REGIONAL ADVOCACY TOOL

Sexual and Reproductive Health and Rights Advocacy in the Pacific

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Development Alternatives with Women for a New Era

This paper is part of an international research effort by feminist authors from the Global South.

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ACRONYMS

ACFID	Australian Council for International Development
AFR	Adolescent Fertility Rate
AIDS	Acquired Immuno Deficiency Syndrome
APA	Asia Pacific Alliance
APF	Asia Pacific Forum
APWLD	Asia Pacific Forum on Women, Law and Development
ARH	Adolescent Reproductive Health
ARROW	Asian-Pacific Resource and Research Centre for Women
AWID	Association for Women's Rights in Development
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CPR	Contraception Prevalence Rates
CRC	Convention on the Rights of the Child
CREA	Creating Resources for Empowerment in Action
CSE	Comprehensive Sexuality Education
DAWN	Development Alternatives with Women for a New Era
DHS	Demographic Health Surveys
DIVA	Diverse Voices in Action for Equality
ESCAP	Economic and Social Commission for Asia and the Pacific
FLE	Family Life Education
FPI	Family Planning International
FSM	Federated States of Micronesia
FWF	Fiji Women's Forum
FWRM	Fiji Women's Rights Movement
GBV	Gender Based Violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MDGs	Millennium Development Goals
MOH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non Government Organisation
NZPGPD	New Zealand Parliamentarians' Group on Population and Development

OHCHR	Office of the High Commissioner for Human Rights
PIFS	Pacific Islands Forum Secretariat
PICs	Pacific Island Countries
PICTs	Pacific Island Countries and Territories
PNG	Papua New Guinea
POA	Programme of Action
PWSPD	Pacific Women Shaping Pacific Development
RMI	Republic of the Marshall Islands
RRRT	Pacific Regional Rights Resource Team
SOGI	Sexual Orientation and Gender Identity
SPC	South Pacific Community
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHRC	United Nations Human Rights Council
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UPR	Universal Periodic Review
WHO	World Health Organisation
WSW	Women who have Sex with Women
YAAP	Young Activists and Advocates from Asia Pacific

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I. EXECUTIVE SUMMARY

The Pacific island region stretches across a large part of the earth's surface, connected by the world's largest ocean. With its relatively small population, the region has often been marginalised in global debates, including on sexual and reproductive health and rights (SRHR). Given the geographical and cultural diversity, there are a wide range of SRHR issues affecting the lives of Pacific islanders.

Sexual and reproductive health services continue to be under-funded across the region, despite an influx of resourcing around HIV prevention over the past decade. This is because integration of services has been poor, with less attention paid to contraceptive information and delivery and other SRH services. Recommendations therefore include: better integration of HIV and other SRH services, which should be comprehensive, gender sensitive, non-judgemental and youth-friendly; increased funding for SRH services as part of increased health and social spending overall; and better alliances between human rights advocates and those working in the health sector in Pacific island countries.

The needs and rights of young people are of critical concern as almost half the population in the Pacific region is under 25. Among youth, young women and girls, young people with disabilities and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) young people face additional barriers in accessing their rights. Recommendations for addressing their concerns include: expanding SRHR programming for youth by recognising and addressing the diversity of young people, specifically groups that are marginalised; strengthening current efforts to scale up comprehensive sexuality education for all adolescents and youth within all countries in the Pacific; improving availability and access to comprehensive youth and adolescent focused SRH services; and promoting empowerment of and SRHR initiatives by and for young women.

The Pacific has some of the highest rates of gender-based violence (GBV) in the world. Violence is a direct violation of bodily integrity and autonomy. GBV flourishes within patriarchal hierarchies in the Pacific, where women and LGBTQI persons face discrimination at multiple levels, including on account of their socio-economic status, ethnicity, disability and place of origin. Recommendations in this area include: review, amend and promote legislation to address all forms of GBV to ensure protection, safety and security of individuals; mobilise SRHR advocates to amend restrictive abortion laws in the region; identify and support regional champions for rights in relation to sexual orientation and gender identity (SOGI); strengthen efforts to gain formal equality for sex workers by decriminalising sex work in accordance with international human rights standards; encourage research and data collection on issues of sexual and reproductive health rights, including abortion and the situation and needs of LGBTQI persons and persons with disabilities.

INTRODUCTION

The Pacific island region stretches across a large part of the earth's surface, connected by the world's largest ocean. With its relatively small population, the region has often been marginalised in global debates, including on sexual and reproductive health and rights (SRHR). The Pacific can be expressed as many different political formations, sometimes including the nations of the economic North, Australia and New Zealand, sometimes including South East Asian countries such as the Philippines, sometimes including the French territories, and sometimes only the independent nations. For the purposes of this paper, we are considering the 22 Pacific island countries and territories served by the Secretariat of the Pacific Community.[1] These range from the largest island nation, Papua New Guinea (PNG), with a linguistically diverse population of over 7 million, who speak more than 800 indigenous languages, to the more culturally homogenous small island developing states of Kiribati, Nauru and Niue, the last of which has a population of less than 2000.

At the international level, all Pacific island governments have committed to ICPD, ICPD+5, ICPD+10, ICPD+15, Beijing, Beijing+5, Beijing+10, Beijing+15, the MDGs, the ESCAP Population and Poverty Plan (2002) and the UN World Summit Outcome Document, all of which, to differing extents, address reproductive health issues (NZPGPD, 2012:11). There are also a plethora of national and regional strategies on SRH, particularly HIV/AIDS, but implementation is incomplete or unclear. In 2003, Health Ministers[2] developed a regional Pacific Plan of Action (Roke and Rogerson, 2008:8). The Pacific Human Resources for Health Alliance Work Plan 2008-2015 is concerned with addressing some of the challenges faced by health systems in the Pacific. The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities exists but needs to be fully implemented according to its Regional Strategic Plan of Action, which involves establishing national Reproductive Health Commodity Security Coordination Committees (FPI et. al, 2009:42; NZPGPD, 2009:13). There is a Regional Strategy for HIV and other STIs (2009-2013) along with an implementation plan. More recently, Pacific Health Ministers endorsed a *Pacific Sexual Health and Well-being Shared Agenda* for 2015-2019 (SPC, 2014).

In UNFPA's most recent review of ICPD PoA progress in the region, all 14 Pacific countries surveyed indicated that SRH was an integral part of their health care; it was included in their health budgets with referral mechanisms and guidelines in place and statistics disaggregated by sex and age (Wilkinson and Walls, 2013:15). All 14 Pacific countries currently have policies in place for improving SRH and operational frameworks for implementing these (Wilkinson and Walls, 2013:37). However, at that time only three[3], PNG, Vanuatu and Tuvalu, had formulated national population policies (Wilkinson and Walls, 2013:7). While there are national strategies for HIV, Wilkinson and Walls (2013) note that these do not generally address additional risk factors such as cultural attitudes, sexual behaviour and the availability and access of information, prevention and treatment. Meanwhile, although family planning programmes have existed throughout the Pacific since the 1960s, the use of modern contraceptives generally remains low throughout the region suggesting that access and knowledge of methods along

[1] *American Samoa, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna. Australia and New Zealand are not included as they are part of the economic North and their socio-economic profile is so markedly different. Given language constraints, we have not been able to draw on much information from the Francophone Pacific.*

[2] *These included those of the Cook Islands, Fiji, Kiribati, Niue, PNG, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu.*

[3] *Samoa and the Solomon Islands have draft population policies.*

with the decision-making power to use them remain urgent issues requiring attention (NZPGPD, 2009:16).

The afore-mentioned international agreements, along with CEDAW and CRC[4], all constitute human rights commitments that together require Pacific governments to implement comprehensive and integrated SRH services (Wilkinson and Walls, 2013). However, national laws relating to abortion, sexual orientation and gender identity (SOGI), and sex work often prevent SRH services from being as comprehensive as these human rights commitments necessitate (Jalal, 2009; UNAIDS, 2010; Godwin, 2012).[5] Most Pacific countries have either weak or non-existent accountability mechanisms to ensure that people's claims on SRHR are being addressed. This is therefore a priority ICPD area, especially in rural areas given that approximately 77% of the region's population is rural (Wilkinson and Walls, 2013:40; NZPGPD, 2009:1).

Because of the region's geographical and cultural diversity, there is clearly a wide range of SRHR issues affecting the lives of Pacific islanders. This paper, one of six Regional Advocacy Tools from the Global South, does not provide a comprehensive overview of these complexities – instead we have focused on certain critical issues in three thematic areas: access to comprehensive and integrated sexual and reproductive health services; the specific sexual and reproductive health needs and rights of young people; and sexual and reproductive rights issues in the Pacific. We present and discuss these issues from a feminist, and sexual and reproductive rights advocacy point of view.

[4] *Both CEDAW and CRC are considered further under Theme 2.*

[5] *However, these laws are discussed more closely under Theme 3.*

II. THEME 1: Access to comprehensive and integrated sexual and reproductive health services

Section A: Background

Comprehensive sexual and reproductive health services[6] that are based upon informed choice and a variety of options are still not fully realised and operational across the Pacific (Narsey et. al, 2010; Buadromo et. al, 2013). The region needs to invest in services, as sexual and reproductive health (SRH) services, including contraception, are key factors in addressing human wellbeing. Contraception and related services can prevent up to 40% of maternal and infant deaths[7] (NZPGPD, 2009:12; Wilkinson and Walls, 2013:35). However, there are persistent barriers that include inadequate resourcing for integrated services, high aid and donor dependency, small sexual and reproductive health budgets and competing attention among Pacific countries towards climate change adaptation, market development opportunities and state-oriented security (Turagabeci and Tuivanualevu, 2012:5). Other barriers include lack of donor coordination and communication, little political will, limited workforce development and training, lack of systems in place particularly in rural areas and/or low usage of existing systems, along with poor communication between and within countries (Roke and Rogerson, 2008:5; FPI et. al, 2009:4).

The lack of integration between general SRH services and specific HIV services is a critical issue affecting delivery and access to SRH services in the Pacific. (FPI et. al, 2009:15). Research supports the integration of HIV and sexual and reproductive health and rights (SRHR) programmes, arguing that it leads to a range of positive public health benefits (FPI et. al, 2009). However, over the past decade, there has been a general failure to recognise the importance of universal access to contraceptive information and services, and along with donor fatigue and competition with HIV prevention services for limited resources, has led to decreased resourcing for family planning (Robertson, 2007 in Narsey et. al, 2010: 35). Globally, financial assistance for addressing STDs/HIV/AIDS increased from 9% in 1995 to 75% of total population assistance in 2007, while assistance for family planning fell (Varma, 2011: 3). Regionally, increases in funding for SRH services and activities have favoured HIV programmes, not taking into account the need for other sexual and reproductive health services, which constitute a higher burden overall in the Pacific (APA, 2008:38).

Another problem is a lack of SRHR data, which is made worse by the mixture of figures arising from multiple sources publishing SRHR statistics on Pacific countries (FPI et. al, 2009:38). However, what can be gathered is that approximately 650,000 women in the Pacific have an unmet need for family planning or contraceptive services (NZPGPD, 2012:1). Among women in the Solomon Islands, 70-90% want to manage their fertility and yet currently only 27% of women use modern contraception (APA, 2008:37). In Samoa, 45% of women and 30% of women in PNG have an unmet need for contraception, but anecdotal evidence suggests that the latter statistic is actually higher (NZPGPD, 2012; Hayes, 2010). Indeed, whilst many Pacific island countries and territories have improved their contraceptive prevalence rates (CPRs) since the 1990s, in the Cook Islands, Tonga, Tuvalu and Samoa CPRs are lower[8] than they were during the late 1990s (Narsey et. al, 2010:102; MOH et. al, 2010). Data collection

[6] *Comprehensive sexual and reproductive health services involve five core components, according to the World Health Organisation (WHO): "improvement of antenatal, perinatal, postpartum, and newborn care; provision of high-quality services for family planning, including infertility services; elimination of unsafe abortions; prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections cervical cancer, and other gynaecological morbidities; and promotion of healthy sexuality" (Glasier et. al, 2006:1596)*

[7] *Although many Pacific countries have experienced great success in reducing maternal mortality rates, with over 90% of births being attended by skilled birth attendants in all but four PICTs, there remain areas still struggling to address this ICPD issue, particularly PNG which has only 11.8 midwives per 10,000 births (NZPGPD, 2009:17).*

[8] *These CPR are drawn from Pacific island countries Ministries of Health data during 2005-2009.*

complicates these issues, and may not show the full scope of the problem. This is because within many Demographic Health Surveys (DHS) such as those in Samoa, Marshall Islands, Kiribati and Nauru, CPR and the data on unmet need for family planning is only collected about married women (NZPGPD, 2012:20; NSD et. al, 2010; MOH et. al, 2010; SPC et. al, 2007; KNSO and SPC, 2009; NBS et. al, 2009).

Papua New Guinea is the only Pacific island country with a serious HIV/AIDS problem, with approximately 0.92% of the adult population living with HIV in 2009 (UNAIDS, 2010b).[9] Apart from PNG, there is a low prevalence of HIV across the region with the Cook Islands, Nauru, Niue, Pitcairn and Tokelau reporting no people currently known to be living with HIV (Wanyeki, 2011:4). Meanwhile, six[10] Pacific countries have had ten or fewer reported cases (Wanyeki, 2011:7). It is important to acknowledge that in many countries there are limited testing facilities available and therefore a likely underreporting of HIV (Wanyeki, 2011:16). In the Pacific island region, the primary mode of HIV transmission is quite clearly through heterosexual contact (Wanyeki, 2011:4). It is critically important to integrate SRH and HIV services, as 98.9% of all HIV infections emerge or are associated with sexual connections, pregnancy, childbirth or breastfeeding in the region (APA, 2008:33).

Globally, funding for family planning has dropped from 55% of total population funding in 1995 to 9% in 2006 (Bangkok Statement of Commitment, 2006). Funds for basic reproductive health services decreased from 33% to 17% of total population assistance and resources for data collection and research, including censuses, fell from 15% to 3% (Varma, 2011:3; NZPGPD, 2009:13). This drop in funding is credited not only to a prioritisation of and focus on HIV/AIDS, which included more than US$77million in 2008[11], but also to the re-emergence of political and religious conservatism in donor countries, particularly the United States (NZPGPD, 2009:13; COA, 2009:61). This issue of funding is particularly significant since approximately 95% of all funding into HIV projects relies upon external funds and major funding rounds have now ended or are coming to a close, such as the Global Fund and the Response Fund (funded by AusAID and NZAID) (COA, 2009). In terms of overall SRHR, apart from PNG, all Pacific countries received less funding than what had been agreed to by the UN Commission for Population and Development. For example, Tuvalu and Fiji received less than US$1.00 per capita, and Samoa was given less than US$2.00 per capita (Gil, 2010:27). Finally, the Cairo PoA estimates that two thirds of all population programmes should be funded domestically; however, to meet this target, Pacific governments would need to increase their funding almost eight times to that which they gave in 2007 (Durano, 2010:12; Gil, 2010:29).

Section B: Assessment

Context

Pacific feminists and sexual and reproductive health and rights 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, 2013:6). Recognising gendered hierarchies, this group highlighted the need for special emphasis on women, girls, LGBTQI persons and disabled persons as these groups are most marginalised from healthcare despite being most in need of SRH services. The Pacific Feminist

[9] *This figure is not as high as earlier estimated, indicating that PNG's HIV epidemic could be levelling off (UNAIDS, 2010b).*

[10] *These are American Samoa, Cook Islands, Nauru, Palau, Vanuatu and Wallis and Futuna (Wanyeki, 2011:7).*

[11] *88% of this was given to PNG which has the most severe prevalence rate of HIV in the region (COA, 2009).*

SRHR Coalition 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." (Buadromo et. al, 2013:6)

However, the region is a long way from fulfilling the Pacific feminist 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 is clearly a critical issue; especially in a context where overall funding for healthcare is particularly low and political will to allocate adequate resources to this sector is often even lower. In Fiji and PNG, for example, total expenditure on health comes to less than 5% of the national GDP (Thanenthiran et. al, 2013:36)[12], and sexual and reproductive health services comprise just a fraction of that small sum. The political manoeuvring and decision-making regarding funding occurs in a landscape inflected by Pacific island cultures and gendered hierarchies and is firmly situated in the neoliberal global marketplace. This plays out differently across the diverse Pacific island region; so while in Kiribati only 0.1% of health expenditure is out of pocket (or paid by the user), in the much larger Fijian economy, the percentage of out of pocket spending as part of overall health expenditure in the country jumps to 19.6% (Thanenthiran et. al, 2013:36). While this is low in relation to other countries within the Asia-Pacific region,[13] the figure in Fiji speaks of a trend towards privatisation and user-pays which runs counter to the aims of ICPD, violates the right to access adequate services and ultimately acts as a barrier to better sexual and reproductive health – particularly for women who are poor, young people and people with disabilities.

Implementation

Aid money and donor priorities have a big impact on the delivery of SRH 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 past decade has been that surrounding the HIV/AIDS pandemic and global efforts to prevent the spread of and to treat HIV. Avelina Rokoduru, Coordinator of the Pacific Sexual and Reproductive Health Research Centre, says that the influx of funding around HIV in the Pacific region has been disruptive (interview, 6 June, 2013). While in recent years there have been moves to make SRH 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 SRH services, such as basic access to contraception.[14] This assertion 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 (SRH) activities" (FPI, 2010:3). The negative impact of

[12] *With the diversity across the region, the numbers look better in the much smaller island state of Kiribati, where health spending is 11.2% of GDP, but this may be a reflection of relative size and aid spending (Thanenthiran et.al, 2013: 36).*

[13] *In Afghanistan for example, the out of pocket spending is a whopping 83% of total health expenditure (Thanenthiran et.al, 2013: 36).*

[14] *Speaking more generally of the situation in the Pacific, the UNFPA Final multi-country programme document for the Pacific Island countries and territories 2013-2017 says: "Stalled or relatively slow fertility declines in many countries can be attributed to a reduced focus on family planning programmes, the diversion of potential family planning funding to other priorities…" (UNFPA, 2012:2)*

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, 2010:7).

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,[15] 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 International study found these to be among several barriers preventing better integration between HIV prevention and treatment and other SRH services, including "weak national policy", "limited and inequitable funding", "poor political support", "persistent stigma and discrimination" and "inadequate health systems capacity" (2010:3). Even where efforts are now being made for greater integration, which is the current "buzzword" in the SRH sector says Rokoduru, these efforts are "ad-hoc, often available only in urban areas and most often, dependent on donor funding and NGO implementation" (FPI, 2010:3).[16] While implementation remains a challenge, there indications of increasing attention at the regional policy level to the importance of service integration. The recently endorsed *Pacific Sexual Health and Well-being Shared Agenda* (SPC, 2014) cites the need to "integrate and link services" as one of five key approaches to achieving sexual health and well-being in the region.

Noelene Nabulivou, of DAWN Pacific, says HIV discourse in the Pacific has had other 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. "The HIV/MSM model that is enabled by resourcing and politically, which is linked into wider narratives, not just HIV but also this SOGI approach at the international level, 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, really hard" (Nabulivou, interview, 21 May, 2013). 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.[17]

Recommendations

SRHR advocates in the region need to continue to push for increased funding for SRH 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. However, this is far easier said than done, particularly in a country like Fiji, where the militarisation of the government has impacted a wide range of human rights – including SRHR. The Fiji Military Forces has been getting a considerable slice of national

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[15] *For example, HIV prevention programmes can usually tell you how many condoms were distributed, but not usually whether they were used, how often and by whom (Rokoduru, interview, 6 June, 2013).*

[16] *It is also unsurprising that it has been difficult to understand exactly how the integration process is being managed, as the Family Planning Study on Integrating HIV & Sexual and Reproductive Health also found that "little information is available on exactly what is being linked and integrated and how effective it is" (2010:3).*

[17] *The Pacific sexual rights movement(s) are discussed in more detail under the third thematic area, sexual and reproductive rights.*

funds, by over-spending the approved budget every year since 2000; following the 2006 coup d'état overspending jumped to FJD50 million (in 2007), and 24m (in 2010) (Narsey, 2011). Meanwhile, health spending decreased in real terms, by 1% between 2009 and 2010; the health budget is also only 4.8% of GDP, which is a "relatively low percentage compared to neighbouring Pacific Island countries and in relation to Fijis economic role and wealth" (Fiji Ministry of Health, 2010: 9).

In order to better serve Pacific communities, **SRH and HIV services must be integrated more effectively; as well as be made more comprehensive, gender sensitive, non-judgemental, youth-friendly, and to better cater for the needs of marginalised groups.** For example, despite a focus on sex workers as recipients of HIV programming, and research on HIV prevention among sex workers in Fiji (McMillan and Worth, 2010), the public sexual health clinics close at 4pm – making them far less accessible to sex workers who work at night (as raised during youth group discussion at the Pacific Conference of Parliamentarians for Advocacy on ICPD Beyond 2014).

There is also 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.

To summarise, our recommendations for improving reach and accessibility of family planning and other SRH services in the Pacific include:

1) Integrating SRH and HIV services to ensure that the larger SRH needs of the population are sufficiently addressed. This will require: a) strong national policy and political support, b) re-structuring of funding and donor aid, and c) health system improvements.

2) Increased funding and budgetary allocation for SRH services as part of increased health and social spending overall.

3) Reducing unmet need for family planning through the provision of contraceptive services that offer diversity in method choice, and that are provided in a gender-sensitive, non-judgmental fashion, responsive to the various needs of sub-populations and marginalised groups.

4) Addressing the socio-cultural barriers that restrict knowledge, access and voluntary use of family planning methods to manage fertility.

5) Building alliances between SRHR advocates and the health workforce to strengthen lobbying efforts at the regional level for fulfillment of the SRHR agenda.

III. THEME 2: The specific sexual and reproductive health needs and rights of young people

Section A: Background

The Cairo Programme of Action 1994 (PoA) recognises that adolescents have specific sexual and reproductive health needs and rights. Meeting these needs within the Pacific context is particularly important in light of its demographic situation, with almost 50% of the population under 25 years of age and a third of the adult working population aged between 15-24 (Narsey et. al, 2010:213; Turagabeci and Tuivanualevu, 2012:6). These young people face high rates of youth unemployment across the region and are migrating in large numbers from rural to urban areas, as well as dealing with issues of violence and alcohol and substance abuse (Noble et. al, 2011; Narsey et. al, 2010:218). This situation, along with limited communication regarding SRHR in communities and families, is conducive to sexual risk-taking among youth in the Pacific (Lata, 2002; Narsey et. al, 2010).

Given this context, a major SRHR issue that requires immediate attention is comprehensive sexuality education (CSE) for young people. Since sex still remains a relatively taboo subject too often CSE is not provided and/or educators are not supported to teach it effectively (FPI et. al, 2009:8). It is also equally necessary to provide CSE for out-of-school youth with the latest ICPD regional study highlighting this as one of two ICPD PoA areas that received the least support within the Pacific (NZPGPD, 2012:13; Wilkinson and Walls, 2013:53). Two particular problematic youth SRHR issues, which highlight the urgency with which CSE must be addressed and reveal high rates of unprotected sexual activity, are also discussed in this section as sub-issues: teenage pregnancies[18] and sexually-transmitted infections (STIs) (NZOPG, 2009; FPI et. al, 2009; NZPGPD, 2012).

Across the Pacific, low usage of contraception among youth constitutes a major risk factor for both STIs and teenage pregnancies. Current statistics reveal that less than 20% of young women and fewer than 50% of young men aged 15-19 reported ever having used a modern method of contraception, including condoms (NZPGPD, 2012:1). On average, one in four young people who are sexually active in the Pacific have an STI (Wilkinson and Walls, 2013:36). Chlamydia rates among pregnant women under 25 are particularly high in the Cook Islands and Samoa at rates of 48% and 40.7% respectively and in Fiji they are just over 30% (SPC et. al, 2010:10; FPI et. al, 2009:14). Meanwhile, adolescent fertility rates (AFR) among girls aged 15-19 years in Pacific countries range from 20 per 1,000 in Tonga and Niue to 81 and 85 in Nauru and the Marshall Islands respectively (Wilkinson and Walls, 2013:3). Teenage pregnancy rates in Vanuatu, Solomon Islands, Papua New Guinea, Nauru and Marshall Islands remain among the highest in the world (NZOPG, 2009:1; Wilkinson and Walls, 2013:2).

The ICPD+10 progress report highlighted efforts taken by PICs to address adolescent SRH issues (UNFPA, 2004). Among those at the regional level were UNFPA and SPC sponsored adolescent reproductive health (ARH) projects that promoted the rights of youth through SRHR services and information both through and outside of formal education programmes (UNFPA, 2004). Regional plans exist for both the prevention and control of STIs and for achieving universal access to RH services and commodities (NZPGPD, 2012:11). However, these regional projects and policies, along with national social policies for youth in 11of 12[19] surveyed PICs (Wilkinson and Walls, 2013), have not generally

[18] *Admittedly, it is problematic to assume that teenage pregnancies are "generally" unwanted and thus reveal the inability of a young woman to control reproduction, however because statistics do not differentiate between wanted and unwanted pregnancies among young people this term is used by the authors to achieve coherency throughout this paper.*

[19] *These were the Cook Islands, Fiji, FSM, Kiribati, Niue, Palau, PNG, RMI, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu with Nauru being the exception (Wilkinson and Walls, 2013:58).*

translated into the full implementation of comprehensive sexuality education (CSE) for adolescents and youth.

The Pacific regional meeting on Adolescent Health and Development in 2010 argued that Pacific countries were beginning to shift towards inclusive and comprehensive sexuality health education (SPC et. al, 2010:42). Ten countries were discussed and percentages given regarding full implementation of Family Life Education (FLE). Vanuatu (60%), Fiji (90%), Solomon Islands (60%) and Kiribati (90%) have made considerable progress towards FLE, whereas the remaining six, Cook Islands (16.50%), Tonga (33%), RMI (33%), FSM (16.50%), Samoa (33%) and Tuvalu (16.50%) have only integrated certain aspects of FLE into their formal curriculums (SPC et. al, 2010:43). This latter group were categorised as having high resistance to CSE (SPC et. al, 2010:43).

Fiji is currently in an advanced stage of implementing CSE throughout national schools and considerable support has been offered through the SPC Adolescent and Health Programme, with the number of schools offering SRH education increasing from 30 in 2008 to 150 in 2012 (NZPGPD, 2012:13). FSM made the provision of sexual and reproductive health information to at least 80% of school dropouts between the ages 10-19 a priority target in 2011 (SPC et. al, 2010:30). Meanwhile, Tonga has attempted to implement information, education and communication strategies specifically targeted at the SRH and rights of young people through youth friendly services and school curriculums (Wilkinson and Walls, 2013:14).

While considerable progress has thus occurred in several countries across the region, the "Family Life" curriculums within most Pacific countries remain primarily focused on reproductive health and very little attention is given to sexual health and rights with almost none to sexuality rights (Turagabeci and Tuivanualevu, 2012:6). Other countries, such as Kiribati, Nauru, Samoa and Solomon Islands still do not include sex education within their formal education programmes and the need for out-of-school youth SRH information services remains a major gap in many countries (Wilkinson and Walls, 2013:53). Peer education programmes, which are particularly strong in many Pacific countries, are attempting to address out-of-school youth; these are generally provided by NGOs, such as Wan Smolbag in Vanuatu and Samoa Family Health Association in Samoa (NZPGPD, 2012:14).

All Pacific country governments have committed to the ICPD PoA and the benchmarks set at the subsequent five yearly reviews, which each articulate the right to education regarding SRHR for adolescents (NZPGPD, 2012:11; Kossen, 2012:155). Each country has also ratified the Convention on the Rights of the Child (CRC) (OHCHR and PIFS, 2009:15), which explicitly requests State parties to 'develop…family planning education and services' for all children under 18 years of age (CRC, art. 24(2)(f)) and protects their right to seek, receive and impart information (art. 13) and be educated (art. 28). The Committee on the Rights of the Child furthers this by demanding that sex information and education not be 'censored, withheld, or intentionally misrepresented in any way by States' (ComCRC, 2003; Kossen 2012:154). Apart from Tonga and Palau, all countries in the Pacific have ratified CEDAW (Latu, 2013)[20]. Although CEDAW itself does not explicitly refer to an adolescent's right to information, the Committee's general recommendation 24 does by explicitly stating that State parties should ensure 'sexual and reproductive health education' for adolescents in 'specially designed programmes' that respect their right to both confidentiality and privacy (Kossen, 2012:154; ComCEDAW, 1999).

[20] *Palau has signed, but not ratified the Convention. Tonga has done neither, but in 2015 the Tongan Government finally committed to beginning the process towards ratification.*

Section B: Assessment

Context: Culture, religion and access to decision-making

Despite these international commitments, the Pacific – like most regions of the world – struggles to bring CEDAW articles, the Beijing PoA and the Cairo agenda home, particularly to the lives of women, girls and LGBTQI persons. A central hurdle in the realisation of these rights, especially for young people, is the cultural and religious context in which they live. While cultural practices and religious expressions are diverse across the region, constantly changing and taking on new forms, they are in general non-conducive to the fulfilment of sexual and reproductive health and rights. Pacific island patriarchal cultures, which sit comfortably embedded within contemporary religious practice, most commonly conservative Christianity, shape and constrain the opportunities for realising rights.

Some well-known examples of harmful cultural practices in the region include "bride price practices (Melanesia and East Timor), traditional forgiveness practices, the burning of mainly female witches for alleged sorcery (Melanesia) and early or arranged or forced marriages" (Jalal, 2009b: 2). Jalal (2009b) also lists punishment rape, exchange of brides as part of dispute settlements (Melanesia), dry sexual intercourse (Kiribati) and virginity tests, which "highlight 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) 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" (2009:18).

> "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." Participants in a focus group discussion in Malaita as part of the Solomon Islands Family Health and Safety Study (SPC and NSO, 2009:150-151)[21]

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 points out, "Cultures are constituted differently at different times and in different places and therefore cannot be generalised", particularly in the Pacific where "generalisations about the region or its sub-regions, and undifferentiated reference to women as a single group is flawed" (2011:10, 4). Similarly, thinking about Pacific young people as a homogenous group in a static context, and ignoring the different avenues they have to negotiate power over their bodies – based on gender, socio-economic status, sexual orientation, gender identity, level of education, country or sub-region of origin, whether they are from a larger island or a smaller one, live in a rural area or a peri-urban one, are of chiefly status or not – would be a mistake.

Therefore it is important to also look beyond these examples of the extreme violations of sexual and other human rights of women and girls, which are often publicly condemned by religious and many cultural leaders, to the more hidden assault against young people's bodily autonomy and integrity in the form of everyday political, cultural and religious proscriptions. 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 types and forms of information they receive about their bodies.

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[21] *However, Underhill-Sem warns against overly "simplistic accounts of bride price, bride wealth and marriage exchanges [that] exposes contemporary prejudices against 'Melanesian countries', and often diverts attention from more systematic practices that belittle many women in the Pacific in the contemporary era" (2011:7).*

> "Women are really challenged by this invisibilising of body parts, invisibilising of narratives on sexual activity, and who they're able to discuss it with, and what parts of the community are acceptable. So it's about fundamentalisms, but also this issue of bodily integrity and autonomy." Noelene Nabulivou of DAWN sharing outcomes of a 2013 Strategy Meeting of Feminists Advancing Sexual and Reproductive Rights in the Pacific (interview, 21 May, 2013).

The DAWN/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, experience various notions of culture as exploited by the powerful to maintain their exclusion from political power.[22] 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) and are extremely underrepresented in national and regional decision making, including the almost complete absence of young women (UNICEF and SPC, 2011:27; 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, 2011:19). The denial of access to decision-making begins in the home, in line with "Pacific Island cultures [that] still demand a respectful silence from younger community members, while the elder members make the decisions" (Carling in McMurray, 2005:32). This silencing further narrows the possibilities for young people to realise their sexual and reproductive health and rights.

Comprehensive Sexuality Education

Young people's access to comprehensive sexuality education is situated in a cultural terrain that drives discussions about sexuality underground. Even where traditional or religious leaders have been progressive in discussing sex and sexuality, this is overwhelmingly from a heteronormative frame, funnelling discussion towards reproductive and sexual health and avoiding mention of sexual rights.[23]

As a result, young Pacific Islanders tend to have limited information about their sexual and reproductive bodies. For example, a UNFPA survey of Samoan adolescents in 1998 showed that very few understood much about menstruation, fertility or STIs (Seniloli, 2002). While adolescent knowledge of reproduction may be expected to have improved in the last 15 years since the survey, UNICEF/SPC's *The State of Pacific Youth* report suggests that there are still serious gaps in young people's understanding of sexuality and reproductive health (UNICEF and SPC, 2011). 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 with them. The adolescents cited lack of basic knowledge and understanding of sexuality and reproduction as an important contributing factor to teenage pregnancy (UNICEF and SPC, 2011:21).

There has been a lot of donor and intergovernmental interest in addressing this issue and comprehensive sexuality education has been promoted across the Pacific in line with international commitments. However, it has been difficult for this programming to gain traction, with clear progress on implementing

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[22] *Underhill-Sem points out "the powerful have much more to lose, and in much of the Pacific men as a group are more powerful. Often, culture is called upon to support this status quo around unequal power relations, thus careful interventions are needed to ensure progressive social transformation." (2011:10)*

[23] *"There is no religious constraint to talking about sex when it is in relation to better physical and spiritual health," said Father Winston Halapua, Bishop of the Anglican Church, Dioceses of Polynesia (Vete, 2004). It is important to note that the now Archbishop Halapua is one of the more progressive senior clergy in the region, having recently called for the Anglican Church in the Pacific to discuss same-sex marriage (Halapua, 2013).*

Family Life Education largely confined to Fiji and Solomon Islands (NZPPD, 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: 30). 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, 2012:13). Anecdotal evidence backs up this assertion, as the relatively progressive Family Life curriculum in Fiji, which includes information on sexuality and equality, is undone when "teachers can be homophobic and bring in [their conservative] religious values, even to other parts of the curriculum" (Carling (SPC), interview, June 2013). 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.

Addressing teenage pregnancy and STIs

Young Pacific islanders have identified a lack of sex education as a leading cause of early pregnancy (see for example UNICEF and SPC, 2011:21).[24] "Teenage pregnancy" was identified as one of eight issues of critical concern for Pacific youth in the *State of Pacific Youth Report* of 2005, with "adolescent mothers" still identified as a disadvantaged group in the follow-up *State of Pacific Youth Report 2011* (McMurray, 2005; UNICEF and SPC, 2011). Early pregnancy is a concern for a number of reasons, including: the health impacts on mother and child[25]; 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 links to violence, both vulnerability to intimate partner violence after the birth (anecdotal evidence, McMurray, 2005:8), as well as coerced sex or rape. For example, 2007 statistics from the Marshall Islands show the highest rates of adolescent pregnancy, alongside "a high incidence of teenage forced sexual intercourse" in comparison to other Pacific Island countries (UNICEF and SPC, 2011:21).

The figures also speak to a broader socio-political and cultural context where young women are 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, 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: 142). Health workers may also prevent access to services (based more on age discrimination rather than disability) where a 16-year-old disabled woman would be perceived as "too young to be using family planning" (Spratt, 2013: 142-143).[26]

A lack of bodily autonomy for young Pacific island women also extends to how they can address a likely

[24] *Some of the discussions captured within the State of Pacific Youth Report (McMurray, 2005; UNICEF and SPC, 2011) may be problematic in that the simple equation of lack of sexuality education = teenage pregnancy may ignore the gendered power relations that govern young people's sexuality. However, many young women and men lacking basic information on how reproduction functions is clearly an important contributing factor to teenage pregnancy.*

[25] *According to the World Health Organisation, globally "adolescents aged less than 16 years face four times the risk of maternal death than women aged in their 20s, and the death rate of their neonates is about 50% higher" (Braine, 2009:410).*

[26] *They are not, however, too young to experience violations of bodily integrity and autonomy in the form of sexual violence. Between half and 60% of disabled women surveyed in Kiribati and the Solomon Islands were coerced or raped during their first sexual experience (Spratt, 2013)*

unintended and unwanted pregnancy.[27] As will be discussed in the next section, abortion is illegal in most Pacific Island countries or permitted only in very limited circumstances. Even where abortion may be 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 economic means to afford an abortion. 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 of Pacific island societies and, for young people, living in a small island state akin to Foucault's Panopticon, makes it near impossible to choose to safely abort a pregnancy.[28]

Similarly, limitations on bodily autonomy and integrity along with the lack of comprehensive sexuality education are affecting the rates of sexually transmitted infections amongst young Pacific islanders. Access to information is just the first hurdle – then there is how young people make decisions about when to have sex, how, and with whom. These decisions are gendered, affected by socio-economic status and security. Coordinator of the Pacific Sexual and Reproductive Health Research Centre, Avelina Rokoduru, describes the rates of STIs among young people in the region as "astronomical", with "low or no condom use" among many of the youth she has surveyed (interview, 6 June, 2013). Rokoduru also noted other general trends among young Pacific Islanders, based on her Centre's research around the region, such as very early sexual debut (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 combined with biases amongst providers that prevent or severely inhibit youth from accessing sexual health services.

> "Health workers themselves are bringing culture and religion into things [and] always make their own judgements about who should get access. So students and single persons – NO. 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)

Policy and implementation

Young people are a popular focus of regional and national policy, including in relation to SRH, however there has been very little headway towards realising the human rights of diverse Pacific young people. The draft *Pacific Youth Development Framework* (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)
- There is little understood about the impact of youth programmes and services – evaluation, monitoring and data collection remain poor

(SPC, 2013: 4)

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[27] *"Teenagers are more likely to report that their birth was unwanted compared with women over the age of 20 years" (UNICEF and SPC, 2011:20).*

[28] *In Samoa young women would often conceal their pregnancies until they were into their last trimester (though longer if possible) to avoid "punishment" (whether verbal, physical, emotional, mental etc.) and to avoid gossip especially and the detrimental effects this had upon their mental wellbeing. For example, a Masters thesis (from Malua Theological college) discussed excommunication from the Congregational Church in Samoa upon discovery of unwed pregnancy. So this concealment means they may not even attempt to access services during pregnancy until birth. (Faleatua, 2012)*

These critiques also apply to national-level responses to the SRHR 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, gender or age.

Recommendations

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 a static and discrete cultural form. This dichotomy allows the conservative argument that rights are 'modern' and foreign, as opposed to 'traditional' patriarchal cultural practices and Christian and other religious values. As HIV prevention advocate Steven Vete pointed out during a recent ICPD conference[29], the myth that it is against Pacific culture to talk about sex is "rubbish", as that is often the main topic of conversation at family gatherings, during communal work and casual kava sessions (personal observation, 14 August 2013; and Vete, 2004).

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 CSE should be made available in both formal and non-formal settings, for primary school age 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.

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* 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 people with disabilities, and Lesbian, Gay, Bisexual and Transgender (LGBT) young people" (SPC, 2013: 9)

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 the Fiji Women's Rights Movement, 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", that was started by a young woman who had faced discrimination as an unmarried mother (Talitha Project, 2010; Carling, interview, 31 May, 2013).

To summarise, achieving progress in young people's SRHR in the Pacific region requires:

1) Strengthening of current efforts to scale up comprehensive sexuality education for adolescents and youth within all countries in the Pacific. CSE curriculums must be "gender-sensitive, disability-friendly, evidence-based, context-specific and [acknowledging of] the evolving capacities of young people" (ARROW, 2012). Special attention should be paid to: a) the revision of content to include sexual and sexuality rights, b) training of educators to provide a safe and non-judgmental

[29] *Pacific Conference of Parliamentarians for Advocacy on ICPD Beyond 2014, 13-15 August 2013, Suva, Fiji.*

environment for youth to potentiate their SRHR and 3) widening access to CSE for out-of-school youth.

2) Improving availability and access to comprehensive SRH services for all adolescents and youth, including the provision of a range of contraceptives that include condoms, safe abortion and STI prevention and treatment services.
3) Training of health care providers to deliver SRH services without bias, discrimination or judgment, to create a stigma free health care environment, and to respect and protect the privacy and confidentiality of those seeking care.
4) Expansion of SRHR programming for youth by recognising and addressing the diversity of young people, specifically groups that are marginalised, such as young women and girls, young people with disabilities and lesbian, gay, bisexual, transgender, queer and intersex young people.
5) Promoting empowerment and SRHR initiatives by and for young women.

IV. THEME 3: Sexual and reproductive rights

Section A: Background

There are multiple sexual and reproductive rights 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 and gender identity, sex work and abortion. Widespread gender-based violence (GBV) throughout the Pacific needs urgent attention, particularly in light of principle 4 of the ICPD PoA (1994). Intimate partner violence (IPV) is highly prevalent, and can significantly reduce contraceptive use and result in a higher likelihood of unintended pregnancy and miscarriage (NZOPG, 2009:16; Narsey et. al, 2010:230; UNFPA, 2010:17). 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; NZOPG, 2009:16; UNFPA, 2010:7). Lesbian, gay, bisexual, transgender, intersex and queer persons, who may already be discriminated against in law are also targets of GBV. Similarly, sex workers are often targets of violence and continue to be formally discriminated against by the law. Finally, abortion in the Pacific remains taboo and thus little research exists on this area, particularly in terms of unsafe abortions (APA, 2008). These are all issues of bodily integrity and autonomy, particularly of women and girls, and must be addressed to progress towards full realisation and implementation of sexual and reproductive rights in the Pacific (Buadromo et. al, 2013).

Papua New Guinea has some of the highest rates of GBV, with 67% of women in rural areas and 56% in urban areas reporting physical abuse by a male partner. Severe violence is also seen in the torture and murder of alleged female 'sorcerers' (APA, 2008:21; Jalal, 2009:57, 73; Wilkinson and Walls, 2013). Gender based violence is a key driver of the HIV epidemic in PNG (Senanayake, 2011:1). Rates of violence are also unacceptably high in other parts of the Pacific, with over 60% of women in Fiji, Solomon Islands, Kiribati and Vanuatu having experienced physical and/or sexual violence (NZPGPD, 2012:1; FWCC, 2014). In Samoa, 46% of women experienced physical and/or sexual violence (SPC et. al, 2007), and in Tonga, 45% of women experienced physical and/or sexual and/or emotional violence (MFMF, 2009).

Jalal's study (2009) ranked specific countries' legislative compliance with CEDAW placing Fiji at 44%, Vanuatu and Samoa at 35%, Marshall Islands 34%, PNG and the Cook Islands at 24%, FSM and Kiribati 23%, Solomon Islands at 20%[30] and Tuvalu with the lowest compliance at 18%. Palau and Tonga have not yet ratified CEDAW.[31] In most Pacific countries, family law remains discriminatory against women. For example, divorce often cannot be obtained without proving fault, and this includes providing proof of habitual cruelty over 2-3 years (Jalal, 2009:8). Solomon Islands, Vanuatu, Cook Islands and Fiji have passed legislation that grants protection orders for married women (Narsey et. al, 2010). Samoa and Palau have also recently passed specific legislation allowing for protection orders for survivors of intimate partner violence (Gina Houng Lee, email communication, 14 August, 2013). While Fiji, Vanuatu and Marshall Islands have specific legislation for IPV, the remaining eleven[32] criminalise forms of sexual and physical violence within their penal or criminal law (Wilkinson and Walls, 2013:46). Every Pacific Island country has yet to implement comprehensive and integrated GBV legislation that covers its multiple forms and is in accordance with substantive equality standards (Narsey et. al,

[30] *The Solomon Islands made changes to their sexual assault legislation in July 2009 so their ranking has increased since this study (Narsey et. al, 2010:245).*

[31] *Palau has signed, but not ratified the Convention. Tonga has done neither, but in 2015 the Tongan Government finally committed to beginning the process towards ratification.*

[32] *Tonga, Samoa and the Cook Islands noted that their Crime Bills or Acts covered domestic violence (Wilkinson and Walls, 2013:46).*

2010:247). Consequently, addressing GBV through appropriate legislation remains an area requiring priority attention for Pacific governments. (Wilkinson and Walls, 2013:48). Finally, and of particular importance is PNG's Sorcery Act, which urgently needs to be repealed (Buadromo et. al, 2013).

Violence and discrimination based on sexual orientation and gender identity (SOGI) constitutes a significant problem across the Pacific (APF, 2010:6; Jalal, 2009b). The Marshall Islands, FSM, Nauru, Fiji, Palau, Samoa, Tuvalu and Vanuatu signed a joint statement at the UN Human Rights Council (UNHRC) in March 2011 against violence and human rights violations based on SOGI (UNAIDS, 2011)[33]. On 1 February 2010, with the reform of the Penal Code, Fiji became the first Pacific nation with colonial-era sodomy laws to legally allow consensual homosexuality (UNAIDS, 2010). The UNHRC Universal Periodic Review (UPR) led to international pressure on other Pacific countries to end their sodomy laws (UNAIDS, 2011). The UPR resulted in Palau and Nauru pledging to decriminalise homosexuality in their countries (UNAIDS, 2011). However, despite this pressure, Samoa, the Solomon Islands, Cook Islands, Kiribati, Tonga, Tuvalu and PNG all refused to reform their laws citing religious and cultural reasons for their decision (UNAIDS, 2011). A further 13 PICTs other than those mentioned do not criminalise private acts of homosexuality (UNAIDS, 2010; Jalal, 2009). There is silence within Pacific legislation regarding lesbian women, which Jalal argues may be the result of law systems not even 'contemplat[ing] the possibility' (2009:39). Finally, all Pacific Island countries, apart from Melanesian countries that recognise polygamy, articulate a lawful marriage as the union between one man and one woman (Jalal, 2009:40).

Very little research exists regarding the legal environments in which sex work and transactional sex operate in the Pacific (Godwin, 2012:173). Likewise, information about the role of sex work and statistical evidence constitutes a gap in written literature; however, anecdotal evidence indicates that many women, including transwomen, do exchange sex for goods, money or services throughout the region (COA, 2009:37; Bruce et. al, 2011; Godwin, 2012:173; McMillan and Worth, 2011). Some evidence suggests that concentrated epidemics of HIV exist among sex workers in PNG, highlighting the need for SRH services to be provided without discrimination (Bruce, et. al, 2011). One study undertaken in PNG in 2010 found that the prevalence of HIV was 17.6% in a sample of sex workers in Port Moresby (Kelly et. al, 2011:29).

Laws pertaining to sex work/transactional sex are greatly varied across the Pacific. Laws in countries and territories influenced by the USA, such as American Samoa, Palau, Marshall Islands, Northern Mariana Islands, Chuuk and Kosrae states of FSM, criminalise both sex work and those activities associated with it (Godwin, 2012). Former British colonies, such as the Cook Islands, Nauru, Niue, Kiribati, PNG, Tonga, Samoa, Tokelau, Solomon Islands and Tuvalu, only criminalise activities associated with sex work, including brothel-keeping, soliciting or living on earnings from sex work, but allow sex work in private (Godwin, 2012). Guam is the only Pacific state to have implemented regulations for addressing sexual health within the sex industry; contrary to this is Fiji's introduction of harsher penalties for those associated with the sex industry as of 2010 (Godwin, 2012:173-174).

Abortion is another taboo issue. However, while safe abortion and post abortion services are considered off-limits issues, many of those working in reproductive health across the region say that abortion attempts commonly occur regardless of its legal status (APA, 2008:31). National statistics are limited largely because social stigma, fear of legal action and strong religious beliefs prevent research and open discussion in Pacific communities regarding abortion. Hence an in-depth regional analysis is difficult (FPI et. al, 2009:32). Anecdotal evidence suggests that unsafe abortion may contribute significantly to maternal death and morbidity across the Pacific, including in PNG, which continues to have the highest

[33] *This is likely to be a result of a successful SOGI lobby at the HRC, rather than reflecting any change in policy towards SOGI rights back home in the Pacific*

maternal mortality rate in the region (FPI et. al, 2009; NZPGPD, 2012:19). Likewise, research reports that where contraceptive prevalence is low and adolescent fertility is high, there is a significantly higher risk factor for unsafe abortion (NZOPG, 2009:20). Several NGOs within the Pacific provide counselling and post-abortion care but must offer these services clandestinely because of legal ramifications for such actions (NZPGPD, 2012:19).

Before considering laws pertaining to abortion in the Pacific, it is important to acknowledge that there is a gap in information and research regarding legislation on this issue, medical policy and grassroots approaches in actuality (Jalal, 2009). Apart from the Marshall Islands and three states of FSM[34], abortion is specifically illegal in PICTs with penalties for women procuring abortion ranging from two years in Vanuatu to seven years in most of the Pacific through to life imprisonment in Kiribati (Jalal, 2009:71). While it is illegal, legislation and/or courts in most countries have implemented defences to charges of abortion: all fourteen countries permit abortion to save the mother's life; nine[35] allow it for preservation of the mother's physical and mental health (APA, 2009:31; Jalal, 2009). Of those countries that have outlawed abortion, only the Cook Islands and Fiji specifically allow it in cases of rape (NZOPG, 2009:20; APA, 2008:31).

Section B: Assessment

Context

Discussions during the recent Pacific Conference of Parliamentarians for Advocacy on ICPD beyond 2014, held in Fiji in August 2013, indicate that conservatism still dominates Pacific politics when it comes to sexual and reproductive rights (personal observation, Suva, 14 August 2013). The Parliamentarians, who came from 13 Pacific island countries, appeared to conform to the standard political approach to SRHR in the region – they were fairly vocal on sexual and reproductive health, but reticent on reproductive rights and silent on sexual rights.[36] There are SRHR 'champions' though, such as member of the High-Level Task Force for ICPD, Dame Carol Kidu, 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. However, she is no longer a sitting Parliamentarian, having retired from PNG politics in 2012.

Gender-based violence

When it comes to gender-based violence, the sheer scale of the problem along with sustained advocacy by women's groups on this issue has made Pacific leaders more willing to engage. A major turning point in terms of regional policy occurred in 2009, during the 40th Pacific Island Forum Leaders meeting in Cairns, when sexual violence and other forms of GBV were recognised as both pervasive and under-reported across the Pacific. Leaders committed to addressing it at a regional level through the Pacific Leaders Declaration on Sexual and Gender Based Violence (2010) (Narsey et. al, 2010:243; FPI et. al, 2009:30). In 2010, the Pacific Regional Rights Resource Team received funding from the UNIFEM Trust Fund to implement a project aimed at improving legislation to protect women from violence (Narsey et. al, 2010:251).[37] Existing Pacific State commitments to gender equality are also pertinent,

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[34] *These are Kosrae, Pohnpei and Yap (Jalal, 2009:71).*

[35] *These are Fiji, Cook Islands, Marshall Islands, FSM, Nauru, Niue, PNG, Samoa and Vanuatu (Jalal, 2009).*

[36] *For example, following the Pacific feminist presentation on sexual rights by DAWN's Dr Claire Slatter, there was complete silence on the part of the Parliamentary delegates. The only comments or questions came from former Parliamentarians, advocates and UN staff (personal observation, 14 August 2013). While closer analysis may identify Parliamentarians who are more interested in addressing SRHR, clearly it is still considered such a controversial issue that they are not comfortable discussing it in a public forum.*

[37] *RRRT implemented training using a legislative lobbying toolkit produced in partnership with the Fiji Women's Rights Movement, which included lessons learned from the 13-year successful lobby for Fiji's progressive Family Law Act (2003) (Bernklau et. al (eds), 2010).*

including the Pacific Leaders Declaration on Gender Equality (2012), along with the Regional Action Plan on Women, Peace and Security (2012).

Also in 2012, the Australian Government announced the Pacific Women Shaping Pacific Development (PWSPD) initiative, an additional AUD320 million over 10 years towards addressing gender inequality in the Pacific island region (AusAID, 2013). PWSPD will include programmes for "more domestic violence legislation... better access to medical services, counselling, safe shelters, and justice", but has no specific mention of SRHR among its three key areas (AusAID, 2013). While women's rights activists have welcomed the funding commitment, there are concerns about what the PWSPD initiative will look like going forward, given recent cuts to the Australian aid budget.[38] Funds were reallocated towards various measures to deal with asylum seekers, including the controversial return of the "Pacific Solution", housing Australian asylum seekers in PNG and Nauru (www.refugeeaction.org.au).[39]The Australian Council for International Development (ACFID) estimates that the reallocation of funds in December 2012 "had a principle or significant impact on women" as 61 per cent of the diverted funds went to women or gender equality related programming (ACFID, 2013:10). While ACFID notes that PWSPD itself continues to be funded in the aid budget, it is unclear if or how funds earmarked for gender equality programming will be restored (ACFID, 2013: 10, 12).[40]

At the forefront of those working against GBV, especially IPV, is the Pacific Women's Network against Violence against Women, which was formed by the Fiji Women's Crisis Centre in 1992, and now includes 23 organisations across 10 countries (Jalal, 2009:64). Meanwhile, specific national programmes targeting IPV through the police force in Samoa, Tonga, Kiribati, Vanuatu and the Cook Islands have been implemented with the support of NZ Police Mentors (Wilkinson and Walls, 2013:251). UNFPA, which has a gender advisor at its Pacific sub-regional office, is working "to strengthen the capacities of health sectors to respond efficaciously to gender-based violence".[41] This work joins other attempts to address the gap between human rights based approaches to GBV and the health sector (particularly SRH providers). This gap exists not just at the policy level, but also at the level of lobbying and advocacy, where women's rights organisations have made (in some cases considerable) headway in improving legislative and to some extent law enforcement responses to violence against women, but with arguably less focus on the role of the public health system. This generalisation may not hold up in every case,[42] but Rokoduru (interview, 6 June 2013) suggests there is still a lot of work to be done with health care professionals, who have struggled with the reframing of GBV as a public health issue in recent years.

Sexual orientation and gender identity

While addressing gender based violence is the most prominent women's rights issue at the regional level, unpacking the patriarchal power hierarchies that nurture this violence, and looking closer at the

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[38] "In December 2012 the Federal Government announced cuts and deferrals of AU $375.1 million from the Australian aid program, redirecting funds earmarked for overseas poverty alleviation to pay for the costs of the domestic asylum seeker program, including mandatory detention costs" (ACFID, 2013b:1).

[39] Officially known as the Regional Resettlement Arrangement (RRA) (Accessed from www.refugeeaction.org.au on16 August 2013).

[40] The region also has the Pacific Trust Fund to End Violence against Women, supported by AusAID, which disperses small grants to organisations around the region. (Ellsberg et. al, 2012:viii).

[41] UNFPA website (Accessed from http://asiapacific.unfpa.org/public/pid/6770 on14 August, 2013).

[42] There have been efforts made in PNG to address survivors' needs through the development of various policies and protocols, with the recognition of violence against women as a health issue by the Ministry of Health. PNG has also led the way in the Pacific in terms of developing a more integrated response to GBV and HIV. However, lack of sustainability of these initiatives, a "collapsing health service" and complex local bureaucracies, situated in a patriarchal cultural context where health service providers' bias affects treatment, has taken away from the impact (UNFPA, 2010b: 42-55).

links between GBV and SRHR is less popular.[43] This is particularly so when looking at GBV in relation to sexual orientation and gender identity, and the marginalisation of lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) persons. DAWN's Claire Slatter, speaking to Pacific Parliamentarians at the ICPD Beyond 2014 conference in Fiji in August 2013, reiterated the earlier call from Pacific feminists for the 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 stigmatised, 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 criminalised and homophobic hate crimes occur." (Buadromo et. al, 2013 in Slatter, 2013:2)

In the struggle for sexual rights, it is not just public policy spaces, law enforcement and conservative island communities that are hostile to LGBTQI persons – some of those working in women's rights also often find it hard to deal with sexuality. For example, the Fiji Women's Forum, a group of women leaders working towards democracy in Fiji, included transwomen from its inaugural gathering in a quietly radical reframing of what it means to be a Fijian woman.[44] However, the space was not always comfortable for trans and lesbian women, 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 reverberates from law to health policy, church pulpits, and down to women's own sense of self. Etta Tuitoga of Diverse Voices in Action (DIVA) for Equality, describes how many of the women whom she works with had a hard time talking about vaginas or masturbation, even though they were women who have sex with women and were in a safe space: "They were ashamed to talk about it - [talking about it] was something new for them" (interview, 4 June 2013). These women found it very difficult to acknowledge themselves as sexual beings, even among other women like them. The experiences of the Fijian lesbian women associated with DIVA also show how poverty, class, race/ethnicity, geography, age, gender and sexuality intersect to marginalise particular bodies and groups of persons. For example, there are cases where "15 to 20 [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" (Tuitoga, interview, 4 June 2013).

These women find it very difficult to access health care, particularly when it comes to sexual or reproductive health: "For example, a young [lesbian] woman, 21, comes from a poor family… she's ashamed to go to the clinic, because she's got a partner… the fear of the community looking down on you, it stops her" (Tuitoga, interview, 4 June 2013). This fear of overt discrimination and shaming can prevent LGBTQI persons from seeking medical help, even when the condition is very serious and painful. For these women, the fear mongering by religious fundamentalists about the spectre of gay

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[43] *There are some programmes making these links though, such as "Stepping Stones, an educational program that fosters gender equality and sexual and reproductive health through community participation and decision-making" (Ellsberg et. al, 2012:x).*

[44] *The outcomes statement of the inaugural Fiji Women's Forum began with the assertion of diversity: "our women speak with voices that represent women with disabilities and living with HIV, as well as different faiths, cultures,* ***sexualities, gender identities****, ages, demographics and opinions." (FWF, 2012; emphasis added)*

marriage in the Pacific is unfounded.[45] "Marriage equality – it's not an issue for us. First we want access to health services" (Shirley Tagi, 4 June 2013). DIVA's Shirley Tagi explains further how socio-economic class can be a more important determining factor in accessing services; it's when poverty and sexuality intersect that the most extreme discrimination occurs: "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, it's double or triple the discrimination" (interview, 4 June 2013).

However, there has been some traction with raising sexual orientation and gender identity issues as part of the discourse surrounding regional and national efforts to prevent HIV/AIDS. The efforts of agencies such as UNAIDS, UNFPA, and SPC, and the proliferation of HIV strategies, national committees and organisations at the regional and national level has 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, and sex workers. While these groups remain on the margins, and face widespread discrimination, they have been the targets and more recently the co-developers of HIV prevention programming. However, as was earlier noted and as Noelene Nabulivou pointed out, the large amounts of money that flowed into the region to address HIV also helped create problematic "movement hierarchies" within the SRHR lobby (interview, 21 May 2013). These hierarchies helped raise the profile of MSM issues, but may have further submerged the needs of lesbian and bisexual women, and transmen. Also, within HIV-related discourse, transwomen are only associated with sex work, which then hides other concerns – such as education, housing and racism – that efforts like condom distribution cannot meet.

Sex workers

Despite this focus on sex workers through HIV advocacy, they remain a group largely excluded from policy-making or access to SRH services. Very little headway has been made in realising the rights of diverse persons engaged in sex work, as these groups remain controversial both within the context of conservative, largely Christian Pacific societies and within parts of the women's movement. For many within the women's movement, it is still challenging to take on the SRHR movement's framing of sex work as work, rather than as prostitution and a form of violence against women.[46] 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. In Fiji, the new Crimes Decree (2009)[47] worsened the situation for sex workers – instead of decriminalising sex work, as recommended under CEDAW, the then military government criminalised clients and brothels, in addition to the sex workers themselves (McMillan and Worth, 2011:7-8). Following the Decree, media coverage centred on police crackdowns against prostitution and sex workers continued to be chased and harassed or arrested for carrying condoms. They also faced harassment and more severe violence by the military, including illegal detention, public humiliation, and physical and mental abuse, including sexual assault, amounting to torture (McMillan and Worth, 2011:15-17).

Abortion

While work on HIV in the Pacific has resulted in some research on the hidden lives of sex workers, abortion remains under-researched and under cover. Here again, the conservative interpretations of culture and religion that dominate Pacific island politics and societies are a barrier to achieving sexual

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[45] *"In June 2005 there was a public march denouncing gay marriage organised by the Methodist Church in Fiji despite the fact that there has been no call by the Fiji LGBT for same sex marriage." (Jalal, 2005:12)*

[46] *For example, the Fiji Women's Crisis Centre, while criticising the criminalising of sex procurement in Fiji, framed their argument in terms of prostitution: "Nowhere in the world where prostitution has been criminalised in this manner has prostitution gone away. I believe that we'd be better served if we address the issue of gender inequalities, looked at women's education, looked at women's economic empowerment. I believe those are things that will help get rid of prostitution." (Ali, 2010).*

[47] *It is worth noting that this same Decree (2009) decriminalised homosexuality.*

and reproductive rights, including the right to bodily autonomy. Even where women participate in national politics, this is no guarantee that women's sexual and reproductive rights will also be raised, as these women are attempting to claim power in their patriarchal contexts. For example, during 2010 campaigning in Tonga, a woman political leader, "Linda Ma'u, a candidate for the Tongatapu No. 4 constituency 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" (Tonga, 2010). In Samoa, following calls to legalise abortion particularly in the case of rape, a church leader said "that should abortion be legalised, people would simply use it as a chance to make money" (RNZI, 2009).

In Fiji, there is a lack of clarity around possible interpretations of the abortion section in the 2009 Crimes Decree, and whether it has regressed rights to bodily autonomy. As with abortion law in other parts of the world, interpretation can expand or narrow rights further. Anecdotal evidence suggests that it is being conservatively interpreted and enforced on the ground, making legal abortion difficult to access. 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. Given women's experiences in the region, Pacific island countries must take action "to expand women's reproductive choices to include safe and legal abortion" (Spratt, 2013: 44).

Recommendations

A **loose coalition of Pacific feminists** is taking on these difficult sexual and reproductive rights 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, the Fiji Women's Rights Movement, Punanga Tauturu in the Cook Islands, DIVA 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, with an outcomes statement that set the agenda for the work of the coalition: "Pacific Feminists and Activists: Re-framing, Re-articulating and Re-energising Sexual and Reproductive Health and Rights!" (Buadromo et. al, 2013). Rights to legal and safe abortion, the decriminalisation of homosexuality and recognition of the full rights of diverse LGBTQI persons, and the decriminalisation of sex work, were among the urgent and immediate calls to action in the statement (Buadromo et. al, 2013:3-4). Other SRHR best practice examples from the Pacific include DIVA's "Free School", a collective learning space for marginalised lesbian women (Tuitoga and Tagi, interview, 4 June, 2013).

However, there are still many gaps in addressing SRHR concerns, particularly at the intersections of economy, ecology and the body. The sexual and reproductive rights issues in relation to **extractive industries** in the Pacific island region need to be further researched and built into feminist advocacy on SRHR. This is of particular concern in PNG, Bougainville, Fiji and the Solomon Islands, where large-scale extraction is already taking place. Extractive industries have played a significant role in conflicts in these countries, particularly in Bougainville, where it sparked an armed conflict that also played out on women's bodies.

Further work could also be done on the **sexuality of persons with disabilities**, and how disability intersects with socio-economic class and gender to affect the realisation of SRHR. 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).

SOGI rights will need strong champions at the regional level to make some headway. 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.

And there is an urgent unmet need for **research on abortion in the Pacific**, which explores associations with teenage pregnancy, maternal health, CSE, and the provision of SRH 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 SRH, it is too controversial to discuss openly, and for rights activists, there is too little information to build an effective lobby around.

To summarise, recommendations for upholding the sexual and reproductive rights of individuals in the Pacific with respect to the issues under discussion include:

1) Review, amend and promote legislation to address all forms of GBV to ensure protection, safety and security of individuals.
2) Identify and mobilise regional champions for rights in relation to sexual orientation and gender identity as a move towards increasing inclusion, freedom and security of minority groups.
3) Mobilise SRHR advocates to amend restrictive abortion laws in the region that limit the reproductive rights of girls and women.
4) Strengthen efforts to gain formal equality for sex workers by decriminalising sex work in accordance with international human rights standards.
5) Improve research and data collection on all issues within the domain of sexual and reproductive health rights, including abortion and the sexualities and SRH needs of LGBTQI and persons with disabilities, which can aid future advocacy and action.

V. CONCLUSION

The struggle for sexual and reproductive health and rights is hugely contested and sits on constantly shifting ground, both in the Pacific region and as regards the Pacific's role in the global arena. Since this research was first conducted between June and August 2013, there have been significant developments. The Pacific Island region has strengthened its reputation for being progressive and steadfast on sexual and reproductive health and rights in Asia Pacific and global negotiations on women's human rights. Strong partnerships between Pacific civil society groups and their Pacific government representatives in these regional and global intergovernmental spaces, have contributed to a 'Pacific wave' for SRHR, addressing climate change and women's rights. Those working in these spaces have begun to see the strong links between these areas of rights, bringing in discussions around climate change to negotiations on related women's human rights. The Pacific has played a particularly important role in recent ICPD+20 and Beijing+20 processes, as well as the ongoing negotiations around the post-2015 development agenda and the Sustainable Development Goals.

However, there are some serious challenges to these recent positive developments. Firstly, the opposition to Pacific advocacy on SRHR in global spaces is well organised and skilled. Secondly, Pacific governments still find it very difficult to tackle SRHR issues back at home and translate these global and regional commitments into national policy, legislation and implementation. This latter challenge is a real barrier to transforming the lives of Pacific women and their families for the better. Pacific people do have the solutions though, and Pacific feminist and women's movements continue to collaborate, organise and strategise towards change. They are making headway and will continue to push until they can bring that Pacific wave all the way back to our own island shores.

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