing small populations in remote rural areas;
- preference for large families;
- misconceptions and inadequate information about contraceptive choices;
- low social status of women; and
- low rates of literacy, particularly amongst women (UNESCO 2013).

Marginalised and vulnerable people may experience additional obstacles to accessing SRHR services. For example, many women, adolescents and young people lack access to independent finances to purchase commodities or cover health care fees, insurance or transportation costs to services. Some have limited autonomy in decision making and in many settings, conservative views regarding adolescent sexual behaviour makes health care workers reluctant to provide information or services to young people (UNESCO 2013).

Sexual and reproductive health strategies must aim to achieve health equity. Population health, which focuses on improving health and wellbeing through health approaches that tackle the disparities in health status between social groups, is essential in achieving sexual and reproductive health equity. Rather than a sole focus on

individual behaviour change, it is crucial to look at a broad range of factors that influence health and wellbeing at a population level; these are known as the social determinants of health (WHO 2010b).

The social determinants of health are the conditions in which people are born, grow, live, work and play that affect their health, safety and wellbeing. The social determinants of health are, for the most part, responsible for health inequities; the unfair and avoidable differences in health status seen within and between population groups (WHO 1986).

The denial and violation of sexual and reproductive rights, as with other basic human rights, is often connected to poverty and other forms of marginalisation, discrimination and violence. Poverty is the cause, as well as the consequence, of poor health and wellbeing, and it compromises the potential of people to fully realise their sexual and reproductive health and rights in many ways, including inadequate food, under-nutrition, anaemia, disease, low educational attainment, poor quality shelter, sexual abuse, intimate partner violence, and poor access to sexual and reproductive health services (Awin 2014).

In 2010, WHO published a report on the social determinants of sexual and reproductive health, examining the complex way in which they exacerbate global health inequities. The report maintains that these determinants work 'at different levels to influence exposure to the risks of unintended pregnancy or sexually transmitted infection, care-seeking behaviours, and access to and use of preventative services, care and treatment' (WHO 2010b).

WHO (2010b) further contends that a focus on people's lifestyle and behaviour will be inadequate in alleviating long-term sexual and reproductive health inequities if such interventions fail to also work towards redressing the social conditions that drive poor health outcomes. Additionally, Women's Health West (2011), argues that, without this focus on the social determinants of sexual and reproductive health, lifestyle and behaviour change interventions are unlikely to see tangible health improvements, particularly among disadvantaged communities.

TAKING A RIGHTS-BASED APPROACH TO SEXUAL AND REPRODUCTIVE HEALTH

> *Sexual and reproductive health and rights are essential for all people, particularly women and girls, to achieve dignity and to contribute to the enrichment and growth of society, to innovation and to sustainable development.*
> *(United Nations 2014)*

In recent years, there has been an increasing recognition that a rights-based approach is crucial in ensuring that communities achieve optimal sexual and reproductive health (Women's Health West 2011). Hunt and Bueno de Mesquita (2010) argue that sexual and reproductive health is among the most sensitive and controversial issues in international human rights law, but is also among the most important. This is because the underlying drivers of poor sexual and reproductive health are multi-faceted and often deeply entrenched. For instance, the lower social status of girls and women in many countries, including Australia, is a key contributor to their poor sexual and reproductive health and represents a violation of their right to health and freedom from violence and discrimination (Hunt and Bueno de Mesquita 2010).

Sexual and reproductive health rights are not separate from other human rights. There is a growing consensus that sexual and reproductive health cannot be achieved and maintained without respect for and protection of human rights more broadly (WHO 2006). A rights-based approach to health seeks to integrate the norms, standards and principles of international human rights agreements into national laws, policies and plans to promote health and development (WHO 2010a).

Reproductive rights 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 (United Nations 1994).

Sexual rights are the application of existing human rights to sexuality and sexual health in order to protect people's rights to fulfil and express their sexuality and enjoy sexual health (WHO 2006).

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

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

These rights are guaranteed by the International Bill of Human Rights comprising the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rig0At the same time, good sexual and reproductive health is also essential in realising a wide range of basic human rights, including:

- the right to life;
- the right to liberty and security of the person;
- the right to health;
- the right to decide the number and spacing of children;
- the right to consent to marriage and equality in marriage;
- the right to privacy;
- the right to equality and non-discrimination;
- the right to be free from practices that harm women and girls;
- the right to be free from torture or other cruel, inhuman or degrading treatment or punishment;
- the right to be free from sexual and gender-based violence;
- the right to education and information; and
- the right to enjoy the benefits of scientific progress.

In the rights-based approach to sexual and reproductive health, the provision of services must conform to the international human rights framework comprising standards guaranteeing availability, accessibility, acceptability, and quality of health facilities, goods, and services. These standards also apply to the underlying determinants of health, including access to sexuality education and information. They include:

- **Availability**: States must ensure that there are an adequate number of functioning health care facilities, services, goods and programmes to serve the population, including essential medicines such as contraception and emergency contraception.
- **Accessibility**: States must ensure that health facilities and services are accessible to their populations, particularly the most vulnerable populations, without discrimination. Health facilities and services must be physically accessible, including for people with physical disabilities, and economically accessible, which entails affordability. Health information must be accessible, meaning that individuals and groups must be able to seek, receive, and disseminate information and ideas on health issues in a language / format of their choice.
- **Acceptability**: Health facilities, services, and goods must be culturally appropriate and should take into account the interests and needs of minorities, indigenous populations, and different genders and age groups.
- **Quality**: Reproductive health care must be of good quality, meaning that it is scientifically and medically appropriate and that service providers receive adequate training.

KNOW YOUR RIGHTS

Everybody has sexual and reproductive rights. States have an obligation to ensure that everyone can freely, without fear, coercion or discrimination:

- make decisions about her or his own health, body, sexual life and identity.
- ask for and receive information about sex, contraception and related health services.
- decide whether and when to have children.
- choose whether or not to marry and what type of family to create.
- have access to comprehensive and integrated sexual and reproductive health services. Nobody should be deprived of health care or information on the basis of who they are or what they can afford.
- live free from rape and other violence, including forced pregnancy, abortion, sterilization or marriage, or female genital mutilation/cutting.

Source: Amnesty International (2011) Realizing sexual and reproductive rights. A human rights framework

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE PACIFIC CONTEXT

Sexual health needs to be understood within specific social, economic and political contexts. In the Pacific, there is a linguistically diverse population of over ten million, who speak more than 800 indigenous languages. Given this diversity, there is an accompanying wide range of SRHR issues that are experienced differently by different Pacific Islanders.

The reproductive health status of their population is a priority for all governments in the Pacific. However, because many Pacific communities have diverse cultures and are very religious, sensitive issues of sexual and reproductive health are often challenging to discuss and address. Consequently, Pacific countries are making slow progress in achieving the Millennium Development Goals Target of 'universal access to reproductive health' (MDG Target 5.b), with only Cook Islands, Fiji, Niue and Palau on track to achieving this target (Pacific Islands Forum Secretariat 2013).

2014 is an important year for the global SRHR agenda because it marks the conclusion of the commitments made in the ICPD PoA. This set out a series of priority issues, including population and development, gender equality and equity, reproductive health and rights, and adolescents and youth. The PoA also described the actions needed to respond to these issues, with agreed goals, a twenty-year timeframe for achieving them, and the bodies responsible for action. The PoA placed the right to sexual and reproductive health, as well as gender equality and women's empowerment, at the core of its recommended population development strategies.

In 2010, in light of the fact that many governments were unlikely to meet the goals and objectives of the ICPD PoA by 2014, the UN General Assembly mandated a comprehensive review of its progress, known as the ICPD Beyond 2014 Global Review. The Pacific component of the review was undertaken in 2012 and it collected up-to-date data to measure progress towards ICPD goals. Fourteen independent Pacific Island countries and territories (PICTs) were surveyed; Fiji, Papua New Guinea, Solomon Islands, Vanuatu, Federated States of Micronesia, Kiribati, Nauru, Palau, Republic of the Marshall Islands, Cook Islands, Niue, Samoa, Tonga and Tuvalu.

The review found that substantial resources, both human and financial, had been devoted to building capacity and extending and delivering services to communities (UNFPA 2013). It also acknowledged the remaining challenges, mostly posed by the geography of the Pacific and the small, scattered populations, which make economies of scale difficult to achieve.

The Pacific Regional ICPD Review report (UNFPA 2013), a regionally focused report that fed into the larger Pacific Regional ICPD Review Report, stresses that population growth rates of some countries are still too high to ensure viable, sustainable futures, and the slow rate of economic development has not kept pace with population growth. The report also emphasises that the realisation of rights and social protection for vulnerable and marginalised groups such as women and children, the elderly, youth and persons with disabilities, is still inadequate. Management of burgeoning urbanisation and development of planning for migration, both internal and international, remain limited. In addition, integrated and comprehensive approaches to achieving reproductive rights and reproductive and sexual health across the region are yet to be fully established, and the integration of population issues into education systems is still under development. Enabling women to enjoy full participation in social, political and economic life remains elusive for most PICTs and gender-based violence was reported very high in many countries (UNFPA, 2013).

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

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

There have been a number of calls from governments in the Pacific for greater focus on SRHR in the region. Some notable examples include:

The Moana Declaration (2013)[2]

The outcome document of the Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, the *Moana Declaration*, is one of the region's key contributions to the global ICPD review. It calls for:

> the creation of an enabling environment to ensure access to sexual and reproductive health and rights for all people and without discrimination, the incorporation of sexual and reproductive health-related issues in development strategies and increased participation of women and young people in decision-making processes.

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

The *Asian and Pacific Ministerial Declaration on Population and Development*, the outcomes document of the Sixth Asian and Pacific Population Conference, sets the population and development agenda for the Pacific over the next decade. In agreeing to it, States resolved to ensure access to a strong health care system that provides a range of good quality, affordable services to address diversified health needs, including sexual and reproductive health needs. They resolved to promote the right of women and girls to enjoy the highest attainable standard of health, including sexual and reproductive health, in order to achieve gender equality. States expressed grave concern at acts of violence and discrimination against individuals on the grounds of their sexual orientation and gender identity, and committed to working to reduce vulnerability and eliminate discrimination based on sex, gender, age, race, caste, class, migrant status, disability, HIV status, sexual orientation, gender identity, or other status.

[2] UNFPA, AFPPD & IPPF, 2013

[3] United Nations Economic and Social Council, 2013a

States reaffirmed that expanding access to sexual and reproductive health information and education and high quality sexual and reproductive health services are essential for achieving the goals enshrined in the *Beijing Declaration and Platform for Action*, the ICPD PoA, the key actions for the further implementation of the ICPD PoA, the Millennium Development Goals and the recommendations arising from their subsequent reviews.

The *Madang Commitment* (2009)[4]

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

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

CONCLUSION

Sexual and reproductive rights are intrinsic human rights. They encompass respect for bodily integrity, the right to choose one's partner, and the right to decide on sexual relations and on having children, among other things. When SRHR is left out from the development equation, we are denying the value of our very existence, as well as that of future generations.

SRHR has continued to evolve and expand in international, regional and national human rights instruments and in political declarations. Some aspects of SRHR are clear-cut. For example, it is clear how reducing maternal mortality and morbidity is directly linked to a woman's right to life and right to health, but SRHR goes much further than women's maternal health. Sexuality is as much a part of being fully human and fully alive as needing food and water to live. It is the essence of the joy of being alive and its meaning is far broader than biological processes; it encompasses spirituality, human nature and culture.

Despite the continuing challenges, there have been notable signs of progress in the Pacific. The number of countries with national population policies is steadily increasing. Sexual and reproductive health programmes have received considerable attention and the integration of sexual and reproductive health into primary health programmes has improved (UNFPA 2013). However, SRHR remains a key development issue, and ensuring that it receives the recognition and attention it deserves is an uphill battle, requiring the full efforts of both state and non-state actors. To have the maximum effect, international human rights and development goals need to be fully recognised, adapted and integrated at a national level. More challenging still, these policies and principles have to be translated into action that has a real impact.

[4] WHO & SPC, 2009

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CHAPTER TWO:

TAKING A COMPREHENSIVE AND RIGHTS-BASED APPROACH TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE HEALTH SECTOR

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and Michelle O'Connor, SPC Public Health Division

> Rights that relate to sexual and reproductive health stem from human rights, which provide a framework from which the sexual and reproductive health needs and aspirations of all people can be considered.
>
> Gruskin et al. 2005

Achievement of an individual's sexual and reproductive health is considered necessary for the fulfilment of one's basic human rights. As such, this essay has been written from the perspective that every person in the Pacific has the right to sexual and reproductive health. Additionally, it considers a programme delivery approach for which policy and legislative guidance can be derived. The authors aim to keep this chapter realistic, practical and grounded in the realities of the Pacific region.

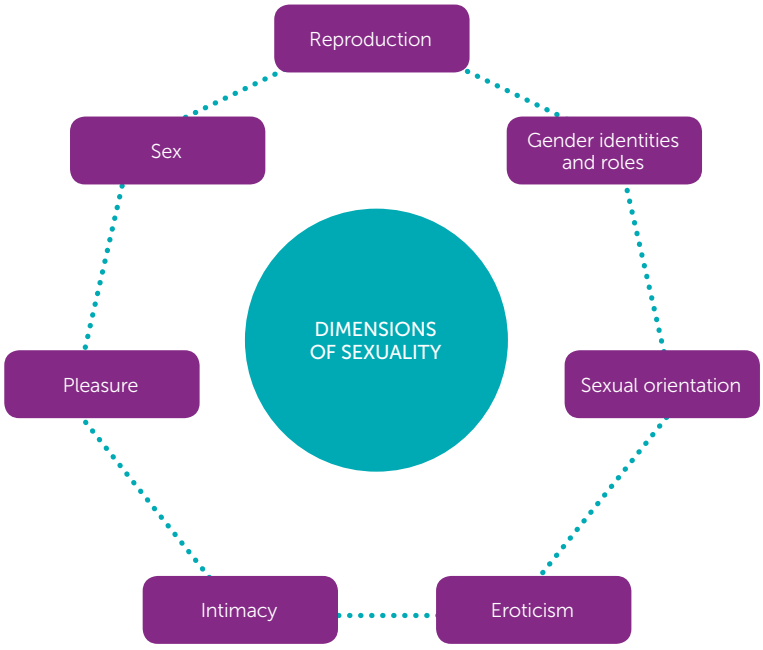
In an ideal world, the sexual and reproductive health and rights (SRHR) needs of all citizens would be met. In reality, however, countries and governments will need to prioritise what they can do with the resources they have available, keeping in mind that they are obligated to provide services that meet the health needs of all citizens, as health is a basic human right.

The services required for a government to meet its obligation to address the health needs of its citizens are defined in each context based on the specific needs of citizens. However, they are all likely to include prevention, treatment, care and support for sexually transmitted infections (STIs) including HIV; family planning and antenatal care; postpartum and post-abortion services; and maternal and newborn health services (UNFPA and Population Council 2010). Unfortunately, many Pacific Island countries and territories (PICTs) are unable to provide basic sexual and reproductive health services to their populations. Additionally, they may fail to offer sexual and reproductive health services to vulnerable or marginalised groups such as youth, lesbian, gay, bisexual, trans*, queer and intersex (LGBTQI) persons, migrants or persons with disabilities in a structured and concerted way.

It can be argued that sexual health and sexuality are central to the realisation of reproductive health. In other words, we come to realise our full reproductive health potential through our sexual health. Likewise, sexual and reproductive health cannot be achieved without a full expression of one's sexuality.

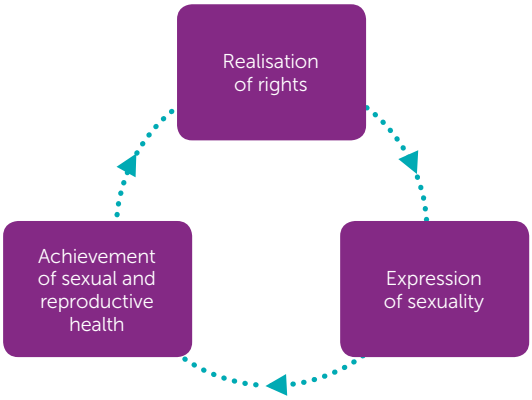
There are a number of dimensions that contribute to an individual's sexuality (see Figure 1). Each of these dimensions is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. Therefore, achieving SRHR involves complementary action across a number of areas and SRHR interventions will be successful only when planning, programming and service delivery are holistic, multi-sectoral and interdisciplinary.

Figure 1: Key dimensions of sexuality



Once an individual is able to fully experience and express their sexuality, their sexual health and thus reproductive health will be realised. This is demonstrated below in Figure 2.

Figure 2: Achieving sexual and reproductive health



The relationship between sexual and reproductive health and rights is indicated in Figure 3, which shows that sexuality and sexual relations are central to the realisation of sexual and reproductive health, which are enshrined by basic human rights principles and packaged as sexual and reproductive rights.

Figure 3: Sexual and Reproductive Rights

Sexual and reproductive rights are grounded in basic human rights. The achievement of sexual and reproductive health will not be fulfilled without the acknowledgment and fulfilment of sexual and reproductive rights.

Sexual rights

According to a technical report of the World Health Organization (2006:5), sexual rights:

...embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- *the highest attainable standard of sexual health, including access to sexual and reproductive health care services;*
- *seek, receive and impart information related to sexuality;*
- *sexuality education;*
- *respect for bodily integrity;*
- *choose their partner;*
- *decide to be sexually active or not;*
- *consensual sexual relations;*
- *consensual marriage;*
- *decide whether or not, and when, to have children; and*
- *pursue a satisfying, safe and pleasurable sexual life.*

Reproductive rights

According to a United Nations report (1994 section 7.3), reproductive rights:

> ...rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly on 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...

INTERSECTIONS BETWEEN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND POPULATION HEALTH

Failure to achieve SRHR has profound implications for the individual, community and society. Lack of access to contraception and safe abortion; gender-based violence, including sexual assault; and STIs, including HIV, can lead to morbidity and mortality, particularly for the mother and child. Complications during pregnancy and childbirth, gender-based violence and AIDS are amongst the leading causes of mortality for young people globally (Amnesty international 2013). Stigma and discrimination; gender inequality, including limits on autonomous decision making; and poor access to health services, commodities and information lead to increased vulnerability to poor sexual and reproductive health outcomes.

A strong link was drawn at the ICPD Cairo Conference in 1994 between SRHR and population productivity and sustainability. These discussions continue as part of the Post-2015 Development Agenda. The provision of sexual and reproductive health services and sexual and reproductive wellbeing is linked to a productive and healthy population; enabling couples to choose the number of children they have enables sustainable population growth.

BARRIERS AND ENABLERS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The clinical scope of sexual and reproductive health

The following is a list of sexual and reproductive health services widely held to be essential services that a country should provide to its citizens (WHO, 2010):

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

It would be ideal if clinics could provide comprehensive and holistic services as identified in the list above. In reality, however, there are likely to be many barriers that make it difficult for one clinic to deliver all these services. It is not within the scope of this paper to discuss what services are available in various countries in the Pacific, other than to state that nowhere in the Pacific is sexual and reproductive health being delivered in a holistic and comprehensive way.

Barriers

The following explores key barriers that may limit the sexual and reproductive health and rights of people in PICTs.

Access to good quality health services

The constitution of the World Health Organization (1946) states that every person is entitled to 'the enjoyment of the highest attainable standard of health'. To achieve this, people need to be able to access affordable and appropriate health care. There are multiple factors, including cultural, religious, financial, logistical, institutional, legal and policy that play a role in determining people's access to sexual and reproductive health services in the Pacific. Those likely to experience the most difficultly in accessing these services include people living in remote areas, poor populations and populations with specific needs, such as young people, persons with disabilities, migrants, people living with HIV, and LGBTQI persons. Another key factor that may operate as a barrier to access is embarrassment about needing, wanting or asking for sexual and reproductive health information and commodities.

Confidentiality

People may choose not to access health services for fear, or experience of, a lack of confidentiality. For example, a person may choose not to access an HIV test for fear that the results will not remain confidential. This is demonstrated by the results of a study into sex work and HIV in Fiji (McMillan and Worth 2010), which found that most participants (sex workers) felt very vulnerable when seeking an HIV or STI test, expressing concerns about the confidentiality of the test results and the context in which those results would be delivered. Respect for privacy and confidentiality is integral to people living healthy sexual and reproductive lives without discrimination, coercion and fear.

Discrimination

Health services have a legal obligation to ensure that all people, regardless of their social identities, such as sexual orientation, gender identity, race, HIV status, age, religion and ethnicity, have access to appropriate social and health services that adequately meet their needs. However, as previously mentioned, PICTs perform poorly in systemically ensuring that their sexual and reproductive health services are accessible to vulnerable and marginalised populations. Examples of discrimination described in other chapters in this reader include, doctors publically shaming young people seeking sexual and reproductive health care and the systemic exclusion of women with disabilities from sexual and reproductive health care services.

Inadequate legislation, policy and guidelines

Inadequate and/or insufficient laws, policies and guidelines can act as barriers by preventing the collection of accurate data, widening service gaps and obstacles, enabling discrimination and preventing access to health services. For example, abortion is illegal in many PICTs, which poses a barrier to the achievement 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.

A study by UNFPA (Spratt 2013: 44) into the experiences of women with disabilities of sexual and reproductive health and violence in Kiribati, Solomon Islands and Tonga concluded that as '...safe and legal abortion is not available... women have no choice but to carry a potentially unwanted pregnancy through to childbirth. In many cases, this may be what the woman would choose regardless of other options. Currently, however, an informed choice is not an option. While it will take time, action must begin to expand women's reproductive choices to include safe and legal abortion'.

It is also widely acknowledged that unsafe abortion is a problem in the Pacific region; however, the data are not available to confirm this. Given that the region has a total fertility rate of below four children per woman, with low contraceptive use (21 per cent modern methods) and as few as eight abortions per 1000 women,

the rate of unsafe abortions could be very high. While acknowledging that the lack of data for the region means that estimates are imprecise, WHO estimates that in 2008, 18,000 women had unsafe abortions in the Oceania region (excluding Japan, Australia and New Zealand). They estimate that for every 100,000 unsafe abortions, 400 result in death (WHO 2011).

Discriminatory or uninformed health professionals

Health professionals may lack a strong understanding of human rights, current laws and policies, or they may hold personal views that disagree with certain rights. Spratt (2013) highlights the need to support health professionals by providing ongoing in-service learning and a range of information, education and communication materials that encourage them to be non-judgmental and to respect confidentiality.

Enablers

Although barriers have a negative influence on achieving SRHR, they also present an opportunity for growth, and many can be turned into enablers. Some examples of enablers are described below.

Existing services

Existing health services provide an entry point for people to achieve their sexual and reproductive health and rights. Such services can be strengthened by: (a) ensuring an essential package of services is provided, which are safe, accessible, affordable and acceptable to all people, especially vulnerable and marginalised populations; and (b) creating links and referral pathways to other specialised services, such as psychosocial support.

Political will, champions, community spirit and support

Any intervention to improve the sexual and reproductive health of a population must be understood and accepted by the community. This requires sensitivity to social, cultural and religious norms.

There are many strong champions and advocates for SRHR in the Pacific. It is essential to engage such champions and advocates; they can help to mobilise community support and drive change.

Political will is also important in facilitating change, particularly through legislation and policy reform, as well as through parliamentarian-led and other high level working groups. This can be enabled by partnerships with key regional development institutions and mechanisms, UN agencies, CROP agencies, and civil society.

Legislation, policy and guidelines

Where they exist and are adequate, legislation, policies and guidelines can promote the achievement of SRHR and in some cases can be used as guides for other countries. Once in place, the next step is to ensure that people are educated about the legislation and policies and that they are implemented correctly.

Health professionals

Existing health professionals can be used to advocate and implement changes that promote SRHR if they are equipped with the appropriate knowledge and skills to do so.

Health communication campaigns and education

Health communication campaigns, such as health promotion, have been taking place in the Pacific for many years. The campaigns encourage people to change their behaviours and access health services, and they equip people with the necessary knowledge to do so. In addition, comprehensive sexuality education and life skills education take place in some PICTs. These programmes can be learned from, improved and expanded.

The above list does not seek to cover all barriers and enablers to accessing sexual and reproductive health services, as the specific barriers and enablers will differ for each context. Instead, the list aims to encourage the identification of barriers and enablers to improving SRHR within the heath care setting and highlight key strengths and areas for improvement.

CONCLUSION

By strengthening health systems so that they are equipped to meet the sexual and reproductive health needs of all Pacific Islanders and by ensuring accessibility of sexual and reproductive health services without discrimination, we are one step closer to achieving the fundamental right to health. This goal is ambitious but not impossible. Successfully achieving it requires dismantling the complex barriers that prevent Pacific Islanders from realising their SRHR, in particular, addressing inadequate and/or insufficient laws, policies and guidelines that limit access to sexual and reproductive health services. Simultaneously, a long-term investment in the factors that enable SRHR must be prioritised. This includes building political will and engaging leaders as champions in the realisation of SRHR. Only through adopting a rights-based approach, which recognises that sexual and reproductive health will not be achieved until people are able to exercise their rights, can Pacific Islanders obtain the highest standard of health to which they are entitled.

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CHAPTER THREE:

THE INTERSECTION OF GENDER INEQUALITY, VIOLENCE AGAINST WOMEN AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Around the world people continue to be stigmatised and discriminated against in relation to their sexual and reproductive health and rights (SRHR). Stigma, discrimination and the violation of people's human rights are inter-related and continue to legitimise each other. Different forms of human rights violations, stigma and discrimination can be seen daily in homes, communities, school, work, within the health care and education sectors, and at the national level with discriminatory legislation and policies.

This essay examines key human rights instruments and consensus documents, demonstrating that sexual and reproductive rights are already recognised in national and international law. It looks specifically at the obligations of governments to ensure women's access to their sexual and reproductive health and rights and examines how gender inequality can inhibit their access. It also explores the rights denials/violations of other marginalised and vulnerable populations.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN INTERNATIONAL HUMAN RIGHTS FRAMEWORKS

Sexual and reproductive rights build on human rights that are already recognised by national laws, international human rights documents and other consensus documents. Figure 1 shows the sexual and reproductive rights that are already recognised in international law.

Figure 1[1]

[1] Ahumada & Kowalski-Morton, 2006

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[2]

International human rights treaties such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) enshrine women's rights to SRHR in international law. They require governments to ensure that women are able to access information and the services needed to freely decide and act on matters relating to their sexual health, sexuality and reproductive health without coercion or discrimination. In the Pacific region, however, women still face many challenges in exercising their sexual and reproductive health rights, even though they are recognised in national legislation and international and regional treaties and frameworks.

It is essential for decision makers to link SRHR to broader human rights contained in international treaties and country specific legislation and policies. Signatory countries to CEDAW should be aware that addressing SRHR is key to ensuring that they meet their obligations under CEDAW. With the exception of Palau and Tonga, all Pacific Island countries and territories (PICTs) have ratified CEDAW. In practice, however, women's rights are still not realised in the Pacific.

Some of the rights in CEDAW that pertain to SRHR:

Article 12. 1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Article 16 The State shall take appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on the basis of equality of men and women:

a) The same right to freely enter into marriage.

b) The same right to freely choose a spouse and to enter into marriage only with their free and full consent.

e) The same rights to decide freely and responsibly on the number and spacing of their children and have access to the information, education and means to exercise these rights.

The *Beijing Declaration and Platform for Action*[3]

In 1994, delegates from all 22 PICTs endorsed a set of principles and plan of action to advance gender equality in the Pacific region. This is the *Pacific Platform for Action on Advancement of Women and Gender Equality.* In Beijing in 1995, this document was presented to the Fourth World Conference on Women, which produced the *Beijing Declaration and Platform for Action* (BPA). Since their adoption, Pacific Islanders have used these two documents to influence national and regional action and international cooperation to empower women in their efforts to achieve political, legal, social and cultural rights. In 2004, the *Revised Pacific Platform for Action on the Advancement of Women and Gender Equality 2005–2015* (RPPA) was adopted and a further review is now under way to determine future priorities. Progress in implementing the gender equality and women's human rights commitments outlined in the RPPA and the BPA is monitored through the Triennial Conference of Pacific Women.

[2] UN General Assembly, 1979

[3] United Nations, 1995

Paragraph 96 of the *Beijing Declaration and Platform for Action states the following about sexuality and bodily integrity:*

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

The Millennium Development Goals (MDGs)[4]

Sexual and reproductive health rights are also enshrined in the Millennium Development Goals (MDGs): a blueprint for eradicating extreme poverty agreed to by all the world's countries. MDG 5: Improve maternal health, sets the following targets, each of which is followed by achievements to date:

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Achievements:

- The maternal mortality ratio dropped by 45 per cent between 1990 and 2013, from 380 to 210 deaths per 100,000 live births. All regions have made progress but accelerated interventions are required in order meet the target.
- In Eastern Asia, Northern Africa and Southern Asia, maternal mortality has declined by around two thirds.
- The proportion of deliveries in developing regions attended by skilled health personnel rose from 56 per cent in 1990 to 68 per cent in 2012.
- The maternal mortality ratio in developing regions is still 14 times higher than in the developed regions.
- The rural-urban gap in skilled care during childbirth has narrowed.

Target 5.B: Achieve, by 2015, universal access to reproductive health

Achievements:

- More women are receiving antenatal care. In developing regions, antenatal care increased from 65 per cent in 1990 to 83 per cent in 2012.
- Only half the women in developing regions receive the recommended amount of health care they need.
- Fewer teens are having children in most developing regions, but progress has slowed.
- The large increase in contraceptive use in the 1990s was not matched in the 2000s.
- The need for family planning is slowly being met for more women, but demand is increasing at a rapid pace.
- Official development assistance for reproductive health care and family planning remains low.

The *2013 Pacific Regional MDGs Tracking Report* (Pacific Islands Forum Secretariat 2013) stated the need to invest in girls' education to improve maternal and reproductive health outcomes. The more years of education a woman has, the more likely she is to make choices leading to better reproductive health outcomes, such as the use of contraception, delayed sexual activity and first pregnancy, antenatal visits, and giving birth in a health facility. For example, in Papua New Guinea, the proportion of teenagers who fall pregnant is twice as high among girls with no education as it is among girls with Grade 7 or higher education (Pacific Islands Forum Secretariat 2013). The report (Pacific Islands Forum Secretariat, 2013: 41) asserts there is a need for an:

> ...holistic and multidimensional approach to improving sexual and reproductive health, addressing not only health system strengthening but also reflecting broader social and attitudinal changes that support women's rights to sexual and reproductive health. These rights are not yet well understood by all women and men, since in many circumstances they are at variance with traditional or religious views on a husband's authority over his wife's body and fertility.

[4] Millennium Development Goals and Beyond 2015 < http://www.un.org/millenniumgoals/>

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Sexual and reproductive health and rights elude many of the world's people because of factors such as inadequate levels of knowledge about human sexuality; inappropriate or poor quality reproductive health information and services; the prevalence of high risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most Pacific countries. Additionally, older women and men have distinct reproductive and sexual health issues, which are often inadequately addressed.

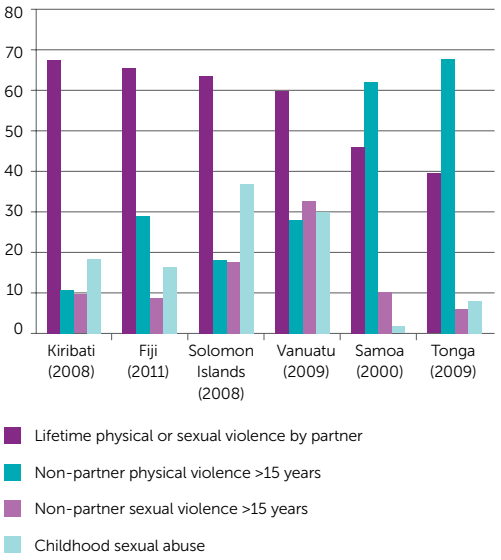
Access to information and services is essential to ensuring women and girls can realise their sexual and reproductive health and rights. In the Pacific, however, various social, cultural, religious and practical barriers exist that prevent women and girls from doing so. At a practical level, women experience barriers to accessing information and services that will assist them in making informed decisions about their bodies and their families. For example, sexual and reproductive health services are usually located in urban centres so women who live outside these areas and do not work are likely to experience difficulty accessing the service. Additionally, the patriarchal cultural contexts of most PICTs mean that SRHR is rarely discussed within families or communities. This makes it difficult for women to seek information and services that will assist them in making decisions about their bodies. Furthermore, the use of contraceptives is not widely accepted and discussions about family planning options are rarely held.

GENDER INEQUALITY AND VIOLENCE AGAINST WOMEN

There is a strong connection between SRHR and the power relations between women and men. Unequal power relations and patriarchal systems of governance in many communities in the Pacific region can lead to attitudes towards women that tolerate violence against women and limit their sexual and reproductive health and rights.

Violence against women in the Pacific is widespread, and there is limited access to justice and support services. The Family Health and Safety Study in Samoa, revealed that 46.4 per cent of ever-partnered women aged 15–49 have experienced emotional, physical or sexual violence by an intimate partner. The same study in Solomon Islands (SPC and UNFPA 2009) and Kiribati (SPC 2010) revealed that 64 per cent and 68 per cent respectively of ever-partnered women aged 15–49 have experienced physical or sexual violence by an intimate partner.

Figure 2: Patterns of violence against women (15–49) in Pacific Island countries[5]



[5] UNFPA Pacific Sub-Regional Office, 2013

These studies also reveal that between 3 per cent and 8 per cent of women had their first sexual experience before age 15, and between 23 per cent and 50 per cent before age 18. Although only a small percentage of women reported that their first sexual experience was below the age of 15, many of those that did (between 23 per cent in Kiribati to 59 per cent in Vanuatu), reported that their first sexual experience was forced. Data for all countries show that the later the first sexual experience, the less likely it was forced (UNFPA Pacific Sub-Regional Office 2013). Among the women whose first sexual experience was after the age 18, only 6 to 20 per cent reported that it was forced. Understanding the link between violence and teenage pregnancy is key to establishing effective prevention strategies.

Jewkes' (et al. 2013) analysis of *The United Nations Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific* revealed that in Bougainville, Papua New Guinea, 60.7 per cent of men admit to raping a woman, 40.7 per cent reported raping a non-partner and 59.1 per cent reported raping a partner. Additionally, 7.7 per cent of men reported raping a man and 14.1 per cent reported committing multiple perpetrator rape, or *lainap*. Of those who reported committing rape, 24.6 per cent were 15 years old or younger when they committed their first rape.

Violence against women has many negative sexual and reproductive health consequences for women and children. These include unwanted pregnancies, abortion or unsafe abortion, sexually transmitted infections including HIV, and pregnancy complications. In addition, it makes it difficult for women to have autonomy over their bodies and therefore they are unable to negotiate for safe sexual practices such as contraceptive or condom use with their partner.

In some instances, violence can lead to reduced use of contraceptives. Various studies in developing countries have revealed that violence or fear of violence from partners can be a barrier to contraception use (Heise L, Ellsberg M, Gottemoeller M., 1999; Fiji Women's Crisis Centre 2013). The Solomon Islands Family Health Safety Study (SPC, 2009), found that women who experienced intimate partner violence were also more likely to have a partner who had stopped or tried to stop them from using a form of contraception. On the other hand, however, studies have found that reported levels of condom use were higher in violent relationships (Garcia-Moreno et al. 2005). This is consistent with research into domestic violence in Fiji (Fiji Women's Crisis Centre 2013), which revealed that women experiencing domestic violence are more likely to have initiated contraception than women who are not experiencing domestic violence; however, they are also more likely to have been prevented from using family planning methods.

Domestic violence and SRHR are also connected when a violent partner limits a woman's mobility and access to health care, and controls who she can see or communicate with. This emotional and physical abuse has enormous consequences for women's mental and physical health, self-confidence and self-esteem. It contravenes their human rights, inhibits their ability to care for themselves and their families, and prevents them from taking up opportunities for social and economic development. Research into intimate partner violence in Fiji (Fiji Women's Crisis Centre 2013) revealed that two in five ever-partnered women surveyed needed to ask permission from their husband/partner before they accessed health care for themselves. This clearly has very serious implications for women's access to sexual and reproductive health services. This finding provides a stark insight into the status of women, whose health is either not seen as important, or who are not seen as competent to make decisions about their own health care (Fiji Women's Crisis Centre 2013).

Another important link between domestic violence and SRHR is that, across a broad range of settings, men who are violent towards their partners are also more likely to have multiple sexual partners (Garcia-Moreno et al. 2005). This increases women's risk of contracting sexually transmitted infections including HIV and suggests that women living with violence may have other reasons for initiating condom use, in addition to the need for family planning (Fiji Women's Crisis Centre 2013).

The Solomon Islands Family Health Safety Study (SPC and UNFPA 2009) revealed that, of women who have ever been pregnant, 11 per cent reported being beaten during pregnancy. Among those, 18 per cent had been punched or kicked in the abdomen when pregnant. The majority of those beaten during pregnancy had experienced physical violence before, and 63 per cent reported that the violence was less severe during pregnancy, indicating that pregnancy may be a protective time for those women. Women who had experienced partner violence, particularly during pregnancy, were more likely to report miscarriages, abortions and having had a child who died (although this correlation was not statistically significant). Abused women were also more likely to smoke and have unplanned or unwanted pregnancies compared with non-abused women.

CONCLUSION

One of the unique aspects of SRHR as a policy and legal issue is that at its core, SRHR is about individuals. It is about their bodies and their rights to make decisions about their bodies. Yet, an individual's ability to make informed decisions about their sexual and reproductive lives is heavily influenced by national, regional and international policies, legislation and agreements. Therefore, anyone seeking to make change in this area needs to be aware of, and engage with, the social, cultural, legislative and political context in their country. It is essential that anyone lobbying for change consults with women about the barriers they experience to realising their sexual and reproductive health and rights and raises their voice in these conversations.

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CHAPTER FOUR:

THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF PERSONS WITH DISABILITIES

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Fifteen per cent of the world's population live with some form of disability and a vast majority live in developing countries (80 per cent), yet the sexual and reproductive health and rights (SRHR) of persons with disabilities are often neglected: both by the disability community and mainstream SRHR organisations. In order to understand the rights of persons with disabilities to sexual and reproductive health, we must start by acknowledging that all people have a right to freely express their sexuality.

This essay takes a rights-based approach to sexual and reproductive health, looking first at the Convention on the Rights of Persons with Disabilities and the sexual and reproductive rights enshrined in it, and then explores some of the discrimination, humiliation, isolation and violence that persons with disabilities often experience, based on their sexuality. This essay also looks at the specific SRHR issues of key groups, including the multiple forms of discrimination women and girls face in society. Lastly, we will look at barriers persons with disabilities may experience in trying to obtain good quality information on living sexually healthy lives, in particular, social attitudes towards persons with disabilities and their sexuality.

This essay provides insight into the lived experiences of persons with disabilities, particularly women, stressing that there is a lack of relevant and basic information on SRHR available to them to ensure that they are aware of their rights and can make informed decisions. It looks at a number of key rights violations, including forced sterilisation, forced contraception and violence against women with disabilities.

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES[1]

The Convention on the Rights of Persons with Disabilities was endorsed by the UN General Assembly in December 2006 and came into force in May 2008. The purpose of the convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

While the convention does not explicitly define disability or persons with disability, Article 1 states that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

The following articles (slightly adapted) in the convention promote the sexual and reproductive rights of persons with disabilities:

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

[1] UN General Assembly, 2006.

ENSURING THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF PERSONS WITH DISABILITIES

The sexual and reproductive health and rights of persons with disabilities are often neglected by the disability community and overlooked by mainstream SRHR organisations, resulting in persons with disabilities being one of the most marginalised groups when it comes to their sexual and reproductive health and rights (Dutch Coalition on Disability and Development 2013).

Persons with disabilities may face numerous barriers to realising their sexual and reproductive health and rights. The Dutch Coalition on Disability and Development (2013) notes the following key reasons these services are often inaccessible to persons with disabilities:

- stigma and discrimination;
- physical barriers;
- lack of accessible information and communication materials;
- discriminatory or negative attitudes of health care providers;
- lack of disability-related clinical services;
- lack of funding, including health insurance; and
- conflict and humanitarian disasters.

All efforts to fully include persons with disabilities, their needs, and their concerns in health policy and programmes must confront multiple challenges. These challenges are not a result of people's disabilities, but instead are imposed by society through stigma and discrimination and a lack of social attention, legal protection, accessible services and understanding and support (Dutch Coalition on Disability and Development 2013; WHO and UNFPA 2009). According to WHO and UNFPA (2009), in order to fully include persons with disabilities and their needs and concerns in health policy and programmes, the following constraints must be addressed.

Lack of awareness, knowledge, and understanding

Although one person in every ten has a disability, persons with disabilities are often 'invisible'. Policy makers and providers often greatly underestimate the number of persons with disabilities and, as a result, they may assign them low priority among groups needing attention. In addition, they may incorrectly assume that persons with disabilities are not sexually active and therefore do not need sexual and reproductive health services.

Prejudice and stigma

Public attitudes differ from place to place and among different types of disability. The great majority of persons with disabilities face prejudice and stigma in their daily lives. This prejudice underlies the deprivation of a wide range of human rights, from freedom of movement and association to health and education and pursuit of a livelihood.

Physical and attitudinal barriers to health services

Physical barriers to access may reflect simple lack of awareness and forethought or else the assumption that 'it costs too much' to remove these barriers. Changing misperceptions and prejudiced attitudes, however, may be more difficult to address than removing physical barriers.

Exclusion of persons with disabilities from decision making

Too often programmes, even those with the best intentions, have treated persons with disabilities as 'targets' or passive recipients of services. In fact, persons with disabilities constitute a significant stakeholder group that should have a place at the table whenever health programmes are planned and decisions are made. Their involvement is the best assurance that programmes will meet needs effectively.

SEXUALITY AND RELATIONSHIPS EDUCATION FOR YOUNG PEOPLE

All people have the right to have access to education and information that can help them to make safe and healthy choices about their bodies and relationships; however, persons with disabilities often do not have equal access to information and education. This can be for a number of reasons, including physical barriers to accessing classrooms, varied learning needs and the values and attitudes of others and their decisions about what education or information to provide (Sexual Health and Family Planning Australia 2013).

Information on sexuality and relationships is essential for young persons with disabilities, who are more likely to require direct instruction to learn positive and protective skills and are more vulnerable to sexual abuse and exploitation. Research consistently shows that sexuality and relationships education is important to young persons with disabilities and can be successful in contributing to knowledge and skill acquisition, as well as influencing positive behaviour development (Sexual Health and Family Planning Australia 2013).

Research into the lived experience of sexuality education of persons with disabilities in Canada (Esmail et al. 2010), found that participants felt that it was 'important for information to be specifically presented to them regarding the unique features and impact of their disability on their present and future sexual functioning'. Participants also emphasised that methods of teaching need to be tailored to the individual needs of the person, regarding the functional limitations of their disability. For example, when delivering education to a young person with an intellectual disability, information may be best supported with visual images and repetition over time. Best practice needs to employ bravery and leadership, with a partnership between the young person, their parents and professionals, which puts the young person's vision and dreams at the centre of the process to achieve personal relationships, community inclusion, dignity and respect.

WOMEN WITH DISABILITIES

No group is as severely restricted, or negatively treated, with respect to their reproductive rights, as women with disabilities. The rights of women with disabilities are set out clearly in Article 23 of the Convention on the Rights of Persons with Disabilities, which states that countries should take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, in order to ensure the right of all persons with disabilities who are of marriageable age to marry and found a family on the basis of free and full consent. Despite this, most States lack a specific and comprehensive law, policy or programmes to address the rights of women with disabilities (Manjoo 2012).

Systemic prejudice and discrimination against women with disabilities continues to result in multiple and extreme violations of their sexual and reproductive rights, through practices such as forced and/or coerced sterilisation; forced contraception and/or limited or no contraceptive choices; a focus on menstrual and sexual suppression; poorly managed pregnancy and birth; forced or coerced abortion; termination of parental rights; denial of/or forced marriage; and other forms of rights denials and violence. These practices and violations are often due to discriminatory attitudes about the capacity of persons with disabilities and denial of information about sexual, reproductive health and contraceptives.

Women with disabilities also experience systemic exclusion from sexual and reproductive health care services (Frohmader and Ortoleva 2013). For example, a United States study showed that women with disabilities were significantly less likely to receive pelvic exams than women without a disability (Stubbs and Tawake 2009). Furthermore, when seeking reproductive health care and services, women with disabilities often face abusive treatment at the hands of health care providers who do not appreciate their particular circumstances and make negative assumptions about their capacity, lives and rights.

These discriminatory and violent practices are framed within traditional social attitudes and entrenched disability and gender-based stereotypes that continue to characterise disability as a personal tragedy, a burden and/or a matter for medical management and rehabilitation.

VIOLENCE AGAINST WOMEN WITH DISABILITIES

Women with disabilities are twice as likely to experience domestic violence as non-disabled women. They are also likely to experience abuse over a longer period and to suffer more severe injuries as a result of the violence (Frohmader and Ortoleva 2013). Women with disabilities may be subjected to a wider range of violence, including physical; psychological; sexual; financial; neglect and social isolation; denial of health care; and forced sterilisation and psychiatric treatment. The perpetrator of the violence may also be their caregiver, someone that the individual is reliant on for personal care, mobility or other types of support (Frohmader and Ortoleva 2013).

The following table from Odette and Rajan (2013) provides an overview of the myths and realities of violence against women with disabilities.

MYTHS	REALITIES
Women with disabilities are seen as sexually undesirable or asexual and cannot be sexually violated.	Over 80 per cent of women with disabilities will be sexually abused in their lifetime. Sexual violence is about power and control and not sexual attractiveness and desirability of the victim.
Authorities are always willing to support women with disabilities when they disclose abuse.	Women with disabilities who disclose abuse to authorities are often seen as not credible or incapable of testifying or giving evidence; particularly women who live with brain injuries, or intellectual, mental or other cognitive disabilities.
Women with disabilities are most often abused by strangers, especially given that no person who commits their life to caring for someone with a disability would abuse them.	Perpetrators most often include family members, intimate partners, peers, and caregivers (such as their doctor, nurse, or social worker) and they can be male or female.

In addition to being at greater risk of experiencing violence, women with disabilities may also experience difficulty in recognising, defining and describing the violence; they may have limited awareness of strategies to prevent and manage it; and they may lack the confidence to seek help and support. Therefore, it is common for women with disabilities not to report violence.

While some States have a specific law on violence against women that generally provides remedies for all women, such laws are often not effectively implemented with respect to women with disabilities (Manjoo 2012). National research into intimate partner violence in Fiji (Fiji Women's Crisis Centre 2013) indicates that 15% of ever pregnant women were beaten during pregnancy, and one-third of these women were punched or kicked in the abdomen while pregnant by their husband/partner. This increases the possibility of women and children becoming disabled due to complications during childbirth.

Access to sexual and reproductive health services

While fertility rates have been examined in only a few types of disability, where such evidence exists, the results indicate that fertility rates for women with disabilities are similar to rates for women without disabilities. Furthermore, persons with disabilities have the same sexual needs and therefore the same need for sexual and reproductive health services as everyone else. They might even have greater needs for SRHR education and care than people without disabilities because of increased vulnerability to abuse (Dutch Coalition on Disability and Development 2013). Despite this, a report on the UNDP study of women and girls with disabilities in the Pacific (Stubbs and Tawake 2009) asserts that sexual and reproductive matters are often considered taboo in the Pacific. The report argues that this is exacerbated by the perception of women with disabilities as asexual and incapable of parenting.

Forced contraceptives and sterilisation

Women with disabilities, like all women, have a right to safe and effective contraception. Yet widespread discriminatory attitudes that portray women with disabilities as either asexual or hypersexual, often see them denied this most basic right. These pervasive negative attitudes, values and stereotypes about the reproductive capacity of women with disabilities make getting accurate information about contraceptive options very difficult.

Although the contraceptive needs of women with disabilities are essentially no different from those of the general population, the pattern of contraceptive use amongst women with disabilities and non-disabled women, differs widely. Women with disabilities (particularly those with intellectual disabilities) are more likely to be sterilised, more likely to be prescribed long-acting, injectable contraceptives and less likely to be prescribed oral contraceptives. In addition, women with disabilities are much less likely to be involved in choice and decision making around the type of contraception they use. Forced contraception and forced sterilisation are acts of violence, forms of social control, and clear and documented violations of the right to be free from torture (Frohmader and Ortoleva 2014).

CONCLUSION

The Committee on the Rights of Persons with Disabilities, the body that monitors implementation of the convention by States Parties, has made it very clear that discrimination against women and girls with disabilities in areas of sexual and reproductive rights, including gender-based violence, is in violation of multiple provisions of the convention. The committee has explicitly articulated the urgent need for States Parties to address these multiple violations. While the sexual and reproductive health and rights of persons with disabilities, particularly matters related to their sexuality and right to a family, may be sensitive issues in the Pacific, these rights must still be advanced.

People with disabilities should have access the same range, quality, and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes. In developing SRHR policies and programmes, it is important that issues relating to persons with disabilities and their sexual health are included and supported. Furthermore, actions towards the elimination or reduction of intersectional discrimination faced by women and girls with disabilities needs to be developed and implemented. The issue has also been raised in Samoa, where the government has been urged to implement Pacific regional initiatives in health and reproductive treatment and awareness programmes to specifically address the unmet needs of women with disabilities in accessing relevant services and programmes. This should be a first step for all Pacific Island countries.

Information on sexual and reproductive health and rights should be readily available to women with disabilities, particularly information on contraceptives, sterilisation and parenting. Awareness raising is necessary and relevant stakeholders, particularly disabled persons organisations, are required to disseminate relevant information in promoting the sexual and reproductive health and rights of persons with disabilities. Tonga provides an example of good practice, with the Pacific Family Health Association targeting women with disabilities in delivery of education and health services to equip them with the skills, knowledge and access to enjoy their sexual and reproductive health and rights.

The best way to begin thinking about SRHR issues for persons with disabilities is to establish a dialogue with local organisations comprised or representative of persons with disabilities and other advocacy organisations working on behalf of persons with disabilities. It is best to speak to persons with disabilities, as they are the best people to articulate their issues.

Persons with disabilities represent a significant portion of the world's population and are part of every community. Attention to the sexual and reproductive health needs of persons with disabilities is important to ensure the protection and promotion of their human rights; to move forward the international development agenda; and to build a truly inclusive society. Although the full picture of sexual and reproductive health issues for persons with disabilities is not yet clear, it is certain that there are significant unmet needs. Like everyone else, persons with disabilities need information about SRHR. They must have the same access as everyone else to programmes, services, and resources that support them to realise their right to make their sexual and reproductive decisions for themselves.

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CHAPTER FIVE:

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN LAW, POLICY AND PRACTICE

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Sexual and reproductive health and rights (SRHR) function within a human rights framework and are significantly influenced by an intersection of social, economic, legal, cultural and political determinants (O'Rouke 2008). Examples of determinates include sexual behaviour and attitudes; biological risk and genetic predisposition; gender roles and power dynamics; and legislative and policy frameworks.

This essay focuses on the role of the law, as one such determinant, in facilitating or acting as a barrier to the realisation of SRHR. It will begin by explaining the key principles that guide the assessment of any law, policy or practice that contributes to the realisation of SRHR. It will then briefly examine the key international human rights instruments that provide international benchmarks in the exercise of SRHR and analyse the status of laws, policy and practice and their shortcomings in specific legal areas such as abortion, young marriage and employment rights.

This essay concludes that policy makers, civil society organisations and citizens in general must use the law as a protective instrument that respects the worth of all individuals and reinforces cooperative efforts to deal with the effects of SRHR violations.

The law is a powerful instrument for advancing SRHR in that it can empower citizens to tackle discrimination and human rights violations effectively. However, the law itself cannot be viewed in isolation. The law must be considered within the political, social and cultural context it operates. Additionally, it should not be forgotten that the law is inextricably linked to the institutions or agencies that are responsible for implementing it.

The following table provides definitions of key terms that are commonly used throughout this essay.[1]

TERM	DEFINITION
Law	A code that regulates people's behaviour in order for us to live in and form a society. Laws should reflect the values of the society that created them and respond to changing values within that society. Sources of law: • The constitution: also known as the supreme law of the land. • Legislation: a broad term to describe acts of parliament. It can include subsidiary legislation as well as rules and regulations. • Customary law: laws that existed prior to the introduction of written law in the Pacific. These govern many issues of traditional importance, such as dispute resolution, inheritance, land ownership and the protection of traditional knowledge. • Common law, case law or precedent: refer to decisions that have been made by judges when they have interpreted legislation in court or addressed a legal problem in the absence of clear legislation. • International law.
Policy	The rationale or the purpose of the law. A policy can be spelt out in detail in a government policy, such as a country's national policy on gender, disability or education. It can also explain the reasons for either retaining or changing the law, policy or practice. The creation or amendment of a law or policy can be triggered by a number of things, including a community's concern about a particular issue; shortcomings in the way the law is written or its practice; or in response to scientific or legal developments.
Practice	How the law or policy is working in reality. Is it fulfilling its purpose? If not, why isn't it working?

[1] SPC RRRT & FWRM 2010

GUIDING PRINCIPLES FOR EFFECTIVE LAWS AND POLICIES

To effectively promote SRHR, laws and policies must be focused on people and be premised on a human rights-based approach. The United Nations Population Fund (UNFPA) (2011) uses the following principles and approaches to guide the implementation of their SRHR agenda:

- Application of a human rights-based approach, which establishes a set of obligations that, if upheld, allow citizens (rights holders) to exercise their reproductive rights through access to affordable and good quality sexual and reproductive health services. UNFPA emphasises the need to build cultural legitimacy for human rights principles so that communities feel ownership over the principles.
- Awareness of how values, practices and beliefs affect individuals in their communities and societies.
- Addressing the social dimensions of SRHR, including economic status, locality, gender, age, religion, disability and indigenous origin. This will involve looking at the lived realities of disadvantaged or marginalised groups.
- Ensuring the active, free and meaningful participation of government, civil society organisations and other implementing agents in facilitating the quality fulfillment of SRHR.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERNATIONAL STANDARDS

The UN Human Rights Treaty System consists of nine core international human rights treaties to which member States can subscribe by becoming a party. Together, these treaties set international standards for the protection and promotion of our human rights, including our sexual and reproductive health rights:

- the International Convention on the Elimination of All Forms of Racial Discrimination; the International Covenant on Economic, Social and Cultural Rights;
- the International Covenant on Civil and Political Rights;
- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
- the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
- the Convention on the Rights of the Child;
- the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families;
- the Convention on the Rights of Persons with Disabilities; and
- the International Convention for the Protection of All Persons from Enforced Disappearance.

Most of the nine human rights treaties mention sexual and reproductive health rights to some extent, although some focus on it in more detail than others. This essay focuses on three key conventions:

Convention on the Elimination of All Forms of Discrimination against Women[2]

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is the international blueprint for the realisation of women's rights. Its guiding principles are substantive equality, non-discrimination and State responsibility. Sexual and reproductive health is a human right that has cross-cutting implications across all articles of CEDAW. For example, Article 16 of CEDAW makes it clear that women have '[T]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights'. Article 10 complements Article 16 in that it reaffirms the importance of 'education' as a means of empowering women to make informed choices based on accessing all pertinent information regarding their exercise of their sexual reproductive health and rights.

[2] UN General Assembly, 1979.

Convention on the Rights of the Child[3]

The Convention on the Rights of the Child is the most widely ratified human rights treaty. It sets the international standards for protecting children to ensure they realise their full potential. The guiding principle 'best interests of the child' underpins the implementation of this convention. For example, it recognises that children must be shielded from harmful practices such as commercial and/or sexual exploitation. Further, a child has the right to access healthcare services, education and rest in order to realise their full potential.

The Convention on the Rights of Persons with Disabilities[4]

The Convention on the Rights of Persons with Disabilities is the core international agreement that enshrines the sexual and reproductive health and rights of persons with disabilities. A number of articles in the convention relate specifically to the sexual and reproductive health and rights of persons with disabilities, including:

- Article 22, which asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information;
- Article 23, which requires States to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life; and
- Article 25, which requires that States ensure equal access to health services for persons with disabilities, with specific mention of sexual and reproductive health services.

Constitutional provisions and sexual and reproductive health and rights

All bills of rights provisions in Pacific constitutions generally reflect international human rights standards (see Part II of the Samoa Constitution 1960; Chapter II of the Solomon Islands Constitution 1978; Part II of the Tuvalu Constitution).

In relation to gender equality, sex remains a prohibited ground for discrimination in most, but not all, Pacific constitutions. For example, Article 15(3) of the Kiribati Constitution does not expressly provide sex as a prohibited ground of discrimination. The Fiji Constitution Decree (2013), however, is innovative in that it prohibits discrimination on the grounds of sex, sexual orientation, gender and gender identity.[5] Fiji's constitution also provides the right to health, as a fundamental human right.[6] Such provisions bode well for women and all sectors of the community in ensuring that the State develops and implements laws and policies in accordance with these international standards set out in the supreme law of the land.

SPECIFIC AREAS OF LAW, POLICY AND PRACTICE UNDER CONSIDERATION

UNESCO (2013) asserts that the following laws and policies can impede access to sexual and reproductive health services:

- Age of legal capacity, including age of consent to sex and medical interventions; rights to privacy and medical records; marriage as a requirement to access services; and age restrictions on access to harm reduction services.
- Criminal laws and police practices, including criminalisation of sex work; same-sex conduct; drug use; and abortion.

This essay discusses two issues currently impeding access to sexual and reproductive health services in much of the Pacific region: legal restrictions on abortion and marriage as a requirement to access SRHR services.

[3] UN General Assembly, 1989.
[4] UN General Assembly, 2006.
[5] Article 26(3)(a) of the 2013 Fiji Constitution Decree
[6] Article 38 of the 2013 Fiji Constitution Decree

Abortion

In most Pacific Island countries and territories (PICTs), abortion is legal only when performed under strict conditions.[7] These conditions fall into one or more of these categories:

a) to save a woman's life;

b) to protect the physical and mental health of a woman; and

c) to prevent foetal impairment.

For instance, under Part 14 of the Fiji *Crimes Decree* (2009), the general rule is that abortion is illegal and that anyone who 'unlawfully performs an abortion' is liable to a conviction of up to 14 years imprisonment.

Countries that permit abortion on medical grounds set a time frame stipulated by law. The Fiji *Crimes Decree* (2009) stipulates 20 weeks. Beyond this time, performance of the abortion will be justified only:

a) where two medical practitioners have agreed that the mother, or the unborn child, has a severe medical condition; and

b) the abortion is performed in a facility approved by the Minister for Health.

Reform of laws relating to abortion has begun in the Pacific region, albeit slowly. The slow progress can be attributed to the law being heavily influenced by social and religious beliefs and attitudes towards women and their role in society, which are discriminatory in nature. The law needs to take into account, in a clear and logical manner, the connection between social and economic burdens and why women may need to procure an abortion. The introduction of mandatory counselling, informed consent and medical safeguards is an important step in the development of the law regarding abortion in Fiji. However, other countries in the region need to take concrete steps to ensure that women have choices and control over their own bodies.

Marriage as a requirement to access sexual and reproductive health services

In most countries of the Pacific region, the legal age of marriage stands at 18 for males and 16 for females. In some countries, however, legislation governing marriage has been reformed to say that both males and females must reach 18 in order to legally marry. Different legal ages for males and females are a barrier for SRHR as they reinforce a view that girls 'mature' more quickly than males and are therefore ready for marriage during adolescence and childhood (Plan International Australia 2014).

In the Pacific, sex outside of marriage is culturally taboo. The stigma and discrimination encountered by unmarried persons when accessing sexual and reproductive health services can hinder their ability to make free and informed choices about their sexual and reproductive health. The potential for economic disempowerment, fear of family criticism, social ostracism or rejection by their partner or parents is high. Societal conservatism about sexual and reproductive health can create multiple layers of discrimination, which can lead to populations being socially and legally marginalised. Fear of accessing formal health services can result in persons using unlicensed or unregulated services (such as unsafe abortions) that may cause severe health risks. A rights-based approach demands the abolition of legal or policy requirements that discriminate against people on the grounds of marital status. Any reform to these laws must address these cultural taboos in a way that respects and enhances the sexuality and autonomy of an individual.

CONCLUSION

Creating an environment that enables sexual and reproductive health to flourish requires a comprehensive and integrated approach that brings together legislation and policy makers, civil society organisations and communities. Effective legislation must be grounded in people's lived realities, their relationships (including with parents and caregivers), and society at-large. It must also be complemented by policy actions, which protect and promote people's rights to the highest attainable standard of health and protect them from harm. Similarly, policies must also be supported by legislation, law enforcement practices and a fair and accessible justice system so that people's sexual and reproductive health and rights are enforceable and those who are denied their rights may receive the justice they deserve.

[7] For example, see Section 117 of the Vanuatu Penal Code (Cap 135) and section 150 of the Kiribati Penal Code (Cap.67)

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CHAPTER SIX:

THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE

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WHO ARE 'YOUNG PEOPLE'?

In Pacific Island countries and territories (PICTs), there is a variety of definitions for young people. In most cases, a combination of an age range and a community or social definition is used. The age range provides a specific category of people that governments and organisations can refer to, making it easy to provide services or implement projects. The community or social definitions, however, refer to the perceptions of the community on who is a young person or youth. This could be a result of cultural ideas about initiation ceremonies, levels of education, having a child, or being employed. For example, a 15 year-old girl with a child may be regarded as an adult because she has a child, while a 15 year-old girl without a child is regarded as a young person. Likewise, a 30 year-old unemployed, unmarried, and childless man may be regarded as a young person because he is not contributing to the needs of his family.

The United Nations (UN), for statistical purposes, defines 'youth' as persons between the ages of 15 and 24 (A/36/215). However, several UN entities, instruments and regional organisations use different definitions, which the UN Secretariat recognises. The World Health Organization (WHO), the United Nations Children's Fund and the United Nations Population Fund for example, use the categories 'adolescent', 'young people' and 'youth' demarcating the age cohorts of 10–19 years, 10–24 years and 15–24 years respectively. These categories overlap in order to account for the great variation in young people's lives and needs. While there is great diversity within each age range, these categories allow agencies to provide targeted services to a specific group of people. It is also easier to gather information and make decisions about the group's needs.

COUNTRY	DEFINITION OF YOUTH
Fiji	Typically, people between 15 and 35 years of age, but social and cultural perceptions of youth can also extend the category to those outside this age bracket (Government of Fiji 2011).
Kiribati	The definition of youth usually includes people between 15 and 29 years of age. Community definition recognises youth as people who have reached puberty, usually 12 years or older, until marriage. An unmarried person is not regarded as an adult until they reach 35 years.
Niue	Youth is defined as people between 15 and 34 years of age 'regardless of marital status, family and personal background, religion, ethnicity or sex' (Government of Niue 2009).
Solomon Islands	Youth is people between 14 and 29 years of age but due to cultural and traditional contexts the definition can cover young people less than 14 and above the age of 29 (Noble et al. 2011).

Unlike the UN, Pacific regional organisations such as the Secretariat of the Pacific Community and the Pacific Islands Forum Secretariat, do not have a clear age definition in recognition that the age ranges and social definitions PICTs use to define young people vary greatly.

How 'youth' is defined is important knowledge for policymaking and for programming. It determines who is targeted for a policy or for a project. This ensures that everyone is on the same page when discussing an issue.

WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

In line with WHO (2006) definition of sexual health explained in Chapter 1, sexual and reproductive health is about our whole body on the inside and out. It is about our overall health. It refers to both our physical wellbeing and our emotional wellbeing, including our mental health. It is about being able to access judgment-free services when needed, including getting information on preventing disease, being able to visit a doctor and get medicine, and being able to talk to a counsellor when you are feeling down or stressed. It is about having safe and respectful relationships; feeling and being safe in our homes and communities; and being able to buy and use contraceptives to prevent pregnancies and sexually transmitted infections (STIs). Sexual health is part of our everyday living. It is about how we view and value each other and ourselves.

Sexual and reproductive health cannot be achieved without recognising, respecting, and protecting human rights. The connection between sexual and reproductive health and human rights is what is referred to as sexual and reproductive health and rights (SRHR). It is not a separate area of human rights but refers to those rights already outlined in human rights documents and national laws.

WHY SHOULD YOUNG PEOPLE BE INTERESTED AND INVOLVED IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

Sexual and reproductive health and rights involves everyone, regardless of age or social situation. The Pacific region has a 'youth bulge' meaning that countries have very large populations of people between the ages of 15 and 24 years. For example, Curtain (2011) points out that if the range were extended to 15 to 30 years then youth would make up over a quarter of the region's entire population. In 2011, it was estimated that 42 per cent of the population of Marshall Islands and 40 per cent of the population of Papua New Guinea were under 15 years of age. In the same year, it was estimated that 38 per cent of the populations of Solomon Islands, Samoa and Tonga were under 15 years of age (SPC 2011). As a result, across the Pacific, there is a large group of people who are becoming sexually active and are entering, or have reached, their reproductive years and need to be aware of their sexual and reproductive health and rights.

A study of young people aged 15 to 24 in Samoa, Solomon Islands and Vanuatu found that about two thirds of young people were sexually active, with the median age at first sex being 16 years. In some cases, the age at first sex was as low as ten years old. Fewer than 20 per cent of girls aged 15 to 19 and less than half of adolescent boys in the Pacific report having ever used a modern method of contraception (including condoms), which is lower than most developing countries (New Zealand Parliamentarians' Group on Population and Development 2012).

This youth bulge has the potential to further strain sexual and reproductive health services, in a region where it is estimated that 650,000 women have an unmet need for family planning (UNESCO 2013).

While there are many issues that affect young people, this essay will discuss five key issues: cultural and religious traditions, access to information, access to youth-friendly health care, freedom from violence, and data collection.

CULTURE AND RELIGIOUS TRADITIONS

Culture and religion have often been used as excuses for inaction in the area of SRHR in the Pacific region (Koya 2009). Attempts to discuss sexual and reproductive health are often quickly glossed over. A lack of understanding of sexual and reproductive health has often led to discussions being simplified to talking about sex, and because of the uneasiness with this topic, these discussions tend to be very short, if they occur at all.

A key aspect of our wellbeing is our relationships, which are maintained and reinforced through collective activities and are at the core of Pacific communities (Koya 2009). Sexual and reproductive health and rights are culturally appropriate in the Pacific; while the word sex may never be used, sex education usually begins from the first point of cultural socialisation in all Pacific cultures. As Koya (2009) notes:

> this can be seen in the first recognition that a girl's relationship with her mother and sisters is markedly different to that with her brothers and father; to the placement of sleeping quarters within the communal living space, and to appropriate behaviour, and language.

It is essential that we acknowledge that culture changes. It is dynamic; it takes account of the innovations that occur in our communities, the new values that we develop, and the ways we work within that new environment. For example, we have developed new ways of staying in contact with each other through the internet and mobile phones. We have even developed a new written language – the text message language. We also inform people of births, marriages and deaths in a new way by posting these messages on social media sites such as Facebook. These changes reflect new ways of maintaining relationships.

Koya (2009) argues that faith, hope, compassion and love are core values emphasised in religious education. She argues that these values extend into respect, tolerance, understanding, connectedness and acceptance. It is easy to see the connection between relationships and these values. Young people can be empowered by enabling them to explore the intersection of SRHR and the cultural and religious value of relationships. Culture and religion can be used to teach SRHR by emphasising the importance of respecting themselves, their partner and their community.

ACCESS TO INFORMATION

Many young people argue that if they had greater access to SRHR information they could make better decisions about their health, their sexual relationships, and their general relationships with their families and communities. Youth consultations as part of the development of the report *The State of Pacific Youth 2011* (Curtain 2011) indicate that there is not enough information provided to young people, especially young women, on the health, economic and family pressures related to pregnancies. Further, there is generally a stigma associated with the information that does exist, and those that access it. This stigma usually relates to cultural and religious ideas of 'correct' behaviour. When accessing SRHR information, a young person risks being labelled bad, shameful, rebellious, a sinner, slut and a variety of other negative labels. This discourages young people from seeking out this information, as well as from practising safe and healthy relationships.

Good quality SRHR information should provide clear, but not overly scientific, information on how a body functions, the reproductive functions, and the variety of contraceptives, including the possible side effects of their use and the need for young women to seek medical advice on the most suitable form of contraceptive for them. Resources should emphasise that a relationship involves two people, so both parties should make decisions about sex and contraception. Sexual and reproductive health and rights information should also include details of available health services, such as counselling services, psychological services and spiritual guidance, including where

and how these services can be accessed. This information should be provided in a neutral way and inform readers about the privacy and confidentiality policies of the services listed. Sexual and reproductive health and rights information should be distributed through youth groups, organisations that work with young people, and businesses that have a large youth market, such as game centres and internet shops.

Comprehensive sexuality education (CSE) is a recognised strategy designed to meet the challenges of providing relevant and useful information to young people. The Commission on Population and Development in 2009 recognised the need to '...provide young people with comprehensive education on human sexuality, on sexual and reproductive health, on gender equality and on how to deal positively and responsibly with their sexuality' (CPD Resolution 2009/1: 7). Key to CSE is the recognition, respect and protection of human rights. This includes gender-specific actions, particularly in relation to gender-based violence.

WHO (2010) suggests that the following are key elements of CSE:

- information about prevention of STIs, contraception, and fertility and reproduction;
- information on gender norms, differences and inequalities;
- the importance of responsibility and joint decision making, communication and negotiation skills;
- information about the role of pleasure;
- information on sexual and gender identity and sexual choice.

Access to SRHR information is not only important for young people but also for their parents. Often it is assumed that parents know how to talk with their children about sexual and reproductive health. However, many parents do not know how to do this. Therefore, information helping parents speak with their children about SRHR is equally important.

ACCESS TO YOUTH-FRIENDLY HEALTH CARE

There are many stories from young people about the way doctors and nurses treat them when they seek SRHR information or medical care. Some young people are publically shamed by the medical practitioner who speaks loudly about why they are seeking help and the type of help wanted. Some are scolded for acting 'too big' or doing something 'sinful'. Others are roughly handled by the medical practitioner, including roughly injecting a person and throwing medical scripts across the consultation table at the person. There are also those who have their test results and details of their medical care reported to their parents or family members without their permission. These stories show a lack of confidentiality and standard of care required of medical practitioners.[1]

A youth-friendly health service need not be a separate type of service or hospital; it simply refers to services that respect a young person's right to medical care without judging them, and that ensure that confidentiality is protected as required by medical ethics and the laws of the country. In a youth-friendly service, a young person seeking information, testing, contraception or care is treated as an individual and independent human being. Their age, education, gender, or marital status is irrelevant to the provision of health care, because their human right to sexual and reproductive health care is respected.

[1] Anecdotal evidence from the author's experience as a high school teacher and youth worker in Fiji.

Many young people experience financial barriers to accessing health care. This includes costs associated with contraception, tests, and medication. Where free services are available, the cost of transportation to and from the service can be a constraint. Health care providers should therefore try to provide youth-friendly and affordable (or free) sexual and reproductive health services. Consideration should also be given to a separate area for young people within existing services such as a specific room or counter away from general public view. This could encourage greater use of the health services by young people, and lessen fears of stigma and retribution from families and communities. Additionally, government and non-governmental organisations can also work together to provide free or subsidised contraception for young people, such as condoms.

FREEDOM FROM VIOLENCE

Sexual violence amongst young people is a troubling trend in PICTs. *The State of Pacific Youth 2011* report (Curtain 2011) points out that in a 2007 survey in Marshall Islands 'a quarter of female high school students...had experienced "dating violence" and a third had been physically forced to have sexual intercourse'. The same survey showed that 26 per cent of female high school students experienced physically forced sexual intercourse in American Samoa; 19 per cent in Palau; 18 per cent in Northern Marianas; and 17 per cent in Guam.

Anecdotal evidence tells us that many young men do not know how to negotiate sexual relationships, and lack access to safe and realistic information.[2] As a result, many resort to pornography as a guide and may be led to believe that violence is acceptable. They may also be led to believe that they are supposed to take a dominant role in sexual relationships and that girls 'want' to have sex even when they say no. This belief is then reinforced by equally misinformed peers. Young women, too, also lack the information and skills to negotiate sexual relationships, and are too often the victims of sexual violence.

Bullying is a rising concern in PICTs, especially in relation to sexual and gender-based violence. Bullying can be both physical and emotional, and is increasingly conducted in cyber spaces such as social media sites. Young people who are lesbian, gay, bi-sexual, trans*[3], queer, or intersex (LGBTQI) are particularly susceptible to bullying. This can often take the form of physical abuse, but a more sinister form is the public 'shaming' of young LGBTQI persons, either verbally or through posts on social media sites or abusive text messages. A cone of silence exists over sexual violence and bullying. Many young people do not report either types of violence for fear that they will not be believed, or that they will be somehow blamed for the violence perpetrated against them. Much of this belief goes back to perceptions that culture and religion are static and unforgiving. However, if we remember that Pacific Island cultures are essentially about respect and dignity, as are religious beliefs and values, we can turn this cone over and have frank and open discussions about our relationships. It is essential that these discussions are based on accurate, relevant information.

[2] Anecdotal evidence collected by the author from discussions with young people, including adolescent health peer group educators and HIV/AIDS peer educators, and Pacific Island public health experts.

[3] trans* includes transgender women and men, trans-diverse and transgender persons. For more information on the sexual and reproductive health and rights issues for persons with diverse sexualities, gender identities and expressions see Chapter Eight.

DATA COLLECTION

There is a serious lack of up-to-date data on young people in PICTs. While a national census takes place every ten years on average, the rapidly growing youth population means that current data are needed to understand the changing needs of this group. In addition, data need to be disaggregated by gender and smaller age cohorts, instead of a large group that encompasses very different needs.

In terms of SRHR, data on gender; access to services, including types of services accessed and unmet needs; sexual behaviour; violence, including the types of violence committed and information about the perpetrators; and economic status, including employment participation and social environments, are some of the data required. These data would allow government policymakers and development agencies to not only plan appropriate strategies and programmes for young people, but also effectively and accurately track their progress.

CONCLUSION

Open and honest dialogue about sexual and reproductive health can be difficult with any population group, but this is especially true of young people. However, the Pacific region's large and growing youth population means that it is crucial for them to be engaged in discussions about SRHR. Failing to do so will result in dire consequences for PICTs, including unsustainable population growth, economic burdens and poor health outcomes. In order for young people to achieve good sexual and reproductive health and achieve their sexual and reproductive rights, a number of barriers must be addressed, including re-defining cultural and religious traditions so they enable SRHR, improving access to sexual and reproductive health information and services, ending violence, and improving data collection.

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CHAPTER SEVEN:

THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF LESBIAN, GAY, BI-SEXUAL, TRANS*, QUEER AND INTERSEX PERSONS[1]

Noelene Nabulivou, Diverse Voices and Action for Equality, and Development Alternatives with Women for a New Era (DAWN) and Shirley Tagi, Diverse Voices and Action for Equality

> Human beings cannot benefit from development progress if their lives are defined by inequity, exclusion, and policies which treat them as less than equal. This is true of all people who encounter marginalisation and injustice, whether they be women living under laws which fail to provide equal status in all spheres of life, or persons of any gender who are ostracised because of their ethnicity, class, sexual orientation, or gender identity.
>
> Helen Clark, UNDP Administrator on the occasion of the International Day for the Elimination of Homophobia and Transphobia (IDAHOT), May 17 2014

[1] See the glossary at the end of this chapter for helpful definitions of key terms.

SEXUAL RIGHTS ARE HUMAN RIGHTS

Human rights refer to every person's freedoms and right to live in dignity. We all have the same human rights. Whatever our sexual orientation, gender identity and expression, sex, national or ethnic origin, religion, language, or any other status, we are equally entitled to our human rights without discrimination. Each one of us holds these rights, which are interrelated, interdependent, and universal.

Sexual rights are a central component of social, economic, cultural, civil and political rights. That is why the *Moana Declaration: Outcome Statement of Pacific Parliamentarians for Population and Development* (UNFPA et al. 2013) called for, 'access to sexual and reproductive health and rights (SRHR) for all our peoples, without discrimination'. The Asia and Pacific ministers also said that governments must, '[w]ork to reduce vulnerability and eliminate discrimination based on sex, gender, age, race, caste, class, migrant status, disability, HIV status, sexual orientation and gender identity, or other status' (United Nations Economic and Social Council 2013).

To be able to experience your sexual rights requires an environment in which every person can control and decide freely on matters relating to their sexuality. It requires that people are free from violence, coercion or intimidation in their sexual lives; have access to sexual and reproductive health information, education and services; and are protected from discrimination based on the exercise of their sexuality. These conditions are our sexual rights, and the governments of every country in the world are required to respect, protect and fulfil these basic human rights (SRI and IPPF, 2012).

Unfortunately, people in every region of the world still face death, imprisonment, torture, violence, discrimination and neglect because of their real or perceived sexual orientation, gender identity and gender expression. Lesbian, gay, bisexual, trans*[2], queer and intersex (LGBTQI) persons are living under intense situations sponsored by unfavourable state law. Approximately 76 countries still criminalise consensual same sex behaviour and many countries have related discriminatory laws, or laws used with discriminatory and arbitrary application.

In 2014 there are still seven Pacific Island countries and two entities that criminalise people based on sexual orientation and gender identity; Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Guam (USA) and Cook Islands (New Zealand). While sanctions may include imprisonment in some cases, prosecutions rarely occur. Meanwhile, same-sex conduct between consenting adults is legal in five Pacific Island countries and two entities: Fiji, Marshall Islands, Federated States of Micronesia, Vanuatu, Palau, Niue (New Zealand) and Tokelau (New Zealand). There are also anti-discrimination laws in Fiji.

Even where criminalising laws do not exist, many states have other discriminatory laws that target people because of actual or perceived[3] sexual orientation and gender identity. These include laws related to 'public decency' for instance, and they are used to target, entrap and detain. References to 'traditional values' justify homophobic and transphobic actions and patriarchal values, and gender stereotypical behaviour is supported by many in communities and the media, and reinforced at political levels.

Violence and discrimination impede enjoyment of human rights and development. Criminalisation, stigmatisation and other forms of marginalisation link violence and discrimination directly to issues of health, education, employment and housing, leading directly to limited social and economic opportunities and poverty.

[2] trans* includes transgender women and men, trans-diverse and transgender persons.

[3] In many circumstances, people are targeted because of perceived sexual orientation, gender identity and expression, which can have to do with appearance, clothing, and fitting or not fitting stereotypical gender norms, speech and written expression, etc.

LGBTQI persons face many kinds of abuse, violence and discrimination:

- homophobic and transphobic violence, including rape, because of assumed or actual sex, sexual orientation, gender identity and/or expression;
- physical beatings and rape because of real or assumed lesbian identity, interwoven with patriarchal notions of control over women and girls;
- arbitrary arrest and imprisonment and state executions;
- beatings and other forms of physical and abuse by law enforcement (the police, the military, prison oficers);
- ill-treatment, including rape and torture in detention;
- 'hate crimes', such as being attacked and murdered on the streets;
- ejection from, denial of entry to and bullying in schools; fear of violence and discrimination affecting young people's ability to say in school, therefore limiting education and employment opportunities;
- ejection from, denial of entry to and social stigma in cultural and social settings, including traditional and religious rites and ceremonies;
- violence by families and kinship networks, faith leaders and traditional leaders (with state accountability to address);
- various forms of verbal, psychological and physical abuse;
- forcible separation from same-sex partners, including lack of access to sick and dying partners in hospitals and private homes;
- forced abduction and incarceration, and denial of freedom of movement;
- kidnapping and loss of custody of children;
- ejection from or denial of access to housing, land and natural resources;
- denial of and discrimination in employment, including in hiring and firing;
- discrimination in and denial of health and other social services; concerns about denial of treatment and fears of breaches of confidentiality and other policies creating a climate of risk and people not accessing health and social services as a result;
- denial of asylum when well founded fear of persecution exists;
- media stories that are discriminatory or inflammatory; and
- other non-recognition and restriction of freedom of speech, association and movement.

Additionally, NGOs and other organisations representing LGBTQI persons may experience violence and discrimination, including:

- harassment
- denial of legal registration of NGOs with mandates on related issues; and
- lack of support and non-inclusion through to active harassment by mainstream civil society and social movements.

GENDER EQUALITY, WOMEN'S HUMAN RIGHTS AND SEXUAL ORIENTATION, GENDER IDENTITY AND EXPRESSION

Gender equality and women's human rights advocates within governments and in civil society, have worked for over two decades to ensure that obligations and commitments under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the *Beijing Declaration and Platform for Action* (BPA) (regionally drawn down through the *Revised Pacific Platform for Action on Gender Equality and Women's Human Rights (2005–2015)* and further strengthened by the *Pacific Forum Leaders Declaration on Gender Equality* (2013)), are fully realised. Advocates have worked on a comprehensive analysis of how gender inequality operates in all dimensions of women's lives, and progressively developed and implemented gender sensitive laws, constitutional provisions, judicial decisions, policies, government structures and resource allocations.

Underpinning this work toward realisation of CEDAW and the BPA is the full range of international human rights instruments, including the UN Charter and the *United Nations Declaration of Human Rights*. These embody non-discrimination as a core principle and require that human rights are guaranteed for everyone without discrimination on grounds that are indicated in a non-exhaustive list, including: race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. 'Other status' has been interpreted to include sexual orientation and gender identity by the decisions and general comments of multiple monitoring bodies of human rights treaties and political human rights bodies.

Despite this, in 2014, no country has achieved universal realisation of obligations and commitments to gender equality and women's human rights. Around the world, far too many women and girls including lesbian, bisexual, transgender and intersex (LBTI) women and trans* persons still face execution, imprisonment, torture, violence and discrimination because of real or perceived sexual orientation and gender identity and expression.

Women already face gender inequality in the Pacific. For LBTI women and trans* persons, this is made worse by fear and actual experience of intersectional violence, discrimination and marginalisation. This affects health, education, employment, housing, economic opportunity, and healthy environments. It also worsens poverty and creates further barriers to educational and economic opportunities. Being young and having limited access to decision making further increases the risk of bullying, social exclusion, mental illness, self-harm and suicide. This is often worsened by discrimination by family and kinship networks, community and religious leaders and education and healthcare service providers. Many LBTI women simply avoid mainstream healthcare services, affecting all aspects of their health and wellbeing.

Sexual and gender-based violence further increases risk of poverty, homelessness and poor health outcomes, and young and elder LGBTQI persons, particularly women, are at overall heightened risk of poverty, violence and homelessness. Worse, this generally goes unreported due to fear of reprisals, or threats to confidentiality, especially in small island, informal urban settlements, and rural communities. While there are increasing numbers of civil society groups advocating for positive and systemic change, there are also many State and non-State blockages, harassment and sometimes legal obstacles placed in the way of such social organising.

In order for CEDAW, BPA and ICPD to be universal in focus and effect, and applicable to all women in the Pacific, both State and non-State actors must explicitly address issues of violence and discrimination based on sexual orientation, and gender identity and expression. As the world reviews progress on 20 years of implementation of the ICPD Program of Action (PoA) there is now an urgent need to accelerate political commitment; overcome financial and legal obstacles; transform weak health systems and adverse social and economic conditions; and eliminate violence and discrimination that prevent women from accessing the necessary health services and information to make informed decisions about their sexual and reproductive lives.

Thirty feminist groups, convened by Realising Sexual and Reproductive Justice (RESURJ), International Women's Health Coalition, and Development Alternatives with Women for a New Era have used the 20-year review of the ICPD conference (Cairo+20) to put out a rallying call to mobilise constituencies toward reclaiming and realising the hard won sexual and reproductive rights and health agenda.

Our Rights, Our Lives: Women's Call to Action Toward Cairo@20 (RESURJ, n.d.) calls for:

- universal access to good quality, comprehensive, integrated sexual and reproductive health services, counselling, and information for women and adolescent girls with respect for their human rights, and with an emphasis on equity and respect for diversity. Comprehensive services include gynaecological care; all forms of safe and effective contraception; safe abortion and post abortion care; maternity care; and prevention, timely diagnosis and treatment of sexually transmitted infections including HIV, breast and reproductive cancers, and infertility. Ideally, these should be integrated, one- stop services tailored to women's needs throughout the life cycle, with effective referral.
- Programmes that empower women, particularly adolescent girls and young women, and women throughout their life cycles to know their bodies and to exercise their rights, especially through comprehensive sexuality education.
- Protection and promotion of reproductive rights as human rights, and international adoption of sexual rights as human rights. Full recognition and implementation, through policies and programmes, of existing and emerging legal standards are urgently needed.
- Young women's leadership at all levels and types of decision-making on sexual and reproductive rights and health, and the meaningful participation of women's organisations in the design of health and development programmes.

[4] Glossary adapted from the NZ High Commission, Fact Sheet H: RESOURCES: Terminology

GLOSSARY OF USEFUL TERMS[4]

Akava'ine

A term used by trans women and/or 'third sex' people to describe themselves in Cook Islands. The meaning of this term is negotiated within the social and cultural context it is used.

Cross-dresser

A person who wears the clothing and/or accessories considered by society to correspond to the opposite gender.

Fa'afafine

A term used by trans women and/or 'third sex' people to describe themselves in Samoa, America Samoa and Tokelau. The meaning of this term is negotiated within the social and cultural context it is used.

Fakafifine

A term used by trans women and/or 'third sex' people to describe themselves in Niue. The meaning of this term is negotiated within the social and cultural context it is used.

Fakaleiti or Leiti

A term used by trans women and/or 'third sex' people to describe themselves in Tonga. The meaning of this term is negotiated within the social and cultural context it is used.

FtM / trans man

Female-to-male / someone born with a female body who has a male gender identity.

Gay

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

Gender

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

Genderqueer

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

Gender expression

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

Gender identity

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

Gender reassignment services

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

Heterosexual

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

Intersex

A general term used for a variety of conditions in which a person is born with reproductive or sexual anatomy that does not seem to fit the typical biological definitions of female or male. Some people now call themselves 'intersex'. Most people who are intersex or have an intersex medical condition identify simply as male or female, and are not trans. Most trans people are not born with intersex medical conditions.

Lesbian

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

Mahu

A term used by trans women and/or 'third sex' people to describe themselves in Tahiti and Hawaii. The meaning of this term is negotiated within the social and cultural context it is used.

MtF / trans woman

Male-to-female / someone born with a male body who has a female gender identity.

Palopa

A term used by trans women and/or 'third sex' people to describe themselves in Papua New Guinea. The meaning of this term is negotiated within the social and cultural context it is used.

Queer

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

Sex

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

Sexual orientation

The direction of a person's sexuality relative to their own sex. Sexual orientation is usually categorised as; homosexual (directed at the same sex), heterosexual (directed at the opposite sex), or bisexual (directed at both sexes). Gender identity is about someone's personal sense of maleness and/or femaleness. Gender identity is different from sexual orientation, which is who someone is attracted to or chooses as a sexual or romantic partner. Trans people may be heterosexual/straight, lesbian, gay or bisexual – just like non-trans people.

Takatāpui

An intimate companion of the same sex. Today used to describe Māori gay, lesbian, bisexual and trans people.

Tangata ira tane

A Māori term describing someone born with a female body who has a male gender identity.

Transgender

A person whose gender identity is different from their physical sex at birth.

Transitioning

Steps taken by trans people to live in their gender identity. These often involve medical treatment to change one's sex through hormone therapy and may involve gender reassignment surgeries (sometimes referred to as gender realignment surgeries by trans people).

Transsexual

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

Vakasalewalewa

A term used by trans women and/or 'third sex' people to describe themselves in Fiji. The meaning of this term is negotiated within the social and cultural context it is used.

Whakawahine, Hinehi, Hinehua

Some Māori terms describing someone born with a male body who has a female gender identity.

Do you want more information on sexual orientation, gender identity and gender expression, and human rights? Take a look at the following resources:

Title: Born Free and Equal: Human Rights, Sexual Orientation, Sex and Gender Identity.

Author: New Zealand Human Rights Commission

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

Please note that the booklet has been developed for Aotearoa/NZ usage, therefore uses many terms familiar to Maori LGBTQI communities.

Title: Born Free and equal. Sexual Orientation and Gender Identity in International Human Rights Law

Author: United Nations Office of the High Commissioner for Human Rights

Link: http://www.ohchr.org/Documents/Publications/BornFreeAndEqualLowRes.pdf

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CHAPTER EIGHT:

KEEPING IT UNDER THE MAT: THE STRUGGLE FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE PACIFIC ISLAND REGION[1]

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[1] An excerpt from Development Alternatives with Women for a New Era (DAWN) Pacific Regional Advocacy Tool.

This feminist analysis will look at 22 Pacific Island countries and territories (PICTs) served by the Secretariat of the Pacific Community (SPC). They range from the region's largest island nation, Papua New Guinea, with a linguistically diverse population of over eight million who speak more than 800 indigenous languages, to the more culturally homogenous small island developing states of Kiribati, Nauru and Niue.

Given this diversity, there is a wide range of sexual and reproductive health and rights (SRHR) issues, which are experienced differently, by different people, in different contexts. This essay focuses on some of the critical issues in three thematic areas: SRHR issues in the Pacific; access to comprehensive and integrated sexual and reproductive health services; and sexual and reproductive health needs and rights of young people; all of which are issues of concern from a feminist and sexual and reproductive rights advocacy point of view.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS ISSUES IN THE PACIFIC

Despite most countries making commitments under a number of international agreements to advance SRHR (such as the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), the *Beijing Platform for Action* (BPA) and the *International Conference on Population and Development Programme of Action* (ICPD PoA)), the Pacific, like most regions in the world, struggles to implement these commitments on the ground. This is particularly the case in the lives of women, girls and lesbian, gay, bi-sexual, trans*[2], queer and intersex (LGBTQI) persons. A central hurdle in the realisation of these rights is the cultural and religious context in which Pacific Islanders live. Pacific Island patriarchal cultures, which are embedded within contemporary religious practice, most commonly conservative Christianity, shape and constrain the opportunities for realising these rights. While cultural practices and religious expressions are diverse across the region and constantly shifting, they are, in general, not conducive to the fulfilment of SRHR.

In Pacific Island politics, conservatism still dominates when it comes to SRHR issues. This is evidenced by discussions at the recent Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014 (Fiji, August 2013), involving 13 Pacific Island countries, which in many instances took a conservative approach to SRHR. This approach, while supportive of sexual and reproductive health, fails to adequately acknowledge reproductive rights and remains virtually silent on sexual rights. There were, however, SRHR 'champions' present, such as Dame Carol Kidu, a member of the High-Level Task Force for ICPD, who was outspoken at the conference about the need for greater action by parliamentarians on the SRHR of marginalised groups, such as LGBTQI persons and sex workers.

There are multiple SRHR issues across the Pacific region, but those that stand out because of their urgency, severity or importance in relation to the ICPD PoA are gender-based violence and the restriction of rights in relation to sexual orientation, gender identity and expression, sex work and abortion.

GENDER-BASED VIOLENCE

The Pacific region has some of the highest rates of gender-based violence in the world. Violence is a direct violation of bodily integrity and autonomy, which is a complex cross-cutting issue that affects other interlinked sexual and reproductive health rights. Gender-based violence flourishes within patriarchal hierarchies in the Pacific, where women and LGBTQI persons face discrimination on the basis of their socio-economic status, ethnicity, disability and place of origin.

Widespread gender-based violence throughout the Pacific is in urgent need of attention. Of substantial prevalence is intimate partner violence (IPV), which can significantly reduce contraception use and thus result in a higher likelihood of unintended pregnancy and miscarriage (UNFPA 2010). Moreover, IPV places women at risk of contracting STIs and HIV, physical and mental injuries, intensified violence during pregnancy and overall diminished wellbeing (APA 2008; UNFPA 2010).

[2] trans* includes transgender women and men, trans-diverse and transgender persons. For more information on the sexual and reproductive health and rights issues for persons with diverse sexualities, gender identities and expressions see Chapter Seven.

The highest rates of gender-based violence exist in Papua New Guinea, with an estimated 67 per cent of women in rural areas and 56 per cent in urban areas reporting physical abuse by a male partner. Gender-based violence is a key driver of the HIV epidemic in Papua New Guinea (Senanayake 2011). Rates of violence are also unacceptably high in other parts of the Pacific, with over 60 per cent of women in Solomon Islands, Kiribati and Vanuatu having experienced physical and/or sexual violence in their lifetime (NZPGPD 2012). Lower, but still unacceptably high rates of violence occur in Samoa, where 46 per cent of women experience physical and/or sexual violence (SPC et al. 2007) and Tonga, where 45 per cent of women experience physical and/or sexual and/or emotional violence (MFMF 2009).

Another significant issue in the Pacific region is the presence of a number of cultural practices that amount to gender-based violence. These include, bride price practices (Melanesia and East Timor); traditional forgiveness practices; the burning of mainly female witches for alleged sorcery (Melanesia); early, arranged or forced marriage; punishment rape; exchange of brides as part of dispute settlements (Melanesia); dry sexual intercourse (Kiribati); and virginity tests (Jalal 2009). Jalal (2009) stresses that 'prevailing forms of violence are often either overtly sexual in nature or are related to women's sexuality and have detrimental mental, physical and reproductive health effects on women'. A consultation in 2009 by the Asia Pacific Forum on Women, Law and Development (APWLD 2009) noted that this violence occurs in the context of fundamentalist expressions of culture and religion because 'power is inevitably and most easily exercised by targeting women through regulation of their bodies, roles, freedoms and rights'. Participants in a focus group discussion in Malaita as part of the Solomon Islands Family Health and Safety Study (SPC 2009) reaffirmed this, stating, 'If a girl's bride price is paid, she has to stay with her husband no matter what... He purchased her; therefore he has the right to beat his wife.'

While these forms of gender-based violence must be addressed, it is important to retain a nuanced understanding of the diversity and complexity of Pacific Island cultures. As Underhill-Sem (2011:10) points out, 'Cultures are constituted differently at different times and in different places and therefore cannot be generalised'. This is particularly the case in the Pacific where 'generalisations about the region or its sub-regions and undifferentiated reference to women as a single group is flawed'.

Pacific leaders are more willing than ever to engage in addressing the issue of gender-based violence. This is in part due to the sheer scale of the problem but it is also a result of the sustained advocacy by women's groups on the issue. A major turning-point in terms of regional policy occurred in 2009, during the 40th Pacific Islands Forum Leaders meeting in Cairns, when sexual and gender-based violence were recognised as both pervasive and under-reported across the Pacific. Leaders committed to addressing this issue at a regional level through the *Pacific Leaders Declaration on Sexual and Gender Based Violence* (2010) (UNFPA et al. 2010; FPI et al. 2009). Other important steps include the *Pacific Leaders Declaration on Gender Equality* (2012), and the *Regional Action Plan on Women, Peace and Security* (2012).

Nationally, legislation to achieve justice for survivors of violence is improving, but remains inadequate. Of the fourteen independent Pacific Island countries surveyed in the ICPD Beyond 2014 Global Review,[3] Fiji, Vanuatu, Solomon Islands and Marshall Islands have specific legislation for IPV, with the remaining ten countries criminalising forms of sexual and physical violence normally within their penal or criminal law (UNFPA 2013). In the past year, Samoa and Palau have passed specific legislation allowing for protection orders in IPV cases. No country in the region, however, has implemented comprehensive and integrated gender-based violence legislation that covers its multiple forms and is in accordance with substantive equality standards (UNFPA et al. 2010). One project aimed at changing this situation is the SPC Regional Rights Resource Team (RRRT) Changing Laws Protecting Women Project, which began in 2009 and is supported by the UN Women Trust Fund to End Violence Against Women. The aim of the project is to fill the existing legislative gaps by assisting Pacific Island countries to support comprehensive integrated violence against women legislation. A comprehensive approach covers not just protection but looks at prevention of violence and support for the survivor. Furthermore, it puts measures in place to ensure the implementation and evaluation of the law.

[3] Fiji, Papua New Guinea, Solomon Islands, Vanuatu, Federated States of Micronesia, Kiribati, Nauru, Palau, Marshall Islands, Cook Islands, Niue, Samoa, Tonga, and Tuvalu.

SEXUAL ORIENTATION, GENDER IDENTITY AND EXPRESSION

While addressing gender-based violence is receiving significant attention and resources at the regional level, unpacking the patriarchal power hierarchies that nurture this violence and looking closer at the links between gender-based violence and SRHR has proved less popular. This is particularly so when looking at gender-based violence in relation to sexual orientation and gender identity and expression (SOGIE), and the marginalisation of LGBTQI persons.

Speaking to parliamentarians from Pacific Island countries at the ICPD Beyond 2014 conference in Fiji in August 2013, Claire Slatter, from the regional network Development Alternatives with Women for a New Era (DAWN) reiterated the call from Pacific feminists for recognition of LGBTQI rights:

> Despite the traditional recognition of the social role of trans* persons in several Pacific societies [such as Fa'afafine and Fakaleiti], persons whose sexual orientation or gender identity does not conform to majority norms are nonetheless often stigmatized, discriminated against, and subjected to bullying and in many cases horrendous sexual abuse, including by close family members. Protection of the rights and freedoms, and recognition and respect for the sexual rights of sexual minorities is way overdue in our region, where in most countries same-sex relationships are criminalized and homophobic hate crimes occur (cited in Buadromo et al. 2013).

It is common for public policy spaces, law enforcement and conservative Island communities to be hostile to LGBTQI persons. In some instances, however, those working in women's rights find working with diverse SOGIE issues uncomfortable. For example, the Fiji Women's Forum, a group of women leaders working towards democracy in Fiji, included transwomen in its inaugural gathering in a quiet, yet radical, reframing of what it means to be a Fijian woman. However, the space was not always comfortable for lesbians and transwomen and the participation of transwomen continues to be debated among the co-conveners.

The invisibilising of certain types of bodies, such as lesbian women's bodies, and denial of their rights occurs in spaces from law to health policies, church pulpits, right down to women's own sense of self. For example, when interviewed on 4 June 2013, Etta Tuitoga of Diverse Voices and Action for Equality (DIVA for Equality) explained that it is common for women she works with to have a hard time talking about vaginas or masturbation because they are ashamed, even though they are women who have sex with women and are in a safe space. She reported that many women found it very difficult to acknowledge themselves as sexual beings, even among other women like them. Further, the experiences of the Fijian lesbian women associated with DIVA demonstrates how poverty, class, race/ethnicity, geography, age, gender and sexuality intersect to marginalise particular bodies and groups of persons. In an interview on 4 June 2013, Etta Tuitoga, Coordinator of DIVA for Equality reported that in some instances 'fifteen to twenty [lesbian women] live in a house, with maybe only two of them working, with no proper sanitation, [no running water], but that's where they go, because they can be who they are, even living in that environment, because that's where they get support'.

Lesbian, bisexual trans* and intersex women often find it very difficult to access health care, particularly when it comes to sexual or reproductive health. Fear of overt discrimination and shaming can prevent LGBTQI persons from seeking medical help, even when the condition is very serious and painful. The most extreme discrimination occurs when poverty and sexuality intersect. Socio-economic class can be a key determining factor in one's access to services. Shirley Tagi of DIVA for Equality, interviewed on 4 June 2013, explains: 'It's actually okay for me to go to hospital. I can take [my partner], but that's at [the private hospital], but if you don't have money or a career, its double or triple the discrimination.'

There has been some traction with raising SOGIE issues as part of the discourse on regional and national efforts to prevent HIV. The efforts of agencies such as the Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund, and the Secretariat of the Pacific Community, and the proliferation

of HIV strategies, national committees and organisations at the regional and national level have raised awareness and a certain policy-level acceptance of the need to address the concerns of marginalised groups. This has been particularly true for men who have sex with men (MSM) and sex workers. While these groups remain on the margins and face widespread discrimination in most contexts, they have been the targets, and more recently, the co-developers of HIV prevention programming.

In an interview on 21 May 2013, Noelene Nabulivou of DAWN agreed that the HIV discourse in the Pacific has had complicated effects. While it has raised the profile, and to a certain extent, normalised some sexual rights issues in regional policy spaces, particularly bringing out the needs and concerns of men who have sex with men (MSM), it may have hidden others. Nabulivou commented that the HIV/MSM model can be very damaging to local work because it sets up a competition and a territorialising that in a small island space can be really hard. The rapid influx of resources around HIV, and the associated policies at the regional level, foster movement hierarchies where activists coalesce around particular identities such as MSM or women who have sex with women (WSW) that are situated differently on the donor agenda. With the big pots of HIV funding now coming to an end in the region (at least in their current form), these movement dynamics will be in flux.

SEX WORK

Sex workers continue to face harassment, extortion and violence at the hands of law enforcement, especially where they are made vulnerable by discriminatory or archaic legislation. When sex workers are considered, it is generally in the context of HIV advocacy, yet they remain largely excluded from policy-making and sexual and reproductive health services. Very little headway has been made in realising the rights of diverse persons engaged in sex work, as they remain controversial, both within the context of conservative, largely Christian, Pacific societies and within parts of the women's movement. Within the women's movement, there are some that are resistant to aligning with the SRHR movement's framing of sex work as work, rather than as prostitution, and a form of violence against women.

The situation for sex workers in Fiji was worsened by the new Crimes Decree (2009). Instead of decriminalising sex work, as recommended under CEDAW, the military government criminalised clients and brothels, in addition to the sex workers themselves (McMillan and Worth 2011). Following the decree, media coverage centred on police crackdowns against prostitution, and sex workers continued to be harassed or arrested for carrying condoms. They also faced harassment and more severe violence by the military – illegal detention, public humiliation, and physical and mental abuse, including sexual assault, amounting to torture (McMillan and Worth 2011).

ABORTION

Sexual and reproductive health and rights, including the right to bodily autonomy, are being constrained by the conservative interpretations of culture and religion that dominate Pacific Island politics and societies.

Policy and legislation play a key role in either enabling or hindering women's rights. However, the interpretation and implementation of a law or policy can be equally significant. The legal and policy environment is strongly influenced by the opinions of politicians and community leaders, especially on issues that are culturally or religiously sensitive. For example, in Samoa, following calls to legalise abortion after the case of a young women who hid a birth while travelling, church leader said: 'Should abortion be legalised, people would simply use it as a chance to make money' (RNZI 2009). Additionally, during 2010 campaigning in Tonga, Linda Ma'u, a woman political candidate, expressed her concern that if Tonga became a signatory to CEDAW, it might mean legalising abortion and same-sex-marriage, two practices that she detested (Matangi Tonga in Pacific Islands Report, 2010).

While the Fiji Crimes Decree (2009) permits abortion under limited circumstances, including rape, anecdotal evidence suggests that it is being conservatively interpreted and enforced on the ground, making legal abortion, even in these limited circumstances, difficult to access.

Pacific Island countries must take action 'to expand women's reproductive choices to include safe and legal abortion' (Spratt 2013), noting that women with disabilities may face additional challenges when forced to continue with an unwanted pregnancy, and are in urgent need of access to emergency contraception and safe, legal abortion all across the Pacific.

ACCESS TO COMPREHENSIVE AND INTEGRATED SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Pacific feminists and SRHR advocates are very clear on what the region needs in terms of access to comprehensive and integrated sexual and reproductive health services. In February 2013, following a regional SRHR strategy meeting, over 30 advocates from ten Pacific Island countries called on States and development partners to 'prioritise universal, comprehensive, integrated, confidential and quality sexual and reproductive health services, counselling, and information' (Buadromo et al. 2013). Recognising gendered hierarchies, this group highlighted the need for special emphasis on women, girls, LGBTQI persons and disabled persons, as those who are most marginalised from healthcare whilst being most in need of these services. The Pacific Feminist SRHR Coalition (cited in (Buadromo et al. 2013:6) went on to define and describe these services:

> Comprehensive services include: gynaecological care; all forms of safe and effective contraception; legal and safe abortion and post abortion care that is informed, affordable, accessible and free from coercion, discrimination and stigma, providing support and protection mechanisms that promote the right to choose; informed maternity care, and prevention; timely diagnosis and treatment of sexually transmitted infections including HIV, breast and reproductive cancers, and infertility. Ideally, these should be integrated, one-stop services tailored to women's needs throughout our life cycles, with effective referral.

Unfortunately, the region is a long way from fulfilling the coalition's vision of comprehensive services, as Pacific Island governments have been very slow to deliver on their ICPD and related human rights commitments.

The lack of funding for sexual and reproductive health services in the Pacific is a critical issue. Political manoeuvring and decision making regarding funding for sexual and reproductive health in the Pacific occurs in the context of cultural and religious norms, as well as the broader global neoliberal marketplace, which condones and perpetuates gender and other inequalities. In most Pacific Island countries, government funding for healthcare is particularly low and there is a lack of political will to allocate adequate resources to the sector. For example, in Fiji and Papua New Guinea, total expenditure on health comes to less than five per cent of the national GDP (Thanenthiran et al. 2013) and sexual and reproductive health services comprise just a fraction of that budget.

Another sign of an under-resourced health sector is the percentage of 'out of pocket expenses' that the user must pay to access basic healthcare. While the percentage of such expenses in most Pacific countries is lower than other parts of the world, including Asia, it remains a significant barrier to accessing healthcare in some parts of the region. For example, in Kiribati, only 0.1 per cent of health expenditure is out of pocket (paid for by the user). In Fiji, however, the percentage of out of pocket spending is significantly higher at 19.6 per cent (Thanenthiran et al. 2013). In Fiji, this is part of a broader trend towards a privatised and user-pays healthcare system, which is counterproductive to the aims of ICPD, violates the right to access basic health services and ultimately acts as a barrier to better sexual and reproductive health, particularly for women who are poor, young people and persons with disabilities.

Aid money and donor priorities have a big impact on the delivery of sexual and reproductive health services, particularly because, as an underfunded area, there is a large reliance on aid for this sector. Arguably, the most important discourse affecting the allocation of donor money over the last decade has been the HIV/AIDS pandemic and global efforts to prevent the spread of and to treat HIV. When interviewed on 6 June 2013, Avelina Rokoduru, Coordinator of the Pacific Sexual and Reproductive Health Research Centre, reported that the influx of funding around HIV in the Pacific region has been disruptive. While

in recent years there have been moves to make sexual and reproductive health services more integrated, when the HIV money first hit the region it led to the proliferation of HIV strategies, STI clinics and other HIV-specific programming and services. While these are admirable, the specialist funding appears to have diverted energy and attention away from other essential sexual and reproductive health services, such as basic access to contraception. This is supported by a 2010 Family Planning International study which found that 'over the past decade, Pacific Island countries have seen a rapid increase in HIV related activities that have largely been disconnected from broader sexual and reproductive health...activities' (FPI 2010). The negative impact of this narrow focus on vertical HIV programmes can include 'the shifting of resources and attention to HIV and away from other key health areas and the movement of skilled health workers and managers from other health areas to HIV programmes in search of better pay' (FPI 2010).

A large part of the problem, Rokoduru suggests, is that these programmes have been mostly 'donor-driven'. She also cites the absence of systematic monitoring and evaluation, which, in concert with a lack of political will, means that States have not been able to develop sustainable models that outlast the initial donor funding. The Family Planning Study on Integrating HIV and Sexual and Reproductive Health (2010) found these to be among several other barriers preventing better integration between HIV prevention and treatment and other sexual and reproductive health services, including weak national policies; limited and inequitable funding; poor political support; persistent stigma and discrimination; and inadequate health systems capacity. Even where efforts are now being made for greater integration, which is the current buzzword in the sexual and reproductive health sector says Rokoduru, these efforts are 'ad-hoc, often available only in urban areas and most often, dependent on donor funding and NGO [non governmental organisation] implementation' (FPI 2010). It is also unsurprising that it has been difficult to understand exactly how the integration process is being managed, as Family Planning International (2010) found that 'little information is available on exactly what is being linked and integrated and how effective it is' (2010).

THE SPECIFIC SEXUAL AND REPRODUCTIVE HEALTH NEEDS AND RIGHTS OF YOUNG PEOPLE

The needs and rights of young people may be the most important area of concern when it comes to the Pacific, where almost half the population is under 25 years old. In their island communities, where conservative interpretations of culture and tradition dominate, young people regularly face systematic discrimination in relation to their sexual and reproductive health and rights. Within this youth population, young women and girls, young people with disabilities and young LGBTQI people face additional barriers in accessing their rights.

Young people are a popular focus of regional and national policy, including in relation to SRHR, but there has been very little headway towards realising the human rights of diverse Pacific young people. The draft Pacific Youth Development Framework (SPC 2013) has identified some reasons for this:

- the many political statements and youth strategies have not been matched with implementation plans, budgets or work programmes;
- regional and national youth policies have been developed but not resourced, and therefore not implemented;
- youth initiatives that have been developed have largely remained at pilot stage and have not been evaluated or taken to scale (if successful); and
- limited understanding about the impact of youth programmes and services – evaluation, monitoring and data collection remain poor.

These criticisms also apply to national level responses to the sexual and reproductive health needs of young people. Even fairly successful programming continues to treat 'youth' as a largely homogenous block, without taking into account needs based on their positioning in relation to ethnicity, disability, socio-economic class, or often even gender. Young people are not a homogenous group, and thinking about them this way ignores the different avenues they have to negotiate power over their bodies, based on gender, socio-economic status, sexual orientation, gender identify, level of education, chiefly status, and their location, including their country of origin and where they live (urban or rural). Among young people, there are groups whose bodies are subject to particularly harsh censure, such as those positioned at the intersection of multiple forms of marginalisation, including by race, gender and sexuality. The spoken and unspoken rules play out on their bodies, describing how different bodies should look and move, what they can and cannot do with those bodies and the information they receive about their bodies.

The DAWN/Fiji Women's Rights Movement (FWRM) feminist strategy meeting is an example of how some young women, lesbian women and young women with disabilities have been organising and pushing back to claim autonomy over their own bodies, with the slogan, My Body is NOT Your Political Battleground (Buadromo et al. 2013). At the meeting they shared stories of how many young people, particularly young women and young LGBTQI persons, have experienced culture being exploited by the powerful to maintain their exclusion from political power. In the Pacific, '[many] young people are not allowed to participate in important development matters and decisions that affect their lives' (young woman in a Solomon Islands focus group discussion, cited in UNICEF and SPC 2011) and are extremely under-represented in national and regional decision making, including the almost complete absence of young women (Noble et al. 2011:19). This is in part 'due to traditional structures and cultural practices which preference older people (men in particular)' (Noble et al. 2011).

The denial of access to decision making begins in the home, where 'Pacific Island cultures [that] still demand a respectful silence from younger community members, while the elder members make the decisions' (Carling in UNICEF Pacific, SPC, UNFPA 2005). This silencing drives discussions about sexuality underground. As a result, young Pacific Islanders tend to have limited information about their sexual and reproductive bodies. The State of Pacific Youth report (UNICEF and SPC 2011) suggests that there are still serious gaps in young people's understanding of sexuality and reproductive health. Adolescents from Pacific Island countries consulted during the preparation of the report described how adults, particularly parents and community leaders, were unwilling to talk about sex.

In consultations for The State of Pacific Youth (UNICEF and SPC 2011) report, young Pacific Islanders identified a lack of sex education as a leading cause of early pregnancy. Early pregnancy is a concern for a number of reasons, including the health impacts on mother and child; the impact on young women's educational attainment and vulnerability to poverty; and the implications for young women's bodily autonomy and integrity. There are troubling inks to violence, including both increased vulnerability to intimate partner violence after birth as well as coerced sex or rape. This is evident in Marshall Islands, where in 2007 research found that the highest rates of adolescent pregnancy in the Pacific coexisted with a high incidence of teenage forced sexual intercourse (UNICEF and SPC 2011).

There has been a lot of donor and intergovernmental interest in promoting comprehensive sexuality education across the Pacific as a means of addressing these issues. However, it has been difficult for this programming to gain traction, with clear progress on implementing family life education largely confined to Fiji and Solomon Islands (NZPGPD 2012). The draft Pacific Youth Development Framework, a joint effort by UN agencies and regional intergovernmental bodies, has identified 'cultural barriers to programmes relating to sexual and reproductive health' as a major challenge for young people's development (SPC 2013). Even where sexuality education is provided to young people in the Pacific, it is mostly 'taught from a traditionally conservative and often religious perspective where abstinence is predominant' (NZPGPD 2012). Even the relatively progressive family life education curriculum in Fiji, which includes information on sexuality and equality, can be undone if teachers bring in their conservative religious values or homophobic attitudes. In this setting, it is particularly difficult for marginalised young people, including young women and young LGBTQI persons, to get the information they need to fully enjoy and make decisions about their bodies.

Even where communities have been progressive in discussing sex and sexuality, this is overwhelmingly from a heteronormative perspective, funnelling discussion towards reproductive and sexual health and avoiding mention of sexual rights. Teenage pregnancy occurs in a context where young women are often disempowered in terms of negotiating sex, pleasure and control over their own bodies. Those at the intersection of being young, a woman, and disabled, face particular challenges in asserting bodily autonomy. Women with disabilities are generally viewed as either potential victims of sexual attack or as abnormal 'hypersexual' beings, or their sexuality is completely ignored (CREA 2008). A study of women with disabilities in Tonga showed that 'a young woman with a disability is unlikely to receive the information she needs, including how her body works, how pregnancy can happen, how to enjoy a safe and respectful sexual relationship and how to prevent pregnancy' (Spratt 2013).

A lack of bodily autonomy for young Pacific Island women also extends to how they can address an unwanted pregnancy. Abortion is illegal in most Pacific Island countries or permitted only in very limited circumstances. Even where abortion is allowed in particular cases, it is very difficult for young women to access these services. They may lack the information on where to go, which doctors to seek out, or they may lack the means to pay dor a termination. For adolescents and young people who have serious difficulty in accessing basic contraceptive commodities and information on reproduction, a safe abortion is well out of reach. The cultural and religious context for young people in Pacific Island societies is akin to Foucault's Panopticon, making it near impossible to choose to safely abort a pregnancy.

Limitations on bodily autonomy and integrity along with the lack of comprehensive sexuality education are contributing to what the Coordinator of the Pacific Sexual and Reproductive Health Research Centre, Avelina Rokoduru, has called astronomical rates of STIs among young people in the region (interview, 6 June 2013). Rokoduru noted that the centre's research has highlighted the following concerning trends among young people: low to no condom use, very early first experience of sex, and patterns of transactional sex by young women living in poverty. These are risk factors for contracting STIs, which are worsened when services are not youth friendly:

> Health workers themselves are bringing culture and religion into things [and] always make their own judgements about who should get access... They view condoms and all other commodities as family planning only, so will actually deny those who fall outside of this (Rokoduru, interview, 6 June 2013).

CONCLUSION

A loose coalition of Pacific feminists is taking on these difficult SRHR issues, in the context of regional and global lobbying in the lead up to ICPD @20 in 2014. This 'exciting emergent movement-building work' is being driven by DAWN, FWRM, Punanga Tauturu in the Cook Islands, Diverse Voices and Action for Equality and the Pacific Youth Council (Nabulivou, email communication, 14 August, 2013). A defining moment was the three-day Pacific feminist SRHR strategy meeting in February 2013 that generated the outcomes statement: Pacific Feminists and Activists: Re-framing, Re-articulating and Re-energizing Sexual and Reproductive Health and Rights!, which sets the agenda for the work of the coalition (Buadromo et al. 2013). The statement includes 'urgent calls to action' on the right to legal and safe abortion, the decriminalisation of homosexuality, recognition of the full rights of diverse LGBTQI persons, and the decriminalisation of sex work (Buadromo et al. 2013). Other SRHR best practice examples from the Pacific include Diverse Voices and Action for Equality's 'Free School', a collective learning space for marginalised lesbian women (Tuitoga and Tagi, interview, 4 June, 2013).

RECOMMENDATIONS

While significant efforts are being made by women's organisations, community organisations, health services and governments to advance SRHR in the Pacific, there is still a plethora of gaps. This essay makes the following recommendations for addressing key gaps.

1. There is an urgent need for research on abortion in the Pacific that explores associations with teenage pregnancy, maternal health, comprehensive sexuality education and the provision of sexual and reproductive health services to young people. This is a very clear need, as the authors encountered a lack of existing research, information or willingness to discuss this issue. For rights-based service providers in sexual and reproductive health, it is too controversial to discuss openly, and for rights activists, there is too little information to build an effective lobby around.
2. Further work is required to build a greater understanding of the sexuality of persons with disabilities, and how disability intersects with socio-economic class and gender to affect the realisation of the sexual and reproductive health and rights of persons with disabilities. Such research and advocacy has implications beyond individuals with disability, because 'disabled sexuality challenges norms of sexuality that marginalise and exclude people' (CREA, 2008).
3. There will need to be strong champions at the regional level to make some headway with SOGIE rights. There also needs to be more extensive multi-country research that explores the SRHR issues facing LGBTQI persons, particularly lesbian and bisexual women. The conversation will need to build on the strong work that has been done by HIV advocates, but expand beyond that to encompass a broader range of SRHR issues and LGBTQI groupings. There is some overlap between this group and sex workers, where formal equality in terms of decriminalising sex work is still a priority.

4. Sexual and reproductive health and rights advocates in the region need to continue to push for increased funding for sexual and reproductive health services, as part of increased health and social spending overall. This is often particularly difficult in the Pacific Island region, where there are few avenues for influencing national budgeting, and financing or national planning is not really considered 'women's business'. In the context of neoliberal globalisation, as well as in response to flows of donor aid, there is also the tendency for Island governments to pull back from funding these areas. Governments must be held accountable to their human rights commitments in very concrete terms; funds allocated towards realising these sexual and reproductive rights in the form of better-resourced services.
5. In order to better serve Pacific communities, sexual and reproductive health and HIV services must be integrated more effectively, with a focus on building comprehensive, gender sensitive, non-judgemental, youth-friendly services that better cater for the needs of marginalised groups.
6. There is a disconnect and knowledge gap between feminists and human rights advocates pushing for the full realisation of SRHR on the one hand, and those working within the public health sector delivering services on the other. Emerging coalitions and SRHR advocates will need to build better alliances within the health sectors across the region. This is essential, and will strengthen the current lobbying at regional policy level.
7. Pacific SRHR advocates must continue to unpack arguments about culture and tradition, and not allow duty bearers to hide behind conservative, simplistic definitions of culture that restrict young people's access to SRHR. Even rights-based approaches to youth development can fall into the trap of oversimplifying youth issues as 'conflict between traditional and modern cultures' (McMurray 2005), thereby implying that each is static and discrete cultural form. This false dichotomy allows the conservative argument that rights are modern and foreign, as opposed to traditional patriarchal cultural practices and religious values. As HIV prevention advocate Steven Vete (Vete 2004) pointed out during a recent ICPD conference, the myth that it is against Pacific culture to talk about sex is 'rubbish', as it is often the main topic of conversation at family gatherings, during communal work and casual kava sessions.
8. Women's rights groups, SRHR advocates and other human rights groups need to hold States accountable to their obligations regarding comprehensive sexuality education for young people. This education should be made available in both formal and non-formal settings, for primary school children to young adults, and must be 'gender-sensitive, disability-friendly, evidence-based, context-specific and acknowledge the evolving capacities of young people' (ARROW 2012). This should not been seen as solely an education sector or health sector issue, but a human rights concern.
9. Rather than formulating programming for 'youth', States, donors and SRHR advocates must recognise and address the diversity of young people. In a positive move, the draft Pacific Youth Development Framework (SPC 2013) has gone some way towards recognising the intersectional, gendered discrimination that young people face, by focusing on five groups of young people that need special attention by policy makers: young women, rural and outer Island young people, urban young people, young persons with disabilities, and young LGBTQI people.
10. When addressing the SRHR needs of young people, programmes by young women and for young women are particularly important. Some best practice examples include the Young Women's Leadership programme at FWRM, which runs an Emerging Leaders Forum for young women and now has a vibrant young women-led Alumni, as well as a GIRLS (Grow, Inspire, Relate, Lead, Succeed) programme for 10–12 year-olds. Also impressive is the Talitha Project for young women in Tonga, which has a 'young mums club' and a 'young women's empowerment group', and was started by a young woman who had faced discrimination as an unmarried mother (Talitha Project 2010; Carling, interview, 31 May 2013).

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