ICPD+25 Shadow Report

Amplifying and accelerating action on young people's SRHR

LARA COUSINS

RIGHT HERE
RIGHT NOW

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RIGHT NOW

Right Here Right Now (RHRN) is a five-year programme and global strategic partnership that is active in ten countries, and the Caribbean sub region. Our partnership envisions a world where all young people are able to access quality and youth-friendly health services, and are not afraid to openly express who they are and who they love. We believe that young people, everywhere, have the inalienable right to make their own choices, and lead happy and healthy lives.

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Right Here Right Now is being implemented globally by a consortium of eight organisations: Rutgers, HIVOS, dance4life, CHOICE for Youth and Sexuality, International Planned Parenthood Federation Africa Region, the Asian-Pacific Resource and Research Centre of Women, the Latin American and Caribbean Women's Health Network, and the Ministry of Foreign Affairs of the Netherlands. It is coordinated by Rutgers.

Rutgers For sexual and reproductive health and rights
Latin American and Caribbean Women's Health Network - LACWHN
arrow
CHOICE FOR YOUTH & SEXUALITY
dance4life
IPPF International Planned Parenthood Federation Africa Region
Hivos people unlimited
Ministry of Foreign Affairs of the Netherlands

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Introduction

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RIGHT HERE RIGHT NOW: BACKGROUND

Right Here Right Now (RHRN)[1] is a five-year programme and global strategic partnership active in ten countries (Bangladesh, Nepal, Indonesia, Pakistan, Kenya, Uganda, Zimbabwe, Senegal, Honduras, Bolivia), and the Caribbean sub-region. Our partnership envisions a world where all young people are able to access quality and youth-friendly health services, and are not afraid to openly express who they are and who they love. We believe that young people, everywhere, have the inalienable right to make their own choices, and lead happy and healthy lives.

In this respect, our partnership strives for the following impact across Africa, Asia, and Latin America:

- The protection, respect and fulfilment of the sexual and reproductive health and rights (SRHR) of young people, including girls, young women and young lesbians, gays, bisexuals, transgender and intersex (LGBTI) individuals, with a focus on:
  - Freedom from stigma, discrimination and violence;
  - Access to comprehensive youth-friendly services;
  - Access to comprehensive information and education on sexuality; and
  - Space for young people's voices.

The RHRN partnership engages in advocacy at national, regional and international levels, in order to ensure progressive and inclusive SRHR norms, standards and policies and to promote accountability. Monitoring, follow-up and review of the 1994 Programme of Action of the International *Conference on Population and Development (ICPD)* is one of the key processes that RHRN follows and influences.

ICPD BEYOND 2014 AND RHRN PRIORITY AREAS

In 1994, 179 governments worldwide met in Cairo, Egypt and adopted the groundbreaking ICPD Programme of Action, positioning human rights at the centre of sustainable development, and recognizing reproductive rights as human rights, as well as young people and adolescents as rights holders in regards to their sexual and reproductive health (SRH). Moreover, in upholding that the full enjoyment of reproductive health implies that "people are able to have a satisfying and safe sex life,"[2] The ICPD Programme of Action reinforced a holistic understanding of individuals' sexual and reproductive wellbeing, accounting not only for the right to be free from abuse or violations, but the right to experience one's sexuality in a fulfilling, satisfying, and in turn pleasurable way.

20 years on, in reviewing achieved progress and challenges in relation to the implementation of the ICPD Programme of Action, governments reaffirmed the enduring significance of the ICPD, advancing the paradigmatic shift sparked at Cairo through regional ICPD Beyond 2014 agreements. In these agreements, governments recognized

1. The RHRN consortium consists of Rutgers (lead), the Asian-Pacific Resource and Research Centre for Women (ARROW), CHOICE for Youth and Sexuality, dance4life, International Planned Parenthood Federation (IPPF) Africa Region, Hivos and the Latin American and Caribbean Women's Health Network (LACWHN).

2. United Nations (1994), *Report of the International Conference on Population and Development*, A/CONF.171/13, www.un.org/popin/icpd/conference/offeng/poa.html, para. 7.2.

that though significant progress had been made over the previous 20 years, such progress had not been universal, and severe inequalities persisted. In addition, there are still key issues that require further attention and action, in order to ensure that the needs and rights of all individuals are met. As such, in regional agreements such as the *Asian and Pacific Ministerial Declaration on Population and Development*, the *Addis Ababa Declaration on Population and Development in Africa Beyond 2014*, and the *Montevideo Consensus on Population and Development*, governments built upon and strengthened previous commitments included in the original ICPD Programme of Action. Notably, governments strengthened their commitments in relation to RHRN priority areas, namely on:

- **Comprehensive sexuality education (CSE):**[3,4,5] Governments across the three regions made commitments related to national policy and implementation of CSE, including commitments to ensure that CSE provides "accurate information on human sexuality, gender equality, human rights, and sexual and reproductive health;"[6] that these programmes are consistent with young people's evolving capacities; to implement such programmes both in and out of school; to link CSE programmes with the provision of SRH services; and that implementation be participatory and include the active involvement of young people themselves.
- **Adolescents' and young people's access to youth-friendly SRH services:**[7,8,9] Governments similarly made commitments regarding national policy, financing and implementation of adolescent SRH services. Among these commitments are achieving universal access to SRH services with particular attention to adolescents' and young people's needs; that such services be implemented with a gender, human rights, intergenerational and intercultural perspective, and respect young people's confidentiality and privacy; ending practices that violate women and adolescent girls' rights, such as parental or marital consent requirements to obtain health services; and that such services should enable adolescents and young people "to have a responsible, pleasurable and healthy sex life" and "to take free, informed and responsible decisions regarding their sexual and reproductive life and the exercise of their sexual orientation."[10]
- **Access to safe abortion services**,[11,12,13] where governments made commitments in relation to national law, policy and implementation. These include realizing universal access to the management of preventable complications arising from unsafe abortion; ensuring in cases where abortion is decriminalized the availability of safe, comprehensive, and quality abortion services; and for States to amend "their laws, regulations, strategies and public policies relating to the voluntary termination of pregnancy in order to protect the lives and health of women and adolescent girls [and] improve their quality of life."[14]
- **Respecting, protecting, and fulfilling the rights of LGBTI individuals,**[15,16,17] for which commitments include promoting "policies that enable persons to exercise their sexual rights, which embrace the right to a safe and full sex life, as well as the right to take free, informed, voluntary and responsible decisions on their sexuality, sexual orientation and gender identity;"[18] promulgating and enforcing "laws to prevent and punish any kind of hate crimes without distinction of any kind, and take active steps to protect all persons from discrimination, stigmatization and violence;"[19] and eliminating discrimination based on sexual orientation and gender identity.

3. United Nations Economic Commission for Africa (ECA) (2013), *Addis Ababa Declaration on Population and Development in Africa Beyond 2014*, ECA/ICPD/MIN/2013/4, www.unfpa.org/sites/default/files/resource-pdf/addis_declaration_english_final_e1351225_1.pdf, paras. 40, 42, 44.
4. United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) (2014), *Report of the Sixth Asian and Pacific Population Conference*, www.unescap.org/sites/default/files/SDD_PUB_APPC6-Report-20140403.pdf, paras. 79, 110, 113, 118, 122, 126, 145, 146.
5. United Nations Economic Commission for Latin America and the Caribbean (ECLAC) (2013), *Montevideo Consensus on Population and Development*, https://repositorio.cepal.org/bitstream/handle/11362/21860/4/S20131039_en.pdf, paras. 11, 14, 40, 59, 122.
6. United Nations ESCAP (2014), *Report of the Sixth Asian and Pacific Population Conference*, para. 146.
7. United Nations ECA (2013), paras. 34, 36, 37, 42, 43, 44.
8. United Nations ESCAP (2014), *Report of the Sixth Asian and Pacific Population Conference*, paras. 75, 78, 79, 109, 110, 112, 116, 118, 122, 123, 126, 144, 145.
9. United Nations ECLAC (2013), paras. 12, 14, 15, 34, 37, 40, 44, 46, 59.
10. Ibid, para. 12.
11. United Nations ECA (2013), paras. 37, 38.
12. United Nations ESCAP (2014), *Report of the Sixth Asian and Pacific Population Conference*, paras. 118, 132.
13. United Nations ECLAC (2013), paras. 40, 42.
14. Ibid, para. 42.
15. United Nations ECA (2013), paras. 4, 18, 34, 35.
16. United Nations ESCAP (2014), *Report of the Sixth Asian and Pacific Population Conference*, paras. 76, 84.
17. United Nations ECLAC (2013), paras. 7, 33, 34, 36, 57.
18. Ibid, para. 34.
19. United Nations ECA (2013), para. 18.

OBJECTIVE AND SCOPE OF THE REPORT

2019 will mark 25 years from when governments first made their historic commitments in Cairo. To dive deeper into the progress made and the remaining gaps in implementation, the following report explores some of the progressive and regressive trends at country, regional and global levels, in relation to the above thematic areas, and particularly in relation to national law, policy, and implementation. Our objective in developing this report is to highlight the critical importance of ICPD+25 review processes addressing the SRHR issues often overlooked and/or left at the margins, namely CSE, youth-friendly SRH services, safe and legal abortion, and LGBTI rights.

Overall, some notable steps have been taken at national, regional, and global levels in relation to these issues; however, these efforts need to be amplified and accelerated. Across different countries and regions, adolescent girls and boys continue to face numerous policy, social, cultural, gender and legal barriers that hinder their ability to realize their SRHR. In many cases, a lack of political will and investment in these most neglected SRHR issues has stalled progress,[20] and is keeping us from achieving the ICPD Beyond 2014 agreements, as well as other commitments such as the *2030 Agenda for Sustainable Development*. We are also seeing pushback and/or backlash regarding young people's SRHR, particularly in regards to these more "taboo" issues listed above, indicating the often-politicized nature of SRHR and young people's health, which further impedes progress and, in some cases, even threatens regression. Meaningful youth participation in policy formulation and implementation, moreover, particularly beyond tokenism, remains a cross-cutting challenge at national, regional, and global levels.

Young people's rights, including their sexual and reproductive rights, are not up for debate. It is therefore critical that both within and beyond ICPD+25 review processes governments not only reaffirm their commitments, but also adopt a proactive, enthusiastic, and holistic approach to progressive policy formulation, implementation, and increased resource allocation. This approach also requires vigilance for any pushback attempts to dilute the agreements outlined either in the ICPD Beyond 2014 framework, or in other human rights commitments. For this, reinforced political will and investment are crucial. This approach, moreover, must be undertaken with the meaningful involvement of young people, as part of recognizing them as rights holders themselves, and in order to effectively understand, address and resolve the barriers they face in regards to their SRHR. This in turn will help ensure that policies, programmes, and services are both reflective of and responsive to young people's realities, and in achieving the vision of the ICPD agenda.

REPORT STRUCTURE

The report is structured as follows:

- one section providing a **global level analysis** of significant trends on RHRN thematic issues;
- **one regional analysis per RHRN region** (Asia-Pacific, Africa, and Latin America and the Caribbean);
- as well as **national-level analyses** per RHRN country in those regions. For each country, two or three of the above-mentioned RHRN thematic areas will be zoomed into in line with the priorities in those countries.

The report also includes global, regional and national recommendations for ways to maintain and further advance ICPD Beyond 2014 commitments in relation to these critical themes, in order to fully realize the health, rights, and wellbeing of adolescents and young people, and their ability to exercise informed and meaningful decision-making power throughout their lives.

20. Starrs, Ann M. et al (2018), "Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission," *The Lancet* (391): 2642-2692, www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf, p. 2642.

Global Level Analysis

SRHR SNAPSHOT

Young people aged 10-24

1.8 billion

comprise of the world's population, **90%** of whom live in developing countries.[21]

Approximately

16 million

girls aged 15-19 years old and

2.5 million

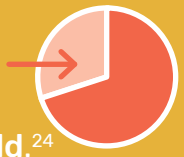
girls under 16 years old give birth each year in developing regions.[22]

Complications during pregnancy and childbirth remain the leading cause of death for **girls aged 15-19 years old**.[23]

In 2016 alone, **610,000** **young people between 15-24 years old** were newly infected with HIV, of whom

260,000

were **adolescents aged 15-19 years old.**[24]

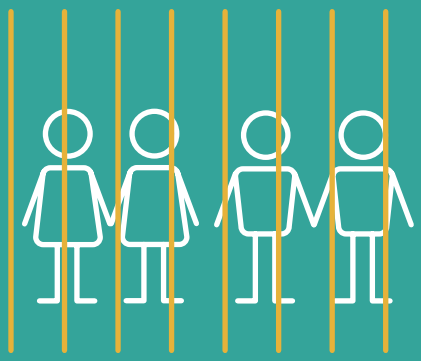


Roughly

3.9 million

girls aged 15-19 years undergo unsafe abortions annually.[25]

Same-sex relationships remain criminalized in approximately 70 countries around the world.[26]



21. United Nations Populations Fund (UNFPA) (2013), *Adolescent and Youth Demographics: A Brief Overview*, www.unfpa.org/sites/default/files/resource-pdf/One pager on youth demographics GF.pdf
22. World Health Organization (WHO) (2018), *Adolescent Pregnancy*, www.who.int/en/news-room/fact-sheets/detail/adolescent-pregnancy.
23. Ibid.
24. Ibid.
25. United Nations International Children's Emergency Fund (UNICEF) (2018), *Turning the Tide Against AIDS Will Require More Concentrated Focus on Adolescents and Young People*, https://data.unicef.org/topic/hivaids/adolescents-young-people/.
26. Carroll, Aengus and Lucas Ramón Mendos (2017), *State Sponsored Homophobia 2017: A World Survey of Sexual Orientation Laws: Criminalization, Protection and Recognition*, Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), https://ilga.org/downloads/2017/ILGA_State_Sponsored_Homophobia_2017_WEB.pdf , p. 8.

Sexual and reproductive health and rights (SRHR) are not "new rights" – they are in fact a set of existing civil, political, economic, social and cultural human rights that are already recognized in national laws and international Human Rights treaties ratified by governments worldwide.[27] These Human Rights treaties and associated commitments include but are not limited to:[28,29]

- the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, which outlines the right of all people to the highest attainable standard of health (Art. 12);
- the *International Covenant on Civil and Political Rights (ICCPR)*, which includes all people's right to life (Art. 6), self-determination (Art. 1), and to not be subjected to torture or to cruel, inhuman or degrading treatment (Art. 7);
- the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)*, which upholds Art. 7 of the ICCPR, while also outlining torture to be any act inflicting severe pain or suffering (either physical or mental) based on discrimination of any kind, "when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" (Art. 1);
- the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, which includes commitments regarding realizing women's equal access and opportunities in political and public life including health and education (Art. 7, 10, 12), women's access to SRH services (Art. 12), and ending gender stereotypes (Art. 5);
- the *Convention on the Rights of the Child (CRC)*, which upholds children and adolescents' right to the highest attainable standard of health (Art. 24) and education (Art. 28), among others; and
- the *Convention on the Rights of Persons with Disabilities (CRPD)*, which affirms the right of persons with disabilities to sexual and reproductive health (Art. 25).

SRHR, in specific reproductive rights, were first recognized as existing human rights by governments at the 1994 ICPD. Since then, this recognition has evolved through elaborations and comments by various Human Rights committees overseeing the implementation of the above Human Rights treaties and instruments, as well as by other Human Rights bodies; and through regional human rights instruments, such as Article 14 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)*.

As such, there is a useful global framework in place regarding SRHR, reinforced by the above HR treaties as well as international consensus documents, such as the 1994 ICPD Programme of Action, the 1995 *Beijing Declaration and Platform for Action* and most recently the *2030 Agenda for Sustainable Development*. Yet while notable progress has been made worldwide in regards to RHRN issues, such progress "has been stymied because of weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively."[30] In effect, in order to accelerate progress there is a need to adopt a more comprehensive, holistic view of SRHR, which involves tackling neglected issues such as adolescent sexuality, abortion, and diversity in sexual orientations and gender identities and expression (SOGIE),[31] as articulated by the Guttmacher-Lancet Commission in the box on page 10.

COMPREHENSIVE SEXUALITY EDUCATION (CSE)

The ICPD Beyond 2014 Review noted the increasing evidence in support of the benefits and value of CSE, recommending that:

> *States should recognize that CSE, consistent with the evolving capacities of young people both in and out of school, is essential to enable them to protect themselves from unwanted pregnancy, HIV and sexually transmitted infections; to promote values of tolerance, mutual respect and non-violence in relationships; and to plan their lives. States should design and implement CSE programmes that provide accurate information, taking into account scientific data and evidence about human sexuality, including growth and development,*

27. UNFPA et al (2014), *Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions*, www.ohchr.org/Documents/Publications/NHRIHandbook.pdf, p. 21.
28. Ibid.
29. Asian-Pacific Resource and Research Centre for Women (ARROW) (2016), *Universal Access to Sexual and Reproductive Health and Rights in Asia: A Regional Profile, Kuala Lumpur: ARROW*, http://arrow.org.my/wp-content/uploads/2016/10/Regional-Profile-Universal-Access-to-SRHR_Asia.pdf, p. 9-10.
30. Starrs, Ann M. et al (2018), p. 2642.
31. Ibid.

A COMPREHENSIVE AND HOLISTIC VIEW OF SRHR

"Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence."

Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission, p. 2646.

anatomy and physiology; reproduction, pregnancy and childbirth; contraception; HIV and sexually transmitted infections; family life and interpersonal relationships; culture and sexuality; human rights protection, fulfilment and empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual abuse, gender-based violence and harmful practices; as well as youth-friendly programmes to explore values, attitudes and norms concerning sexual and social relationships; promote the acquisition of skills and encourage young people to assume responsibility for their own behaviour and to respect the rights of others; are gender-sensitive and life-skills-based; and provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality.[32]

Since 2014, there has been growing international agreement on the importance of CSE, supported by evidence. In 2018 the United Nations Educational, Scientific and Cultural Organization (UNESCO) launched the revised edition of the *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach*,[33] supported by UN Women, UNAIDS, the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF) and United Nations Population Fund (UNFPA). This guidance confirms in its evidence review that the provision of sexuality education does not result in an increase of sexual activity, sexual risk-taking behaviour or STI/HIV infection rates. Rather, using a rights-based approach in CSE programmes leads to positive effects such as increasing young people's knowledge and improving their attitudes and

32. United Nations (2014), *Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014: Report of the Secretary-General*, A/69/62, www.unfpa.org/sites/default/files/pub-pdf/ICPD_beyond2014_EN.pdf, para. 347.

33. United Nations Educational, Scientific and Cultural Organization (UNESCO) et al (2018), *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach*, Paris: UNESCO, http://unesdoc.unesco.org/images/0026/002607/260770e.pdf.

skills related to SRH, as well as significant longer-term effects regarding psychosocial and some behavioural outcomes. There has also been mounting evidence of the ineffectiveness of abstinence-only education programmes, in that they are ineffective in delaying sexual initiation, reducing the frequency of sexual activity or reducing the number of sexual partners.[34] In contrast, CSE programmes that recognize sexual activity among adolescents and young people as normative behaviour, that seek to increase the safety of behaviour, and that focus on human rights, gender equality and empowerment, "have demonstrated impact in several areas: improving knowledge, self-confidence and self-esteem; positively changing attitudes and gender and social norms; strengthening decision-making and communication skills and building self-efficacy; and increasing the use of condoms and other contraceptives."[35]

Human Rights bodies have also emphasized the importance of CSE. For example, the Committee on the Rights of the Child in its General Comment No. 20 (2016) affirmed that "age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards and developed with adolescents, should be part of the mandatory school curriculum and reach out-of-school adolescents."[36] The Committee on Economic, Social and Cultural Rights similarly affirmed the right to CSE as part of realizing the right to SRH.[37]

Ongoing challenges consist of intense attacks by opposition movements against CSE. Though opposition to CSE has existed for many years, recent years have shown targeted and organized attacks at global, regional and national levels, buttressed by the persistence of myths and misconceptions about CSE. Examples of global opposition include anti-CSE campaigns and documentaries, attacks on specific UN organizations (such as UNFPA, UNESCO, or the WHO) and NGOs (such as the International Planned Parenthood Federation) who work on CSE,[38] as well as targeted advocacy towards Member States in UN negotiations to omit any references to CSE in UN outcomes or resolutions. All of these cases are fed by the same fear-mongering and false information about CSE, such as that it "teaches children to masturbate," "to be promiscuous," or "to become gay;" that it violates "parental rights;" that CSE proponents are motivated by commercial interests; and/or that CSE is not education but ideological indoctrination, among other false claims.[39] These attacks have often blocked progress in advancing or integrating CSE in global level intergovernmental commitments. This can be seen in how governments were unable to ensure the explicit recognition of CSE in the 2030 Agenda for Sustainable Development, securing only indirect references via Sustainable Development Goal (SDG) targets 3.7[40] and 4.7.[41]

More generally at national level, we see that the global opposition messages are propagated, spreading false information and fear against any sexual education curricula that go beyond an abstinence-only approach. One such example is a 2018 petition against Comprehensive Sex Education in Kenya, meant to block the roll-out of CSE curricula in the country.[42] This opposition has often impeded the implementation of sexuality education programmes and policies that have been proven to save lives and improve the health and well-being of young people and adolescents, such as in the case of Uganda, where attacks on CSE resulted in an overall ban on sexuality education in the country.[43,44]

35. Sidze, Estelle M. et al (2017), *From Paper to Practice: Sexuality Education Policies and Their Implementation in Kenya*, New York: Guttmacher Institute, www.guttmacher.org/report/sexuality-education-kenya.
36. Committee on the Rights of the Child (2016), *General Comment No. 20 (2016) on the Implementation of the Rights of the Child During Adolescence*, CRC/C/GC/20, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GC/20&Lang=en, para. 61.
37. Committee on Economic, Social and Cultural Rights (2016), *General Comment No. 22(2016) on the Right to Sexual and Reproductive Health*, E/C.12/GC/22, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en, para. 9.
38. Shameem, Naureen (2017), *Rights at Risk: Observatory on the Universality of Rights Trends Report 2017*, Toronto: the Association for Women's Rights in Development (AWID), www.oursplatform.org/wp-content/uploads/Rights-At-Risk-OURs-Trends-Report-2017.pdf, p. 65.
39. Ibid.
40. Target 3.7: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes." United Nations (2015), *Transforming Our World: The 2030 Agenda for Sustainable Development*, A/RES/70/1, www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E.
41. Target 4.7: "By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development." Ibid.
42. Magut, Agewa (2018), "Lobbies Urge State to Review Proposed Sex Education Curriculum," *Daily Nation*, www.nation.co.ke/news/education/Lobbies-urge-State-to-review-proposed-sex-education-curriculum/2643604-4260360-n0m1a6/index.html.
43. Bbosa, Denis (2017), "Time to Lift Ban on Sex Education in Schools," *Daily Monitor*, www.monitor.co.ug/News/Education/Time-to-lift-ban-on-sex-education-in-schools/688336-4007894-mm27t8z/index.html.
44. Fallon, Amy (2017), "NGOs Turn to Courts to Unravel Uganda's Ban on Sexual Education," *Devex*, www.devex.com/news/ngos-turn-to-courts-to-unravel-uganda-s-ban-on-sexual-education-89979.

Furthermore, though many countries have a national policy or curriculum in place that supports the provision of some form of sexuality education,[45] this does not necessarily result in the effective implementation of CSE or young people's access to comprehensive information.[46] This is particularly the case for very young adolescents (VYAs) aged 10-14 years old,[47] and young people who are out of school. When CSE policies and curricula are implemented, moreover, there is often a predominant focus on SRH information (usually biology and reproduction), with little emphasis on skills development for young people – a central component of a rights-based approach to CSE, and integral to ensuring young people's ability to make informed and empowered decisions regarding their SRHR.

ADOLESCENT SRH SERVICES

There has been substantial progress in terms of increased international recognition of the importance of ensuring young people, and particularly adolescents' access to youth-friendly SRH services. This can be seen in the updated *Global Strategy for Women's, Children's and Adolescents' Health* (2016–2030) (the Global Strategy), which now includes an explicit focus on adolescents' health and development as integral to the strategy, incorporates a life-course approach to health and wellbeing, and identifies adolescents as central to achieving the 2030 Agenda SDGs.[48] It can also be seen in the development of the WHO's *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation*.[49] This guide focuses on what is special about programming for adolescent health; includes examples of how to involve adolescents and young people in developing health-related programming; and emphasizes both expanding budgets for adolescent health priorities in national health plans and "designing laws and policies that treat adolescents' rights to health, protection and autonomy as universal, indivisible and interrelated."[50] UNESCO's 2018 *International Technical Guidance on Sexuality Education* also emphasizes that CSE is most impactful when linked with non-school based youth-friendly SRH services, particularly in terms of reaching marginalized young people such as out-of-school youth.[51]

Similarly, the Committee on the Rights of the Child has held that:

> *all adolescents should have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person, including on family planning, contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections, counselling, pre-conception care, maternal health services and menstrual hygiene […] There should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization.*[52]

There has also been increased emphasis on recognizing young people's evolving capacities and specific needs, where there is a "legal presumption of competence that an adolescent seeking preventive or time-sensitive sexual and reproductive health goods and services has the requisite capacity to access such goods and services," as recommended by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.[53]

Challenges largely relate to the implementation of governments' related commitments, and in actually ensuring adolescents' access to SRH services and goods. Though there is growing international guidance on adolescent SRHR, nationally there are

45. For example, a 2015 UNFPA review of national CSE curricula and policies in 48 countries in Africa, Asia-Pacific, Eastern Europe, Central Asia, and Latin America and the Caribbean "indicated that the majority of countries have policies that support CSE in schools." Woog, Vanessa and Anna Kågesten (2017), *The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show?*, New York: Guttmacher Institute, www.guttmacher.org/report/srh-needs-very-young-adolescents-in-developing-countries.
46. Ibid.
47. Ibid.
48. Every Woman Every Child (2015), *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030): Survive, Thrive, and Transform*, www.who.int/life-course/partners/global-strategy/ewec-globalstrategyreport-200915.pdf?ua=1 .
49. World Health Organization (WHO) (2017), *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation – Summary*. Geneva: WHO. www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/.
50. Ibid, p. 18.
51. UNESCO et al (2018), p. 30.
52. Committee on the Rights of the Child (2016), paras. 59-60.
53. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2016), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, A/HRC/32/32, http://ap.ohchr.org/documents/dpage_e.aspx?si=A%2FHRC%2F32%2F32, para. 60.

still many taboos and even laws that stand in the way of implementation, where in many settings, adolescent girls and boys face various policy, social, cultural, gender and legal barriers that obstruct their access to SRH information, commodities and services. For example, as of 2015, 35 countries had at minimum one policy limiting access to contraceptive services, such as denying provision to unmarried women, or requiring that minors have parental consent in order to access such services.[54] Social norms and taboos surrounding adolescent sexuality also hinder both healthcare providers' delivery of SRH services, as well as adolescents' access, particularly if they are unmarried. Prohibitive costs associated with SRH services may also impede access, in that young people may have limited access to cash for associated user fees, and/or limited financial self-sufficiency to access SRH services independently of their parents.[55] Among adolescents living with disabilities, as well as those who are in fragile/humanitarian settings, the barriers are even greater.[56,57,58] In effect, while young people have diverse SRH needs, they are often treated as a homogenous group, ignoring their diversity in terms of age, being in and out of school, SOGIE, geographical location, and socio-economic status, hence worsening the discrimination faced by them.

When adolescents are able to access SRH services in terms of contraceptives, they are usually only offered condoms or other short-term methods, where providers often mistakenly believe that long-acting methods such as IUDs and implants are not appropriate for women who have never had a child.[59] In terms of VYAs, there is no available evidence regarding the extent to which they are able to access SRH services; however, given the evidence regarding the structural, cultural, legal, and financial barriers faced by older adolescents, it is highly likely that it is even more challenging for younger adolescents to access SRH care.[60]

ABORTION

As noted in the ICPD Beyond 2014 Review, "important gains have been made in reducing deaths due to unsafe abortion since 1994, most notably in countries that have undertaken complementary and comprehensive changes in both law and practice to treat abortion as a public health concern."[61] In effect, since 2000, 27 countries have liberalized their abortion laws, where only one country (Nicaragua) has restricted access.[62] Some of these recent successes include Mozambique's 2015 revision of its Penal Code to permit abortion on certain grounds;[63] the 2017 liberalization of the abortion law in Chile, permitting abortion in limited cases;[64] the May 2018 referendum in Ireland to overturn the country's abortion ban;[65] and historic steps undertaken towards the legalization of abortion in Argentina.[66]

There has also been increased recognition by Human Rights bodies of ensuring young women and girls' access to safe abortion services. For example, the Committee on the Rights of the Child "urges States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions."[67] Similarly, the Committee on Economic, Social, and Cultural Rights in its General Comment No. 22 on the right to sexual and reproductive health mentions abortion 26 times, emphasizing the negative outcomes and rights violations that stem from denying access to abortion; safe abortion as an integral part of SRH services; as well as States' legal obligations to repeal and/or reform their abortion laws, as part of upholding their human rights obligations.[68] There have also been numerous recommendations by treaty monitoring bodies such as the CEDAW Committee,

54. Starrs, Ann M. et al (2018), p. 2658.
55. UNFPA et al (2015), *Sexual and Reproductive Health of Young People in Asia and the Pacific: A Review of Issues, Policies, and Programmes*, Bangkok: UNFPA, http://unesdoc.unesco.org/images/0024/002435/243566E.pdf, p. 90.
56. *Every Woman Every Child* (2015), p. 11.
57. UNESCO et al (2018), p. 25.
58. Starrs, Ann M. et al (2018), p. 2670.
59. The Global Consensus Statement on Expanding Contraceptive Choice for Adolescents and Youth states that there is no medical reason to prevent adolescents from using long-acting reversible contraceptive methods. Starrs, Ann M. et al (2018), p. 2667.
60. Guttmacher Institute (2017), *Very Young Adolescents' Sexual and Reproductive Health Needs Must be Addressed*, www.guttmacher.org/news-release/2017/very-young-adolescents-sexual-and-reproductive-health-needs-must-be-addressed .
61. United Nations (2014), para. 368.
62. "Abortion: Access and Safety Worldwide" (2018), *The Lancet* 391: 1121, www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30624-X/fulltext?code=lancet-site.
63. Durr, Benjamin (2015), "Mozambique Loosens Anti-Abortion Laws," *Aljazeera*, www.aljazeera.com/indepth/features/2015/01/mozambique-loosens-anti-abortion-laws-150120081246992.html.
64. Reuters Staff (2017), "Chile Court Ruling Ends Abortion Ban; New Law Allows in Limited Cases," *Reuters*, www.reuters.com/article/us-chile-abortion/chile-court-ruling-ends-abortion-ban-new-law-allows-in-limited-cases-idUSKCN1B1234.
65. "Irish Abortion Referendum: Ireland Overturns Abortion Ban" (2018), *BBC News*, www.bbc.com/news/world-europe-44256152.
66. Goñi, Uki (2018), "Argentina Congress Takes Historic Step Towards Legalizing Abortion," *The Guardian*, www.theguardian.com/world/2018/jun/14/argentina-congress-vote-legalise-abortion.
67. Committee on the Rights of the Child (2016), para. 60.
68. Committee on Economic, Social and Cultural Rights (2016), paras. 10, 13, 18, 21, 28, 34, 40, 41, 45, 49, 57, 59.

CAT and the Human Rights Committee (HRC). These bodies have condemned absolute abortion bans as incompatible with international human rights standards, and called on states to expand abortion laws and/or decriminalize abortion, and increase access to safe abortion services and post abortion care.[69] As well, although the 2030 Agenda does not include a specific target on reducing unsafe abortion, the global indicator 5.6.2 ("Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education")[70] helps provide an entry point to further track countries' progress regarding the decriminalization of abortion.

However, of abortions occurring globally in 2010-2014, an estimated 45% of abortions (25 million) were still unsafe.[71] The majority of these abortions were unsafe due to various barriers in access to services, including legal restrictions, where most low-income and middle-income countries continue to have restrictive abortion laws, entailing that abortions in these regions are much more likely to be illegal and unsafe than in higher-income regions. This can be seen in how according to the 2018 Guttmacher-Lancet study, recent estimates indicate that in the Global South 50% of abortions are unsafe, compared with 13% in the Global North.[72]

Moreover, "liberalization of laws alone does not guarantee access to safe abortion; the change in the law must be followed by investments in building up a cadre of trained providers, ensuring they provide safe, confidential care, and raising women's awareness of their right to such care – all of which can take years."[73] In effect, even in countries where abortion is legal, access to abortion services continues to be compromised in a number of ways, because of the persistence of abortion-related stigma and discrimination, among other factors.[74] The stigma attached to abortion is pervasive across different settings, existing in both high-income and low-income countries, and in countries with liberal and restrictive abortion laws.[75]

Abortion-related stigma and discrimination is also further reinforced through regressive international policy developments, such as the reinstatement and expansion of the Global Gag Rule (GGR).[76] This failed, archaic, and dangerous policy is effectively an attack by anti-SRHR proponents on abortion rights, and the rights of women and girls to decide over their own bodies. Moreover, its re-implementation is set to rollback previous gains made in ensuring women and girls' health and rights, where the GGR is projected to contribute to at least 6.5 million unintended pregnancies, 2.1 million unsafe abortions, and 21,700 maternal deaths, among other grave outcomes.[77]

It is also concerning that in humanitarian crisis settings, safe abortion services are rarely provided, in spite of the high risk of sexual violence and unintended pregnancies in these environments. While many service providers assume that abortion services are illegal in these settings, the majority of these countries permit abortion to save a woman's life and in some, also to preserve her health; abortion laws have also been liberalized in several countries that have high numbers of displaced persons or refugees.[78]

LGBTI RIGHTS

Global progress on LGBTI rights has included significant developments in Human Rights forums, such as the establishment of the Independent Expert on sexual orientation and gender identity,[79]

69. Center for Reproductive Rights and UNFPA (2013), *ICPD and Human Rights: 20 Years of Advancing Reproductive Rights Through UN Treaty Bodies and Legal Reform*, www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf. See chapter 3 on Abortion.
70. United Nations (2017), *Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 Agenda for Sustainable Development*, A/RES/71/313, https://undocs.org/A/RES/71/313, p. 10.
71. Starrs, Ann M. et al (2018), p. 2661.
72. Ibid.
73. Ibid p. 2662.
74. For more resources on the stigma related to sexual and reproductive healthcare including abortion, and its impact on abortion seekers, supporters, and providers, please see: Cook, Rebecca J. and Bernard Dickens (2014), "Reducing Stigma in Reproductive Health," *International Journal of Gynecology and Obstetrics* 125(1): 89-92, https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1016/j.ijgo.2014.01.002; Kumar, Anuradha et al (2009), "Conceptualizing Abortion Stigma," *Culture, Health & Sexuality* 11 (6): 625–639, www.ipas.org/~/media/Files/Ipas Publications/KumarCHS2009.ashx; Kumar, Anuradha (2013), "Everything is Not Abortion Stigma," *Women's Health Issues* 23 (6): e329–e331, www.ncbi.nlm.nih.gov/pubmed/24183406.
75. Starrs, Ann M. et al (2018), p. 2662.
76. To learn more about the GGR's history and impact, see CHANGE: Center for Health and Gender Equity (2018), *Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018*, www.genderhealth.org/files/uploads/change/publications/Prescribing_Chaos_in_Global_Health_full_report.pdf.
77. CHANGE: Center for Health and Gender Equity (2017), *Impact of Trump's Global Gag Rule on Women's Health*, http://iawg.net/wp-content/uploads/2017/09/GGR_Fact_Sheet_UPDATED_May_2017-003.pdf.
78. Starrs, Ann M. et al (2018), p. 2671.
79. Office of the United Nations High Commissioner for Human Rights (OHCHR) (2018), *Independent Expert on Sexual Orientation and Gender Identity*, www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/Index.aspx. 80.Committee on the Rights of the Child (2016), para. 34.

a major achievement in and of itself. There have also been notable recommendations from Human Rights bodies regarding the rights of young and adolescent LGBTI individuals; where, for example, the Committee on the Rights of the Child in its General Comment No. 20 (2016), emphasizes "the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy," and urges States to:

> *repeal all laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation, gender identity or intersex status and adopt laws prohibiting discrimination on those grounds. States should also take effective action to protect all lesbian, gay, bisexual, transgender and intersex adolescents from all forms of violence, discrimination or bullying by raising public awareness and implementing safety and support measures.*[80]

The Committee also stresses that governments should undertake specific efforts to address the stigma and fear-related barriers LGBTI adolescents face in terms of accessing SRH services.[81] Likewise, the Committee on Economic, Social and Cultural Rights in its General Comment No. 22 notes that:

> *"Non-discrimination, in the context of the right to sexual and reproductive health, also encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity and intersex status. Criminalization of sex between consenting adults of the same gender or the expression of one's gender identity is a clear violation of human rights. […] State parties also have an obligation to combat homophobia and transphobia, which lead to discrimination, including violation of the right to sexual and reproductive health."*[82]

The 2006 *Yogyakarta Principles*, as well as the *Yogyakarta Principles+10 (YP+10)*, similarly indicate progressive trends in terms of global norm-setting in Human Rights forums regarding LGBTI rights.[83]

However, significant challenges remain, as evident in the highly challenged mandate of the Independent Expert on SOGI by some UN Member States.[84,85] Additionally, while more than 120 countries have decriminalized homosexuality, same-sex relations are still criminalized and can lead to a prison sentence in approximately 70 countries worldwide.[86] Even where same-sex relations are decriminalized, moreover, governments may have other laws or policies in place that contribute to a hostile environment for LGBTI groups, and perpetuate related stigma and discrimination. One such example is Russia, where in 2013 the government enacted a law banning the spread of "propaganda of non-traditional sexual relations" among minors (also known as the "gay propaganda" law), which was ruled discriminatory by the European Court of Human Rights.[87,88]

Indeed, studies have shown mixed progress globally regarding the social acceptance of LGBTI individuals. In one study of 141 countries, results indicated that while average levels of acceptance for LGBTI people and rights have increased worldwide since 1980, this social acceptance has become more polarized, increasing in the most accepting countries and decreasing in the least.[89] In turn, LGBTI communities worldwide continue to experience serious and widespread human rights violations, including violent attacks, torture, arbitrary detention, denial of rights to assembly and expression, and discrimination in health care, education, employment and housing.[90]

81. Ibid, para. 60.
82. Committee on Economic, Social, and Cultural Rights (2016), para. 23.
83. *The Yokgyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2007), http://yogyakartaprinciples.org/wp-content/uploads/2016/08/principles_en.pdf.
84. OutRight Action International et al (2017), *Defending the Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity*, http://arc-international.net/wp-content/uploads/Report-Defending-IE-SOGI.pdf .
85. ARC International (2016), *United Nations SOGI Mandate Safeguarded in Face of Hostility*, http://arc-international.net/united-nations-sogi-mandate-safeguarded-in-face-of-hostility/.
86. Duncan, Pamela (2017), "Gay Relationships are Still Criminalized in 72 Countries, Report Finds," *The Guardian*, www.theguardian.com/world/2017/jul/27/gay-relationships-still-criminalised-countries-report.
87. Ibid.
88. Rankin, Jennifer (2017), "Russian 'Gay Propaganda' Law Ruled Discriminatory by European Court," *The Guardian*, www.theguardian.com/world/2017/jun/20/russian-gay-propaganda-law-discriminatory-echr-european-court-human-rights.
89. Flores, Andrew R. and Andrew Park (2018), *Polarized Progress: Social Acceptance of LGBT People in 141 Countries, 1981 to 2014*, The Williams Institute, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Polarized-Progress-April-2018.pdf .
90. Office of the United Nations High Commissioner for Human Rights (OHCHR) (2015), *Discrimination and Violence Against Individuals Based on Their Sexual Orientation and Gender Identity: Report of the Office of the United Nations High Commissioner for Human Rights (OHCHR)*, A/HRC/29/23, www.ohchr.org/en/hrbodies/hrc/regularsessions/session29/pages/listreports.aspx, para. 5.

Punitive laws, moreover, such as those criminalizing same-sex relationships, push groups like LGBTI individuals underground and hinder their access to health services.[91] In effect, in many countries LGBTI individuals continue to face significant barriers in accessing SRH information and services. These include pervasive stigma and discrimination, criminalization of their sexual practices, violence, and in some cases even fear for their lives. When LGBTI individuals do receive services, they might not disclose their sexual orientation, activities, or gender identity to their health providers, which limits their ability to receive the care they need. They may also receive poor quality SRH information care, either because of service providers' judgmental attitudes, or their insufficient knowledge regarding the specific needs of LGBTI persons.[92]

RECOMMENDATIONS

Based on this shadow report and its analysis, we have the following general recommendations to be considered in the review of the ICPD in 2018 and 2019:

- Adopt a comprehensive, holistic definition of SRHR as proposed by the Guttmacher-Lancet Commission, and utilize this definition of SRHR as the basis for any reviews and/or resolutions related to ICPD+25, future sessions of the Commission on Population and Development as well as the 2030 Agenda.
- Utilize the commitments made via the 2030 Agenda to synergize and accelerate progress towards the realization of the ICPD vision and agenda.
- Recognize the provision of CSE as integral to improving the health and rights of adolescents and youth, as well as realizing gender equality and sustainable development.
- Ensure that commitments to adolescent-friendly SRH services move towards action and that the ICPD+25 review recognizes the barriers in implementation that continue to exist at national level, including restrictions based on marital status or third-party consent, lack of health worker skills and the need for their adequate training, and the importance of addressing taboos around adolescent sexuality.
- Build on the guidance provided by Human Rights bodies and recognize the right to safe abortion as an integral part of reproductive rights, while also reaffirming commitments to end unsafe abortion and liberalize abortion-related laws.
- Condemn policies with harmful ripple effects beyond the borders of countries that adopt them, such as the Global Gag Rule that adversely affects the SRHR of women and adolescents in the Global South.
- Ensure commitments by all relevant stakeholders that work in humanitarian, conflict or post-conflict settings to integrate SRHR information and services, including access to safe abortion, in humanitarian response and/or relief efforts.
- Protect people with real or perceived diverse SOGIE from all forms of violence and discrimination, and ensure that barriers obstructing access to SRH services (including those that are a result of stigma) are addressed, in particular for young LGBTI.
- Ensure that the ICPD+25 regional and global reviews are inclusive at every step of the process, with meaningful spaces for young people in all their diversity and civil society to participate and contribute to the outcomes of the reviews. Institute transparent, gender- and age-responsive, and participatory monitoring, review, and accountability mechanisms at all levels, to follow up on the implementation of the ICPD PoA and the outcomes of its reviews as well as the 2030 Agenda.
- Invest in the rights-based collection and use of disaggregated data, at least according to income, age, gender, marital status, disability, migration and citizenship status, education level, geographic location, ethnicity, and other characteristics relevant in national context, in order to inform decision-making, budgeting, programming, and monitoring of the implementation of the ICPD PoA and the ICPD Beyond 2014 agreements.

91. Starrs, Ann M. et al (2018), p. 2657.
92. Ibid, p. 2670.

RIGHT HERE
RIGHT NOW

Meaningful Youth Participation

Governments worldwide have recognized and affirmed the centrality of young people to sustainable development and the importance of meaningful youth participation through a number of intergovernmental outcomes. These include the 2007 *World Programme of Action for Youth*,[93] the Commission on Population and Development Resolution 2012/1,[94] the 20 year Review of the ICPD Programme of Action,[95] and the respective Regional Outcome Documents of the ICPD Beyond 2014 Review.[96,97,98]

During the ICPD Beyond 2014 process, young people also asserted their interest and right to being involved in the policies and programmes that affect their lives, through the 2012 Bali Declaration which was part of the Beyond 2014 review.[99] The importance of meaningful youth participation has also been reaffirmed by Human Rights bodies, such as by the Committee on the Rights of the Child in its General Comment No. 20 (2016). The Committee held that "States should ensure that adolescents are involved in the development, implementation and monitoring of all relevant legislation, policies, services and programmes affecting their lives, at school and at the community, local, national and international levels,"[100] in accordance with Art. 12 of the Convention on the Rights of the Child.

There have been some notable efforts in working towards achieving this in reality. For example, at the global level, there currently is a UN Strategy on Youth under development, which is noteworthy, though the extent to which this strategy will be effective in ensuring MYP in guiding UN youth policies remains to be seen. Young people's inputs were also incorporated in the *AA-HA! Guidance*, where the document also emphasizes and encourages involving young people in the formulation of health-related policy and implementation, through providing examples from different countries of ways of involving adolescents in decision-making, and investing in their leadership capacity.[101] The Major Group on Children and Youth (MGCY), moreover, is a formally recognized UN space for youth participation in the review of the 2030 Agenda and the SDGs. At regional level, there are also some notable efforts, such as with the African Union's *Roadmap on Harnessing the Demographic Dividend Through Investments in Youth*, where in drafting the roadmap the AU attempted to consult a broad spectrum of stakeholders, including young people. They also used virtual consultations, including social media, that provided the opportunity for various stakeholders – mainly youth – to make inputs remotely; as well as utilized several key youth events to solicit the inputs of various stakeholders.[102]

And at national level, in RHRN countries and sub-regions there have been some positive examples of efforts to include young people in policy development and implementation, among them:

93. United Nations (2010), *World Programme of Action for Youth*, A/RES/62/126, www.un.org/esa/socdev/unyin/documents/wpay2010.pdf .
94. Commission on Population and Development (2012), *Resolution 2012/1 Adolescents and Youth*, www.un.org/esa/population/cpd/cpd2012/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf.
95. United Nations (2014).
96. United Nations ECA (2013), paras. 8, 69, 79.
97. United Nations ESCAP (2014), *Report of the Sixth Asian and Pacific Population Conference*, para. 148.
98. United Nations ECLAC (2013), para. 8.
99. *ICPD Review Bali Global Youth Forum Declaration* (2013), www.unfpa.org/sites/default/files/resource-pdf/Bali%20Declaration%20English.pdf.
100. Committee on the Rights of the Child (2016), para. 23.
101. World Health Organization (WHO) (2017), p. 14.
102. These included the 2016 Accra Conference on "Realizing the Demographic Dividend"; Ghana, 8-12 February, 2016; a 2016 Dialogue with African Youth and Adolescents Network (AfriYAN) on "Empowering Young People to Harness the Demographic Dividend"; and the 5th Pan-African Summit of the Young Leaders of the United Nations (ROJALNU) in Gabon. African Union Commission (2017), *AU Roadmap on Harnessing the Demographic Dividend Through Investments in Youth*, http://wcaro.unfpa.org/sites/default/files/pub-pdf/AU%202017%20DD%20ROADMAP%20Final%20-%20EN.pdf , p. 11.

- **Pakistan:** In the development of its provincial youth policy, the Khyber Pakhtunkhwa (KP) government collaborated with CSOs and UNFPA for policy drafting and development; and consultations with youth-led organizations, media reps, and CSOs were held to discuss the various components of the draft policies before it was sent for approval. The Punjab government similarly held many consultations with youth organizations and youth from different areas in drafting its provincial youth policy.

- **Uganda:** The Adolescent Health Technical Working Group at the Ministry of Health for the first time invited 5 youth representatives from CSOs to participate in 5 consultative meetings for the review of the *National Adolescent Health Policy and SRHR service standards and guidelines* in October 2017. This led to the development of a position paper by the youth representatives which was presented to the Technical Review team, with recommendations for budget allocations to support the implementation of this policy.

- **Zimbabwe:** The Ministry of Health and Child Care conducted an end assessment on youth-friendly services in health institutions, in which young people were involved as part of the district teams that conducted the assessments.

- **Bolivia:** Young people participated in the development of the *Plurinational Plan for the Prevention of Pregnancies in Adolescents and Young People (2015-2020)*. This Plan is currently in place, with implementation undertaken through departmental platforms for pregnancy prevention, which are largely comprised of youth organizations and strategic sectors of the departmental and municipal governments.

- **Caribbean:** Following recommendations by CARICOM Secretariat officials, RHRN platform youth have been able to participate in the Commonwealth Youth Ministers Meeting, as well as officially attend and engage in regional meetings of the Pan Caribbean Alliance against HIV/AIDS (PANCAP). This included two PANCAP workshops in 2018 with youth leaders and CARICOM youth ambassadors to develop a Caribbean Youth Advocacy Framework on SRHR, funded by CARICOM.

In general, however, ensuring meaningful youth participation in policy formulation and implementation, particularly beyond tokenism, remains a cross-cutting challenge at national, regional, and global levels. In UN spaces, while some Member States have included young people in their national delegations, youth are often left without or with little influence in their delegation's activities, positions or statements. As well, even when there are formal spaces for young people's involvement in policy-making, there may still be challenges in terms of ensuring meaningful inclusivity within those spaces, working with diverse youth (rather than only the same youth advocates repeatedly), and navigating internal power dynamics such as those related to gender and age. There is also the challenge of ensuring the participation of younger youth; for example, while there are youth ambassadors and advocates within AU structures, these tend to be older youth, given that the AU defines young people as those 35 and under. As such, efforts could be strengthened to ensure the engagement and participation of younger youth, particularly adolescents.

Moreover, when public consultations with youth are undertaken, they are often within formal government structures. This entails that such consultations run the risk of being implemented with more privileged youth, while leaving out other young people who are unaware of how or are unable to access or navigate these structures. Youth consultation processes thus need to be more open and transparent, so that diverse young people can provide inputs and participate; undertaking these consultation processes in partnership with civil society may help in this regard (as CSOs may be able to better reach and engage diverse groups of young people, and/or those beyond formal structures/processes). In effect, meaningful youth participation has to do with who has the ability to access relevant information, effectively provide inputs and influence decisions and outcomes, rather than solely with who is physically present in policy formulation, implementation, and monitoring spaces.

RECOMMENDATIONS

In order to address the above limitations and better realize young people's meaningful involvement, we recommend the following actions:

- Undertake measures to ensure meaningful youth participation that is representative of young people in all their diversities, in terms of age, gender, race, ethnicity, SOGIE, socioeconomic background, and geographic location, among other markers.
- Support MYP through consultative processes as well as established platforms, such as youth committees and commissions at country, regional, and global levels, so as to integrate their inputs in policy and programmes development processes.[103]
- Support youth and youth-led organizations' meaningful participation in national, regional and global policy dialogue and programme development, including through strengthening young people's skills and confidence to engage in policy, programme design, communication, advocacy and research, as well as implementing strategies to increase support among adult stakeholders. Invest in young people's capacity-strengthening regarding the 2030 Agenda and ICPD Beyond 2014 frameworks, so that they take ownership.[104,105,106]
- Provide sufficient financing for youth issues and youth-led organizations and movements.
- Undertake diverse measures to work towards MYP, such as through online and virtual initiatives (e.g. via social media or mobile phones), citizens' hearings and community scorecards.[107]

103. ARROW (2018), *Comprehensive Sexuality Education in Asia: A Regional Brief*, Kuala Lumpur: ARROW, http://arrow.org.my/wp-content/uploads/2018/03/ARROW-RP-CSE-AP-WEB.pdf, p. 26.
104. UNFPA et al (2015), p. 12.
105. ARROW (2017), *Asia-Pacific Youth Call to Action: Sustainable Solutions to Eradicate Poverty and Promote Prosperity*, http://arrow.org.my/wp-content/uploads/2017/07/APY-CTA-Web-Version.pdf, p. 2-3.
106. *ICPD Review Bali Global Youth Forum Declaration* (2013), p. 39-40.
107. Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (2017), *Report 2017: Transformative Accountability for Adolescents: Accountability for the Health and Human Rights of Women, Children, and Adolescents in the 2030 Agenda*, Geneva: WHO, http://iapreport.org/files/IAP%20Annual%20Report%202017-web%20_%20without%20endnotes.pdf.

RIGHT HERE
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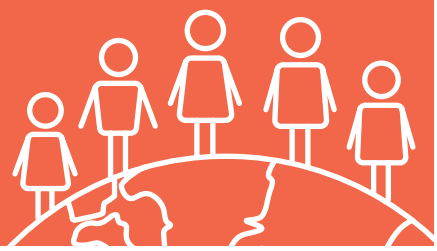
Asia-Pacific

Regional level analysis

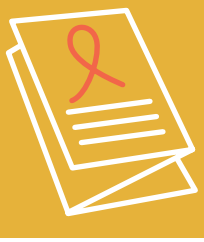
SRHR SNAPSHOT

Approximately **1 billion** young people in Asia-Pacific are between **10-24 years old**, making up **27%** of the total population in the region.[108]

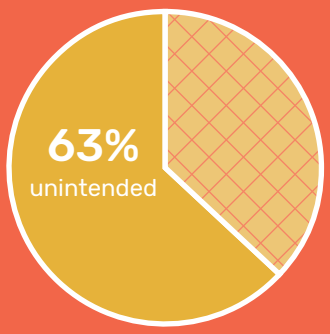


Most young people in the region live in settings where there continue to be strong traditional norms and taboos regarding sexual behaviour, particularly in relation to premarital sex among young women and adolescent girls.[109]

Less than a third of young people in the region have comprehensive knowledge of HIV.[110]



Up to **63% of adolescent pregnancies** in the region are unintended, in turn contributing to a substantial though underreported burden of unsafe abortion.[111]



Although most countries have laws prohibiting child marriage, **more than a third** of young women in the region **were married by 18**, and **one in eight married by 15**.[112]

Negative socio-cultural and religious attitudes and beliefs regarding sexual and gender diversity contribute to significant stigma and discrimination against LGBTI young people.[113]

108. UNFPA et al (2015) p. 19.
109. Ibid, p. 34.
110. Ibid, p. 8.
111. Ibid, p. 7.
112. Ibid, p. 24.
113. Ibid, p. 35.

A strong framework is in place in Asia-Pacific in regards to monitoring the implementation of governments' SRHR-related commitments. This can be seen in how all countries in the region have ratified at least one human rights treaty that explicitly applies to elements of SRHR (such as the ICCPR, ICESCR, CAT and CEDAW), and/or applies to a specific group (such as adolescents and young people via the CRC, or people living with disabilities via the CRPD).[114]

Within this framework, the 6th Asia Pacific Population Conference held in 2013 resulted in a number of gains for young people in the *Asia and Pacific Ministerial Declaration on Population and Development*, as well as demands put forward by the youth contingent. These include meeting the comprehensive SRH service, information and education needs of young people; their full participation and engagement and respect for their rights to privacy, confidentiality and informed consent; and designing and implementing youth-friendly CSE programmes.[115] However, many countries in the region lack leadership, political will and commitment regarding the full realization of the ICPD agenda.[116] This, combined with an emerging trend of restricting the discourse on SRHR issues as well as the rise of socially conservative and anti-rights movements,[117] has contributed to mixed results regarding the advancement of young people's SRHR in the region, particularly in terms of CSE, youth-friendly services, abortion, and LGBTI rights.[118] Another concern is the deterioration of the safety and security situation in a number of countries across Asia-Pacific along with attacks on dissenting voices, resulting in a shrinking space for CSOs and human rights defenders (HRD)s.[119]

CSE

Across the region, in most countries there are laws and policies regarding young people's SRH and/or sexuality education. However, the implementation of CSE programmes is often inconsistent and/or insufficient, hindered by intersecting factors such as:

- bureaucratic shifts and changes within relevant ministries;
- inconsistent integration of CSE in various policies (e.g. the inclusion of sexuality education in population and health laws and policies, but not education policies);
- discrepancies regarding CSE curricula implementation;
- stigma regarding young people's sexuality, and religious strongholds.[120]

Other challenges include a lack of teacher training; limited teaching resources; lack of supervision and monitoring of CSE programmes; the often optional rather than compulsory status of CSE as a subject in school curricula; as well as perceived or real opposition from leaders, parents, communities and religious leaders.[121]

Even where CSE provision is reportedly high, there are challenges in terms of the nature of the content. Many national curricula focus on knowledge (often limited to biology and reproduction) with limited or no content addressing behaviour change, skills development, rights and discrimination, safe abortion, sexuality, consent, SOGIE, or gender norms, among other integral topics.[122,123] Moreover, when provided CSE is often institutionalized and limited to in-school settings, entailing limited access for out-of-school youth or youth in informal education systems.[124] It is also often common for CSE-related topics to only be included in secondary level curricula, thereby missing the opportunity to reach younger students with age-appropriate CSE information and skills before they become sexually active.[125]

114. ARROW (2016), *Universal Access to Sexual and Reproductive Health and Rights in Asia: A Regional Profile*, p. 9-10.
115. Asian Forum of Parliamentarians on Population and Development (AFPPD) (2013), *Youth Demand: Youth Forum of the 6th APPC*, https://us5.campaign-archive.com/?u=07dde6fc057e11ba724e57a42&id=9814d39bbb.
116. *Asia-Pacific CSO Call to Action* (2017), http://arrow.org.my/wp-content/uploads/2017/11/Call-to-Action-ICPD.pdf.
117. CIVICUS (2018), *State of Civil Society Report 2018: Year in Review: Top Ten Trends*, www.civicus.org/documents/reports-and-publications/SOCS/2018/socs-2018-overview_top-ten-trends.pdf.
118. Brace-John, Tara (2018), *Squeezed Out: Shrinking Civil Society Space Threatens Progress Toward Universal Health Coverage*, https://blogs.savethechildren.org.uk/2018/05/squeezed-shrinking-civil-society-space-threatens-progress-toward-universal-health-coverage/.
119. CIVICUS (2018), p. 12.
120. ARROW (2018), p. 12, 18-19.
121. UNFPA et al (2015), p. 69.
122. Ibid.
123. ARROW (2018), p. 18-19.
124. Ibid, p. 19.
125. Ibid, p. 23-25.

ADOLESCENT SRH SERVICES

Nearly all countries in the region mention youth-friendly health services in their SRH, HIV, or youth-related policies. It is also worth noting that the majority of Asia-Pacific countries have developed or are in the process of developing standards or guidelines in relation to youth-friendly service delivery and implementation. However, other policies and legislation that affect young people's access to comprehensive SRH services also need to be addressed. For example, the persistence of policy or legal restrictions on the access of unmarried young people to some services (such as contraception in Indonesia and Malaysia), parental or marital consent requirements, and the criminalization of non-heteronormative behaviours continue to result in limited access and negative SRH outcomes among young people, even when "youth-friendly" health services exist.[126,127]

In effect, many young people in Asia-Pacific continue to face considerable barriers when it comes to accessing SRH services, which in addition to the aforementioned legal and policy barriers include: health providers' judgmental attitudes and poor SRH counselling skills; lack of privacy and confidentiality; stigma and discrimination; costs of services; and inconvenient opening hours.[128,129] Furthermore, socio-cultural norms prohibiting premarital sex often deter young people from seeking SRH care, for fear of potential repercussions if they disclose sexual activity and there is a lack of confidentiality.[130] Other common challenges relate to the implementation of youth-friendly SRH services, including insufficient budget to implement national standards and guidelines; infrequent or non-existent monitoring and quality improvement processes; substandard record-keeping and data management; shortages of SRH commodities such as condoms; insufficient publicity and awareness of services among young people; and inadequate access for young people in rural areas and underserved urban areas.[131]

ABORTION

As abortion is largely legal in the region's two most populous countries, China and India, and 17 out of 50 countries and territories in the region permit abortion without restriction as to reason, the majority of women in Asia-Pacific live under relatively liberal abortion laws.[132] Since the 1994 ICPD, moreover, five countries in the Asia Pacific region (Bhutan, Cambodia, Fiji, Indonesia, and Nepal) have liberalized their abortion related laws.[133] However, abortion continues to be restricted in many parts of the region; and it is illegal altogether, or no explicit legal exception to save the life of a woman is provided in the law in Palau and the Philippines.[134,135,136] Some countries also continue to have policy barriers such as mandatory spousal authorization for abortion services, which is the case in Indonesia and Maldives.[137] Moreover, even where abortion is broadly legal, many women and girls continue to face obstacles to accessing safe abortion services. Among these are the challenges of finding providers who are trained to perform abortion, as well as substandard conditions in health facilities, including inadequate supplies and equipment.[138,139,140] In India, for example, a country where abortion has been legal on a number of grounds since 1971, "the public sector – which is the main source of health care for rural and poor women – accounts for only one-quarter of facility-based abortion provision, in part because many public facilities do not offer abortion services."[141]

These challenges in relation to service provision are often further exacerbated by a lack of awareness of the legal status of abortion among both women and service providers, an ongoing issue in countries such as Nepal, Pakistan, and India. Studies have indicated that only four in ten women in Nepal are aware that

126. UNFPA et al (2015), p. 84.
127. United Nations ESCAP (2014), *Sustaining Progress on Population and Development in Asia and the Pacific: 20 Years After the ICPD*. Bangkok: United Nations ESCAP, www.unescap.org/sites/default/files/SDD_PUB_ICPD-report-e_0.pdf, p. 29.
128. UNFPA et al (2015), p. 82.
129. United Nations ESCAP (2014), *Sustaining Progress on Population and Development in Asia and the Pacific: 20 Years After the ICPD*, p. 29.
130. UNFPA et al (2015), p. 82.
131. UNFPA et al (2015), p. 92.
132. Guttmacher Institute (2018), *Abortion in Asia*, www.guttmacher.org/fact-sheet/abortion-asia.
133. ARROW (2013), *Reclaiming & Redefining Rights: ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia-Pacific*, Kuala Lumpur: ARROW, http://arrow.org.my/wp-content/uploads/2015/04/ICPD-20-Asia-Pacific_Monitoring-Report_2013.pdf, p. 77-84.
134. Guttmacher Institute (2018), *Abortion in Asia*.
135. ARROW (2016), *Universal Access to Sexual and Reproductive Health and Rights in Asia: A Regional Profile*, p. 15.
136. Center for Reproductive Rights (2018), *The World's Abortion Laws*, www.worldabortionlaws.com/map/.
137. ARROW (2013), p. 77-84.
138. Guttmacher Institute (2018), *Abortion in Asia*.
139. ARROW (2013) p. 77-84.
140. Guttmacher Institute (2017), *National Estimate of Abortion in India Released*, www.guttmacher.org/news-release/2017/national-estimate-abortion-india-released.
141. Ibid.

abortion is legal in the country;[142] similarly, though the law in Pakistan allows abortion on a number of grounds, it is often perceived as illegal, and in India, roughly only 29% of informal providers are aware that abortion is legal.[143] Service providers in turn are often reluctant to perform induced abortion, and are usually conservative in their interpretation and application of abortion-related laws. Both women and service providers also effectively take risks in seeking and providing abortion services, in that in almost all countries across the region (even those which have legalized abortion), there are prohibitive penalties associated with induced abortions that fall out of the purview of permitted legal grounds, including fines and/or imprisonment.[144] Moreover, abortion-related stigma (largely stemming from religious and cultural perceptions of womanhood)[145] continues to be a particularly prominent challenge in the region, even in countries with more progressive abortion laws, in turn limiting both the provision and uptake of the procedure. Overall, these barriers to accessing safe and legal abortion services are reflected in the numbers of women who seek and receive treatment for complications from unsafe abortion, where approximately 4.6 million women in the region are treated for such complications each year.[146]

LGBTI RIGHTS

In Asia-Pacific, there has been substantial headway towards the realization of LGBTI rights. Progress can be seen in that, through using HIV as an entry point for greater advocacy for LGBTI rights, a number of policies, statements and resolutions that address SOGIE have been developed, as well as increased LGBTI community-government partnerships. There has also been a general increase in LGBTI visibility across Asia-Pacific, through community mobilization, pride marches and festivals, and via social media; as well as increased visibility of LGBTI people in politics, media and the private sector, thereby helping to facilitate a more supportive environment for LGBTI people across the region. In addition, there has been a series of landmark developments in law and policy reform in some countries, including the decriminalization of homosexual activity, the enactment of legal protections from discrimination relating to SOGIE, as well as progressive court rulings regarding the rights of transgender people.[147]

However, "the pace of social change across the region is patchy, and where positive is typically gradual and should not be overstated."[148] Hostile social, legal, and policy environments continue to persist in many Asia-Pacific countries, in part because of contributing factors such as conflict, religious extremism, weak governance and economic underdevelopment. Moreover, "traditional social values and religious beliefs can sometimes create barriers to LGBTI inclusion, and cultural taboos can restrict the open discussion of sexuality in many societies."[149] In some countries there is also the persistence of discriminatory anti-sodomy laws inherited from their countries' colonial past, which effectively criminalize any "carnal intercourse against the order of nature," i.e. any sexual activity that falls outside of a heteronormative frame.[150] Such laws negatively affect the societal treatment of LGBTI individuals, where even if they do not result in arrests and sentencing, they still contribute to ostracization and stigmatization.[151] In some cases there has even been a backlash against LGBTI populations, where a resurgence of religious orthodoxy has contributed to a rise in violence and intolerance towards LGBTI communities, including punitive religious laws predominantly affecting LGBTI people, and their demonization for political reasons.[152] Another challenge is that certain populations of the LGBTI community remain neglected or invisible. "While HIV brought attention to gay men, MSM and transgender women, the health needs and human rights of lesbians, transgender men and bisexual people, including young LGBT people, have received little attention and intersex issues are almost completely absent."[153]

142. Ministry of Health, Nepal, et al (2017). *2016 Nepal Demographic and Health Survey Key Findings*, Kathmandu: Ministry of Health, Nepal, http://nepal.unfpa.org/sites/default/files/pub-pdf/NDHS%202016%20key%20findings.pdf, p. 15.
143. ARROW (2013), p. 80-82.
144. Ibid, p. 81.
145. Ibid, p. 80.
146. Guttmacher Institute (2018), Abortion in Asia.
147. United Nations Development Programme (UNDP) (2015), *Leave No One Behind: Advancing Social, Economic, Cultural and Political Inclusion of LGBTI People in Asia and the Pacific – Summary*, Bangkok: UNDP, www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/leave-no-one-behind--advancing-social--economic--cultural-and-po/ p. 5.
148. Ibid, p. 5.
149. Ibid, p. 7.
150. ARROW (2016), *Universal Access to Sexual and Reproductive Health and Rights in Asia: A Regional Profile*, p. 28.
151. Ibid.
152. UNDP (2015), p. 7.
153. Ibid.

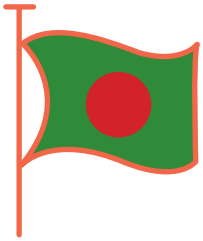
RECOMMENDATIONS

The above mixed results regarding the advancement of young people's SRHR in Asia-Pacific illustrate the serious need for governments in the region to reaffirm their political will and commitment towards the realization of the ICPD agenda. "Lack of cohesive policies across national and sub-national levels create barriers in implementing international and regional commitments."[154] Moreover, lack of effective monitoring frameworks at the regional level make it challenging to track progress and gaps in terms of fulfillment of regional human rights agreements. It is thus important that governments in the region work to ensure better synergies between international/ regional commitments, and their national implementation, via the following actions:

- Reaffirm and implement international and regional resolutions, including the *Asian and Pacific Ministerial Declaration on Population and Development*, the ESCAP Resolution 70/14 on *Enhancing Participation of Youth in Sustainable Development in Asia and the Pacific*, and the SAMOA Pathway, amongst others. Ensure their nationalization and localization.
- Implement, monitor and report on SRHR holistically within the mechanisms of implementation of the SDGs, which in this region are the Asia-Pacific Forum on Sustainable Development (APFSD) and the Asia- Pacific Population Conferences (APPC).
- Create and implement a regional monitoring framework that can track progress of countries in the region and persisting gaps, and keep governments in the region accountable to their people.
- Address the shrinking spaces for civil society and HRDs, while ensuring institutional spaces and funding for youth and women's organizations and marginalized voices.

154. *Asia-Pacific CSO Call to Action* (2017).

Bangladesh



SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

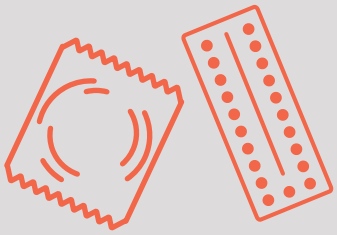
	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	2000	1998	1984	1998	1990	2007
Date of last review	Reviewed in 2017	N/A	Reviewed in 2016	Report was due in 1999	Reviewed in 2015	N/A
Next report due date	Report is due in 2021	Reviewed in 2018	Report is due in 2020	Report was due in 1999	Report due in 2021	Report submitted in 2017

SRHR SNAPSHOT

There are 29.5 million adolescents in Bangladesh, including 14.4 million girls and 15.1 million boys, representing nearly one-fifth of the country's total population of 144 million.[155]

About 85% of girls in rural areas are married by the age of 16.[156]

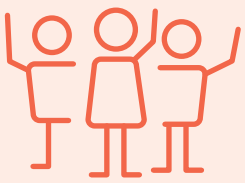
Contraceptive use rate among adolescents aged 15-19 is only 42%.[157]



Adolescents aged 15-19 contribute up to one-fourth of total fertility rate.[158]

HIV information and awareness is severely lacking among adolescents and young people in Bangladesh, especially young women.[159]

Few public health interventions are in place that specially cater to adolescents' SRH needs.[160]



Conservative attitudes and traditions, combined with social stigma, affect the SRHR of adolescents, especially girls.

155. Ainul, Sigma et al (2017), *Adolescents in Bangladesh: A Situation Analysis of Programmatic Approaches to Sexual and Reproductive Health Education and Services*. Washington, DC & Dhaka, Bangladesh: Population Council, The Evidence Project, http://evidenceproject.popcouncil.org/wp-content/uploads/2017/02/Bangladesh-ASRH-Report_January-2017.pdf.
156. UNFPA (2012), *Marrying Too Young: End Child Marriage*, New York: UNFPA, www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf.
157. Ainul, Sigma et al (2017).
158. Ibid.
159. Ibid.
160. Ibid.

In many respects, the current policy framework in Bangladesh on young people's SRHR is promising, with national policies such as the *Adolescent Reproductive Health Strategy (2006)*, and the recently developed and approved *National Adolescent Health Strategy (2017-2030)*. However, policy implementation is lacking and needs to be strengthened, in terms of CSE curricular content and provision; youth-friendly SRH information and services, particularly for unmarried youth and adolescents (and especially girls);[161] and addressing the ongoing discrimination, stigma, harassment and violence faced by persons with diverse SOGIE.[162,163]

CSE

The CSE content and curriculum provided in Bangladeshi public schools, which is meant to adhere to the guidelines of the National Curriculum and Textbook and Board (NCTB), is currently insufficient. It leaves adolescents with very little conceptual understanding of issues such as reproduction, affirmative sexuality, sexual behaviour, gender, and sexual and gender diversity. The undertone of the current content also perpetuates gender stereotypes and stigma related to sexuality, and fails to address the SRH needs of adolescents and young people. For example, the chapter on menstruation and puberty has connotations of purity and perpetuates the concept of menstrual blood being dirty. It also prohibits premarital sexual intercourse and discourages open discussions about HIV and AIDS.[164,165,166]

The implementation of this curriculum is also very limited; teacher training on CSE has not yet been effectively institutionalized and therefore teachers are often unable to approach teaching the module in an effective manner. Teachers do not use a rights-based approach and often stigmatize issues around SRH, influencing the transfer of information with their judgements and perceptions. Moreover, the curriculum is implemented for grade 6 and above, hence an important opportunity is lost in terms of reaching out to adolescents before their ideas and perceptions around these issues are formed. Girls' dropout rate is also higher from secondary school onward, so their access to CSE and SRHR information becomes even more limited. The curriculum is also not uniform or consistent. For example, the curriculum being taught in Madrassa is different from the curriculum of Bangla and English medium public schools.[167,168]

The *Adolescent Reproductive Health Strategy* of 2006 recommended the inclusion of CSE in the school curriculum, with special services for out-of-school and married adolescent girls.[169] However, implementation remains hindered by stigma and the reluctance of teachers to discuss SRH issues.[170] While some CSOs have developed supplementary materials to address young people's knowledge gap on SRHR, in 2017 the government circulated that, before any extra curriculum materials could be used in schools, they must have prior government approval, effectively banning these supplementary materials. Moreover, the textbooks which do contain SRHR content are not addressed in a regular exam/evaluation process and, consequently, these particular chapters are not regarded important by teachers or even by students.

161. Ibid.
162. Wong, Christina Misa and Shanthi Noriega (2013), *Exploring Gender-Based Violence Among Men Who Have Sex with Men, Male Sex Worker and Transgender Communities in Bangladesh and Papua New Guinea: Results and Recommendations*, FHI 360, www.wewillspeakout.org/wp-content/uploads/2013/11/GBV-Study-report_Final-FHI_PNG-and-Bangladesh.pdf.
163. ARROW and the Sexual Rights Initiative (SRI) (2018), *Submission to the Universal Periodic Review of Bangladesh, 30th Session*, www.sexualrightsinitiative.com/wp-content/uploads/UPR-Bangladesh-RHRN-Final-Submission.pdf, p. 3.
164. Sabina, Nazme (2016), *National Report: Religious Extremism and Comprehensive Sexual and Reproductive Health and Rights in Secondary and Higher Secondary Education in Bangladesh*, Dhaka & Kuala Lumpur: Naripokkho, ARROW, http://arrow.org.my/wp-content/uploads/2017/03/National-Report-Final-with-cover.pdf .
165. ARROW and SRI (2018), p. 3-4.
166. Citizens' Initiatives on CEDAW, Bangladesh (2016), *Eighth CEDAW Shadow Report to the UN CEDAW Committee*, http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/BGD/INT_CEDAW_NGO_BGD_25377_E.pdf, p. 5-6.
167. Sabina, Nazme (2016).
168. ARROW and SRI (2018), p. 2-4.
169. ARROW (2016), *Country Profile on Universal Access to Sexual and Reproductive Health and Rights: Bangladesh*, http://arrow.org.my/wp-content/uploads/2017/04/Bangladesh-Country-Profile-on-SRR.pdf.
170. ARROW and SRI (2018), p. 4.

ADOLESCENT SRH SERVICES

Currently there are timely policies in place in regards to adolescents' SRH needs. The *National Adolescent Health Strategy (NAHS) 2017-2030*, approved in 2017, envisions that by 2030 all adolescents in Bangladesh will be able to enjoy a healthy and productive life in a socially secure and supportive environment. Guided by human rights principles, this strategy also states that all adolescents, irrespective of their gender, age, class, caste, ethnicity, religion, disability, civil status, sexual orientation, geographic divide or HIV status, have the right to attain the highest standard of health. In line with the NAHS, The Ministry of Health and Family Welfare has expressed its commitment to ensure the effective implementation of this strategy. While a progressive policy is within reach, comprehensive implementation is needed quickly, in order to address the barriers young people experience in attempting to access youth-friendly health services, particularly if they are unmarried.

Existing reproductive healthcare services do not cater to the SRH needs of unmarried adolescents due to stigma and structural barriers. A recent analysis of the effectiveness and gaps in existing adolescent SRH interventions and programmes revealed SRH clinical service delivery remains primarily limited to married women and girls and mainly covers family planning, antenatal care and deliveries. Limited targeted clinical services (free of parental consent requirements) are available to unmarried adolescents, hindering their access to contraception, HIV prevention, STI treatment, and other SRH services, and making them vulnerable to health risks and discriminatory treatment. The government has attempted to address these challenges by initiating Adolescent Friendly Health Centers, however, the reach of these initiatives remains limited due to several factors, including quality of the services, the density and location and capacities of the staff at these facilities. Unmarried youth and adolescents also hesitate to access these services due to the issues of privacy, confidentiality, and significant stigma associated with unmarried adolescent seeking SRH services.[171,172]

LGBTI RIGHTS

While the Constitution in Bangladesh guarantees the right to freedom from discrimination and equal access to services for every citizen,[173] there is no practical application of such fundamental principles when it comes to the rights of persons of diverse SOGIE.[174] In 2014, Bangladesh took a critical step forward in giving official recognition to the long-marginalized Hijra population by officially acknowledging the community as the "Hijra sex" or "third gender," including for the purposes of voting, travel, identification and other core civil rights.[175] However, the government neglected to define this gender category, or provide a definition of transgender persons, thereby effectively failing to protect the rights of all transgender populations and other gender-diverse groups. The absence of a legal definition has led to abuses in the implementation of the legal change regarding recognition of Hijras,[176,177] and in the absence of a rights-based procedure for the legal recognition of the Hijra community and other transgendered persons, they remain vulnerable to violations of their human rights.[178] In addition, the progressive nature of this law can be questioned, in that such individuals are required to undergo often humiliating medical examinations, resulting in further stigmatization.[179]

Moreover, section 377 of the Bangladesh Penal Code criminalizes all non-normative sexual acts as "unnatural offences." This results in gender-diverse and sexually diverse communities, among others, being subjected to stigma, discrimination and violence, and also creates significant barriers for their access to many fundamental services, including SRH healthcare and legal redress. This criminalization further perpetuates the social stigmatization of persons with diverse SOGIE and makes them even more vulnerable to discrimination, harassment and violence, from family members, schoolmates, police, and at the workplace, healthcare facilities, and government offices.[180] The criminalization also potentially affects the security of HRDs and activists who work for the rights of these diverse communities.[181]

171. Ainul, Sigma et al (2017).
172. ARROW and SRI (2018), p. 4
173. *The Constitution of the People's Republic of Bangladesh* (1971), http://bdlaws.minlaw.gov.bd/pdf_part.php?id=367.
174. ARROW and SRI (2018), p. 5.
175. Ahmed, Shale (2015), *Recognition of 'Hijra' as Third Gender in Bangladesh*, Bandhu Social Welfare Society, www.csbronline.org/wp-content/uploads/2016/08/ShaleAhmed_HjraRights_CSBR-ILGAAsia2015.pdf .
176. Human Rights Watch (2016), *"I Want to Live With My Head Held High:" Abuses in Bangladesh's Legal Recognition of Hijras*, www.hrw.org/report/2016/12/23/i-want-live-my-head-held-high/abuses-bangladeshs-legal-recognition-hijras.
177. Hossain, Adnan, (2017), "The Paradox of Recognition: Hijra, Third Gender and Sexual Rights in Bangladesh," *Culture, Health & Sexuality* 19(12): 1418-1431, www.tandfonline.com/doi/full/10.1080/13691058.2017.1317831.
178. Ahmed, Shale (2015).
179. ARROW and SRI (2018), p. 5.
180. Wong, Christina Misa and Shanthi Noriega (2013).
181. ARROW and SRI (2018), p. 2-6.

In 2017, the National Human Rights Commission in Bangladesh agreed to establish a desk for reporting SOGIE-related issues. Longstanding demands from civil society have also resulted in the formulation of a draft Anti-Discrimination Act that addresses, among other issues, discrimination on the grounds of gender identity and profession. However, the draft law has still not been passed, thereby delaying the provision of legal protection for gender and sexual minorities from discrimination in all aspects of their lives, including their sexual and reproductive lives.

RECOMMENDATIONS

CSE

- Evidence-based, scientific and nonjudgmental information and skills-building need to be incorporated into the NCTB by the Ministry of Education. The curricula should include content on SRHR, support services, sexual harassment, GBV, cyber-crime, child marriage, critical reasoning, and negotiation skills. Content should also be rights-based rather than perpetuating gender stereotypes and stigmatization.
- The development of the curriculum by the NCTB should be done through a consultative process engaging women, girls, young people, parents, teachers, and CSOs to ensure that the CSE curricula covers SRHR issues comprehensively, consists of progressive content, and addresses current shortcomings.
- Age-appropriate CSE should start from the primary level and synchronized across different education systems.

YOUTH-FRIENDLY SRH SERVICES

- The NAHS needs to be revised and effectively implemented to ensure that a range of SRH services, including contraceptives and menstrual regulation services, are of good quality, affordable and accessible for both unmarried young men and women, free from parental consent requirements and available in all public health facilities.

LGBTI RIGHTS

- The government should provide a clear, inclusive and dignified definition in the law of what constitutes the "third gender" and also clarify the distinction between "intersex" and "transgender" and other gender identities, by enacting legislation that protects and promotes the fundamental rights of individuals with diverse gender identities, through consultations with the Hijra community, the transgender population, intersex persons, SRHR experts, human rights activists and NGOs, and by taking their recommendations into account.
- The government should amend Section 377 of the Penal Code 1860 to decriminalize nonnormative consensual sexual acts, and address stigma, discrimination, harassment and violence against persons with diverse SOGIE.
- The government should pass the Anti-Discrimination Act, thereby ensuring the legal protection of gender and sexual minorities from discrimination in all aspects of their lives.

Indonesia

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	2006	2006	1984	1998	1990	2011
Date of last review	2013	2014	2012	2008	2014	N/A
Next report due date	Report was due in 2017	Report due in 2019	Report was due in 2016	Report was due in 2012	Report due in 2019	Report was submitted in 2017

SRHR SNAPSHOT

Young people aged 10-24 years old represent approximately 28% of the total population, or 65 million people in Indonesia.[182,183]

An estimated 41% of Indonesian women have experienced at least one form of violence in their lifetime (physical, sexual, emotional and/or economic).[184]

Approximately one in seven girls is married before turning 18 years old, with child marriage rates as high as 35% in some regions of the country.[185]

Roughly 1.7 million women and girls under 24 years old give birth each year in Indonesia, of which almost half a million are teenagers.[186]

HIV and SRHR knowledge levels among young people are low, with data indicating that only 49.4% of girls and 50.1% boys aged 15-19 years know that one-time sexual intercourse can lead to pregnancy; and 75.2% girls and 76.5% of boys are unable to recognize signs of STIs.[187]

Religious and cultural values make it taboo for people to talk about sex and particularly young people's SRH needs, while also reinforcing anti-LGBTI beliefs and attitudes.

182. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on His Mission to Indonesia*, A/HRC/38/36/Add.1, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G18/084/20/PDF/G1808420.pdf?OpenElement, para. 73.

183. Central Bureau of Statistics [Indonesia] (2015), *Penduduk Indonesia: Hasil Survei Penduduk Antar Sensus 2015*, Jakarta: Badan Pusat Statistik, www.bps.go.id/index.php/publikasi/1155.

184. UNFPA (2017), *New Survey Shows Violence Against Women Widespread in Indonesia*, www.unfpa.org/news/new-survey-shows-violence-against-women-widespread-indonesia.

185. Girls Not Brides (2018), *Child Marriage Around the World: Indonesia*, www.girlsnotbrides.org/child-marriage/indonesia/.

186. Utomo, Iwu (2013), *Indicators and Correlates of Adolescent Pregnancy in Indonesia*, UNFPA Indonesia, http://indonesia.unfpa.org/sites/default/files/pub-pdf/Indicator_and_Correlates_of_Adolescent_Pregnancy_in_Indonesia.pdf, p. 6.

187. Statistics Indonesia et al (2013), *Indonesia Demographic and Health Survey 2012: Adolescent Reproductive Health*, Jakarta: BPS, BKKBN, Kemenkes and ICF International, https://dhsprogram.com/pubs/pdf/FR281/FR281.pdf.

As noted by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Indonesia has undertaken some commendable steps towards realizing the health of its diverse population, such as efforts to develop a universal health-care insurance system and to achieve universal health coverage by 2019.[188] However, though there is diversity of race, ethnicity, language, religion, and belief systems in Indonesia, the country's pluralism is currently threatened by a rise of conservatism in society.

Indonesia is presently characterized by regulations and policies from central and local governments which refer to only one religion and moral standard, and in turn increasing cases of violence and intolerance against non-majority groups; threats to freedom of expression and sexual diversity; a predominance of heteronormative culture and conservative gender ideology; and also policies and laws that are not in favor of young people[189] or LGBTI groups.[190] There is also a lack of social acceptance of young people's sexuality and of sexual diversity, which is reflected in the insufficient availability of information and restricted access to SRH services, as well as in violence and discrimination towards LGBTI individuals.

CSE

The right to obtain information, protection and assistance to realize every citizen's reproductive rights in accordance with social ethics and religious norms is secured at the national level in Article 5C of the Population Law No. 52/2009 as well as in Article 73C of the Health Law No. 36/2009. Government Regulation No. 87 of 2014 on *Population Development, Family Development, Family Planning and Family Information System*, includes the right to receive correct information about reproduction in order to be able to make healthy and responsible decisions in one's sexual life. Government Regulation No. 61 of 2014 on Reproductive Health also states that young people have a right to receive communication, information and education as part of reproductive health services in formal and non-formal environments.[191]

The Indonesian government has made some progress on implementing CSE through setting an objective on "increased knowledge and understanding of reproductive health for young people" in the *Midterm National Development Plan 2015-2019* and the *Strategic Plan 2015-2019* of the Ministry of Education and Culture (MoNE), to increase the average age of marriage and to reduce the number of teenage pregnancies. Also, in addition to the above-mentioned 2014 governmental regulations outlining young people's right to reproductive health information and education, the government issued a presidential instruction on the prevention of child sexual abuse.[192] This presidential instruction stipulates that reproductive health and child empowerment should be included in the curriculum to be implemented by MoNE, the Ministry of Health (MoH) and the Ministry of Religious Affairs (MoRA). However, implementation and monitoring of these regulations, as well as the requirement for more coordination among ministries, has often been slow. There have also been few regulations regarding the content of the education materials, which to date has often not been comprehensive, gender-sensitive nor rights-based, while predominantly emphasizing abstinence.[193,194] The pornographic law No.44/2008 is also potentially restrictive as it prohibits all materials that depict anything that is considered to violate moral norms in society, a restrictive stance which is also reflected in the Law on Information and Electronic Transactions, No.11/2008.[195]

In an effort to boost the quality of adolescents' SRHR materials, UNFPA and UNESCO introduced the International Technical Guidelines on Sexuality Education (ITGSE) in Indonesia in 2012. Based on the ITGSE, the MoH developed National Reference

188. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), paras. 32-34.
189. Parker, Lyn and Pam Nilan (2013), *Adolescents in Contemporary Indonesia*, UK: Routledge.
190. Human Rights Watch (2016), *"These Political Games Ruin Our Lives:" Indonesia's LGBTI Community Under Threat*, www.hrw.org/report/2016/08/10/these-political-games-ruin-our-lives/indonesias-lgbt-community-under-threat.
191. Rutgers WPF Indonesia et al (2017), *Joint Submission to the Universal Periodic Review of Indonesia*, www.sexualrightsinitiative.com/wp-content/uploads/Indonesia-NGO-coalition-UPR27-Stakeholder-Submission-FINAL.pdf, p. 3.
192. Ibid, p. 2-3.
193. Ibid.
194. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), para. 76.
195. Rutgers WPF Indonesia et al (2017), p. 4.

Material for Teachers on Adolescent Reproductive Health Education, launched at national level in 2015.[196] Promisingly, the MoNE has since developed a Draft of a National Curriculum on Diversification of Reproductive Health Education intended for elementary, junior and senior high schools, incorporating modules which are supported by UNFPA, UNICEF, and UNESCO, and which draw on the ITGSE. This curriculum is set to be launched over the course of 2018 via a Regulation of the Minister of Education and Culture (PERMENDIKBUD). Potential challenges relate to implementation, in terms of ensuring teachers are equipped with sufficient capacity to effectively use standardized delivery methods and relay the content as outlined in the modules.

ADOLESCENT SRH SERVICES

As observed by the Special Rapporteur, "positive initiatives have been launched to create a supportive environment for young persons' sexual and reproductive health, such as the incorporation of adolescent sexual and reproductive health in the *National Action Plan on School Aged Child and Adolescent Health 2017–2019*."[197] Adolescent friendly reproductive health services are also being implemented through the young people-Friendly Health Care programme in a few centres on a pilot basis, and introduced in a limited number of communities.[198] And in 2009, the rights of young people to information, services and commodities for SRHR was ratified by Health Law No. 36.

However, premarital sexual activity is highly taboo in Indonesia, and contraceptives are only available for married couples, as stated in the Health Law No. 36/2009 and Government Regulation No. 61/2014. Moreover, based on Health Minister Regulation No. 74/2014, adolescents under 18 years old must be accompanied by and/or be provided with informed consent from their parents in order to access health services related to HIV prevention. Besides that, service hours in public health services (08.00-15.00) make it nearly impossible for young people (mainly students) to visit during opening hours. And while the MoH has developed guidelines for service delivery to young people, these guidelines do not cover the minimum standard of SRHR services for young people such as contraception, HIV prevention, and safe abortion. Furthermore, a proposed revision in the Criminal Code contains articles which criminalize the "showing of" and the "promotion of device" to prevent pregnancy. If these articles are to be retained and/or enforced, the provision of services or contraceptives to unmarried individuals will further become a criminal act,[199] and "risk creating additional barriers for women and certain key populations in the realization of their right to health."[200]

LGBTI RIGHTS

Though there is no national legislation that criminalizes same-sex relationships in Indonesia, legislation that perpetuates discrimination on the basis of sexual orientation still exists. For example, law No. 44 of 2008 on Pornography includes "lesbian" and "homosexual" as examples of "deviant sexual behaviours" in its explanation page.[201] Government Regulation No. 54 of 2007 on the Implementation of Child Adoption prohibits same-sex couples from adopting children.[202] Moreover, Government Regulation No. 61 of 2014 on Reproductive Health uses the term "sexual orientation disorder" in one article and includes "homosexual/lesbian" as examples of "deviant sexual behaviours" in the explanation part of another article.[203]

In effect, the right to protection from discrimination on the grounds of SOGIE is not specifically recognized by the State, resulting in ongoing intimidation and violence towards LGBTI individuals. This lack of state protection was apparent when the existence and position of LGBTI persons became a topic of heated public controversy in early 2016. Public officials gave statements rejecting, stigmatizing or discriminating against LGBTI people, which led to outbursts and actions towards LGBTI groups and resulted in violations of their civil, political, economic, social and cultural rights.[204] In Indonesia, there seems to be a

196. Ibid, p. 3.
197. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), para. 74.
198. Susilo, Zumrotin K. (2014), *Country Profile on Universal Access to Sexual and Reproductive Rights: Indonesia*, Kuala Lumpur: ARROW, http://arrow.org.my/wp-content/uploads/2015/04/Country-Profile-SRH-Indonesia.pdf.
199. Rutgers WPF Indonesia et al (2017), p. 4.
200. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), para. 89.
201. Rutgers WPF Indonesia et al (2017), p. 6.
202. Ibid.
203. Ibid.
204. Ibid, p. 6-8.

lack of understanding on human rights in general and on LGBTI rights as a part of human rights. The omission of SOGIE-related information in current reproductive health education contributes to a lack of understanding of sexual diversity in the society at large, which in turn perpetuates religious and cultural stances that are antithetical to LGBTI rights.

Cases of violence and discrimination based on sexual orientation are reported all over Indonesia, such as in Aceh.[205,206] Local governments, like Aceh, are allowed to make their own local regulations that may criminalize same-sex relationships or transgender identities or expressions, even though at national level this is not punishable. As such, a bylaw based on Sharia by the name Qanun Jinayat was implemented in Aceh at the end of 2015[207] with punishments including that anyone doing *liwath* (anal sex between two consenting men) or *musahaqah* (tribadism between two consenting women) will be punished by the maximum of 100 lashes or 1,000 grams of gold fine or 100 months of imprisonment. This implies that two women hugging in public can be accused of breaching this bylaw as seen in a case in 2015.[208]

A recent positive development in Indonesia came through the Chief of Police's Circular Letter No. SE/6/X/2015 as it included the prohibition of Hate Speech on the basis of sexual orientation. However, this circular serves as guidance for police officers only. Furthermore, while the government has undertaken efforts to conduct numerous human rights training courses for police and military officers, government agencies have still failed to address various forms of violence and discrimination against LGBTI, especially during the rise of public controversy and rejection such as in January-March 2016.[209] There have also been alarming attempts to nationally criminalize LGBTI and consensual same-sex behaviour,[210,211,212] thereby further escalating and reinforcing stigma towards LGBTI people.

205. Simanjuntak, Hotli (2010), "Gays, Lesbians face discrimination in Sharia Aceh," *The Jakarta Post*, www.thejakartapost.com/news/2010/01/20/gays-lesbians-face-discrimination-sharia-aceh.html.
206. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), para 87.
207. Rutgers WPF Indonesia et al (2017), p. 5.
208. Ibid.
209. Ibid, p. 5-6
210. Hodge, Amanda (2018), "Indonesia on the Brink of Banning All Sex Outside of Marriage," *The Australian*, www.theaustralian.com.au/news/world/indonesia-on-the-brink-of-banning-all-sex-outside-marriage/news-story/422bb0543035e91e9c7ab093ca36fc3b.
211. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2018), para 89.
212. Rutgers WPF Indonesia et al (2017), p. 6.

RECOMMENDATIONS

CSE

- The government should implement, monitor, evaluate and allocate adequate resources to the delivery of CSE, and ensure that it is evidence-based and in line with the ITGSE. CSE content should go beyond biological explanations of reproduction, and promote gender equality, human rights, and an understanding of diverse SOGIE, in order to prevent related violence and discrimination.
- The government should engage in a collaborative relationship with civil society including young people and teachers to promote CSE according to the ITGSE by UNESCO within and outside the school environment, thereby also ensuring the meaningful participation of young people in the policies and programmes that affect their lives.
- The government should ensure sufficient training for teachers to fully implement and deliver CSE and RH education related modules, in line with the ITGSE.

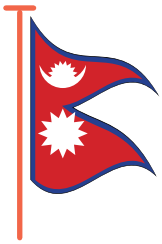
ADOLESCENT SRH SERVICES

- The government should ensure that access to SRH services for young people is in place and not restricted by the pornography law, ITE law or the Criminal Code.
- The MoH should integrate contraception provision for all (irrespective of marital status) into essential reproductive health packages (including the guidelines) as part of the government's mandate via regulation No. 61/2014 about reproductive health, including allocated budget for full implementation.

LGBTI RIGHTS

- The government, through the Ministry of Justice and Human Rights, should uphold the rights of all Indonesians to be free from violence, stigma and discrimination on any basis, and should ensure the rights of diverse groups, including LGBTI persons.
- In accordance with the Constitution of 1945 article 28E, the government should directly and unequivocally provide protection for the freedom of association, freedom of assembly, and freedom of expression, for all citizens including LGBTI persons, by protecting every peaceful assembly from forced dissolution.
- The government must reject any requests to criminalize LGBTI persons and/or consensual sexual activity.

Nepal



SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1991	1991	1991	1991	1990	2010
Date of last review	2014	2014	2011	2007	2016	2018
Next report due date	Report is due in 2018	Report is due in 2019	Report was submitted in 2017	Report was due in 2016	Report is due in 2021	Report is due in 2024

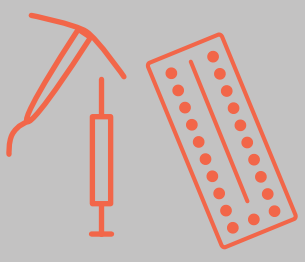
SRHR SNAPSHOT

Adolescents and young people make up approximately one third of Nepal's 26.5 million population.[213,214]

Nepal has one of the highest rates of child marriage worldwide, where 37% of girls are married before turning 18 years old.[215]

17% of young women aged 15-19 in Nepal are already mothers or pregnant with their first child.[216]

One in four married women aged 15-19 have an unmet need for contraceptives.[217]



Only 26% of young women and 34% of young men have comprehensive knowledge about HIV and AIDS.[218]

Barriers such as geographical terrain, intergenerational gaps in attitudes of youth and family elders, taboos surrounding speaking about sex, prohibitive costs and lack of communication and correct information continue to hinder young people's access to SRH services.

213. UNFPA Nepal (2017), *Health Minister Launches Mobile App to Promote Adolescent Sexual and Reproductive Health in Nepal*, http://nepal.unfpa.org/en/news/health-minister-launches-mobile-app-promote-adolescent-sexual-and-reproductive-health-nepal.
214. UNFPA Nepal (2017), *Population Situation Analysis of Nepal (With Respect to Sustainable Development)*, UNFPA Nepal, https://nepal.unfpa.org/sites/default/files/pub-pdf/Nepal%20Population%20Situation%20Analysis.pdf, p. 3.
215. Girls Not Brides (2018), *Child Marriage Around the World: Nepal*, www.girlsnotbrides.org/child-marriage/nepal/.
216. Ministry of Health, Nepal, et al (2017), http://nepal.unfpa.org/sites/default/files/pub-pdf/NDHS%202016%20key%20findings.pdf, p. 4.
217. Ibid, p. 6.
218. UNAIDS (2018), *Nepal*, www.unaids.org/en/regionscountries/countries/nepal.

Nepal is known as one of the most progressive countries in the region in terms of SRHR laws and policies. However, full implementations of the laws and policies needs to be strengthened, particularly in terms of young people's access to CSE, safe abortion services, and LGBTI rights. Moreover, policy and programme implementation is set to be further challenged by the country's political transition to federalism, in that there currently is limited clarity regarding governance mechanisms and how to operationalize the federal structure. As each provincial government will have its own policies, this might also risk the adoption of regressive policies, and pose challenges for consistency.

CSE

In Nepal, there have been some positive developments in terms of young people's access to CSE. In the public school system, CSE is taught from grade 6 onwards, where the curriculum incorporates some components of SRHR under the subject of Environment, Population, and Health. The curriculum however is not as comprehensive as it should be, in that its focus on sexual health and sexuality could be strengthened, as well as its focus on SRHR-based life skills. Also, the curriculum does not include advice on where to go for further information, nor does it promote discussing these issues at home with parents or siblings. Moreover, though the CSE curriculum is meant to be introduced in grade 6, in practice the bulk of the course is introduced in grade 9 when students may have already received SRH-related information from less reliable sources, and/or initiated sexual activity. Likewise, the implementation of CSE in schools has been hindered by a lack of a conducive teaching-learning environment, inadequate teacher training and skills development, and lack of proper monitoring mechanisms. Notably, the Curriculum Development Center and National Center for Education Development (NCED) under the Ministry of Education (MoE) have been revising the school level CSE curriculum for students and CSE training for teachers, also in the aim of having CSE taught from grade 3 onwards.

Nepal also has a significant number of young people who are out of school, where according to the MoE's 2011-2012 Annual Report, the overall dropout reveals that around 40% of children leave during various levels of schooling. The situation is even worse in community-based schools and in the schools of Terai Region. The Ministry of Youth and Sports has established Youth Information Centers, with the motive of providing information to young people regarding SRHR, economic opportunity and employment, leadership and civic education which are currently operating in all the 75 districts of the country. It has been an important resource in reaching out to young people, especially those that never attended school or are out of school. However, the Youth Information Centers currently focus more on sports rather than SRHR information.

ABORTION

Abortion was legalized in Nepal in 2002, where it is currently available up to 12 weeks' gestation on request, up to 18 weeks' gestation in cases of rape or incest, and at any time if the pregnancy poses a risk to the woman's life, physical or mental health, or if there is a fetal abnormality.[219] Notably, the legalization of abortion has contributed to a sharp decline in maternal mortality, falling from 580 maternal deaths per 100,000 live births in 1995 to 190 per 100,000 in 2013.[220]

Despite this progressive legislation, access to safe abortion information and services remains a challenge, particularly among young people. Abortion-related stigma in Nepal continues to be very high, of which one indication is that only 4 out of 10 women know that abortion is legal in the country.[221] Moreover, the costs associated with the procedure are often prohibitive, leading to women and girls seeking unsafe options and putting their health and lives at risk.[222] There also is a lack of regulations and monitoring of illegal abortion; where the Ministry of Health and Population has estimated in its 2014-2015 Joint Annual Review Report that approximately 200,000 abortions remain undocumented and

219. Guttmacher Institute (2017), *Abortion and Unintended Pregnancy in Nepal*, www.guttmacher.org/fact-sheet/abortion-unintended-pregnancy-in-nepal.
220. Ibid.
221. Ministry of Health, Nepal, et al (2017), p. 15.
222. Guttmacher Institute (2017), *Abortion and Unintended Pregnancy in Nepal*.

that the majority of them are unsafe. In 2015, the government announced that its budget for the fiscal year would provide for free safe abortion services from government health institutions. However, due to the lack of implementation directives, it has yet to be fully put into practice. Currently, the Family Health Division has revised the directive principles regarding abortion services, focusing on the aspects of quality and service delivery, which is an important step towards ensuring that once approved and disseminated, the directive principles ensure accessibility and availability of quality safe abortion services. However, the revised directive principles still require approval from the Ministry of Health, while further work is needed to ensure that the directive principles also provide guidance to health care centers on how to provide quality abortion services that are also both stigma-free and youth-friendly.

Moreover, while conditional abortion is currently legalized, it is situated under homicide-related provisions in the criminal act of the Civil Code (Muluki Ain). This needs to be amended in order to better ensure that abortion is free and accessible, increase public understanding of the legal status of abortion, and to help counter related stigma. Currently a Reproductive Health Bill has been tabulated before Parliament, which includes provisions regarding free and safe abortion; however, it has yet to be passed.

LGBTI RIGHTS

Efforts to ensure the rights of LGBTI are progressively taking place, with increasing recognition in the Constitution and other legal documents. The new Constitution promulgated in 2015 recognized the Third Gender as citizens of Nepal and prohibits discrimination based on gender; the Ministry of Women Children and Social Welfare has also announced the formulation of a steering committee comprising representatives from the LGBTI community to draft the "Same Sex Marriage Bill." The bill however has not yet been developed, and in the absence of laws for same sex marriage, third gender people and others from the LGBTI community are also unable to adopt children. Moreover, several laws and guidelines that were formulated before the 2015 New Constitution still need to be revised, in order to fully ensure the rights of LGBTI individuals in Nepal. Another major challenge of LGBTI individuals in Nepal is that the public is still not sensitive to LGBTI rights, which needs to be enhanced through awareness-raising initiatives, in order to reduce the stigma and discrimination they face. There also still remains little government data regarding the LGBTI population in Nepal, which needs to be strengthened.

RECOMMENDATIONS

CSE

- Continue efforts to ensure the effective implementation of CSE curriculum for young people both in and out of school, with adequate budget allocation and monitoring mechanisms. Ensure both young people's and civil society's participation in the revision and strengthening of the CSE curricula, budget, and associated monitoring mechanisms.
- Continue efforts to provide CSE at an earlier age, consistent with young people's evolving capacities, to ensure that they are receiving evidence-, life skills- and rights-based information early on in their psychosocial development.
- Continue efforts by the NCED to strengthen teacher training on CSE, and allocate sufficient budget for this training.

ABORTION

- Continue efforts to ensure that quality, stigma-free and youth-friendly safe abortion services are accessible and available at all public health institutions, with adequate budget allocation and proper monitoring mechanisms.[223]
- Pass the Reproductive Health Bill with provisions for safe abortion services, so that safe abortion has a distinct provision in the legal mechanism, and is not included in the Killing (Homicide) Act.
- Reduce women's and young people's recourse to clandestine procedures by disseminating information about the legal status of abortion and where to obtain legal abortion services.[224]

LGBTI RIGHTS

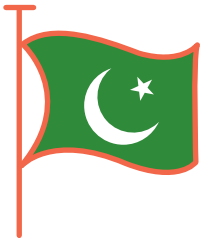
- The government should support the Same-Sex Marriage Committee and accelerate the passing of the same-sex marriage bill, which should also include provisions regarding adoption, property inheritance rights, divorce and other relevant legal rights.
- The government should undertake awareness-raising events and initiatives to further generate public support and create an enabling environment for marriage equality.
- The government should implement measures to ensure better data collection regarding the LGBTI population in Nepal, to further inform the development and implementation of relevant social and health policies.

Lastly, an overarching recommendation is that during Nepal's political transition to federalism, it will be essential to ensure that the formulation and implementation of SRHR laws and policies at provincial level is consistent across the country, in ensuring a comprehensive, rights-based approach.

223. Guttmacher Institute (2017), *Abortion and Unintended Pregnancy in Nepal*.

224. Ibid.

Pakistan



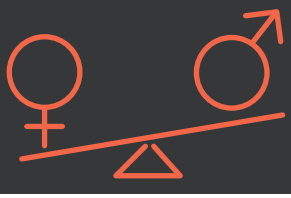
SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	2010	2008	1996	2010	1990	2011
Date of last review	2017	2017	2013	2017	2016	N/A
Next report due date	Report is due in 2020	Report is due in 2022	Report was due in 2017	Report is due in 2021	Report is due in 2021	Report was due in 2013

SRHR SNAPSHOT

Approximately two thirds of the country's total population of nearly 208 million[225] is currently below the age of 30.[226]

Pakistan has a very high Gender Inequality Index of 0.5 (ranking 121 out of 155 countries in the 2014 Index).



The overall contraceptives prevalence rate among women of reproductive age is 30% which is even lower among married women ages 15-24 (17.6%).[227,228]

Due to prevailing socio-cultural norms, young girls, after entering puberty, face greater challenges in accessing education opportunities and health care than young boys.[229]

Homosexuality is currently criminalized under section 377 of the Pakistan Penal Code, and LGBTI individuals are often subject to emotional, verbal, and physical abuse.

The median age of marriage for girls in Pakistan is 19.5, indicating that half the numbers of girls are married off before the age of 20.[230]

225. Jorgic, Drazen (2017), "Pakistan's Population Surges to 208 Million: Bureau," *Reuters*, www.reuters.com/article/us-pakistan-census/pakistans-population-surges-to-208-million-bureau-idUSKCN1B51AU.
226. UNDP Pakistan (2017), *Summary Pakistan National Human Development Report: Unleashing the Potential of a Young Pakistan*, Islamabad: UNDP Pakistan, www.pk.undp.org/content/dam/pakistan/docs/HDR/NHDR_Summary%202017%20Final.pdf, p. 1.
227. Right Here Right Now (RHRN) Pakistan (2018), *Policy Brief on Youth Friendly Health Services*, p. 2.
228. Population Council and UNFPA (2009), *The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People: Pakistan 2006/07*, New York: Population Council, www.popcouncil.org/uploads/pdfs/PGY_AdolDataGuides/Pakistan2006-07.pdf.
229. Rahnuma Family Planning Association of Pakistan and SRI (2017), *Submission to the Universal Review of Pakistan, 28th Session*, www.sexualrightsinitiative.com/wp-content/uploads/Stakeholder-UPR-Submission-Pakistan.pdf, p. 3.
230. National Institute of Population Studies [Pakistan] and ICF International (2013), *Pakistan Demographic and Health Survey 2012-13*, Calverton: National Institute of Population Studies and ICF International, www.nips.org.pk/abstract_files/PDHS%20Key%20Findings%20FINAL%201.24.14.pdf .

In Pakistan, there have been several initiatives to improve reproductive health and family planning. However, policy formulation has been uneven, with implementation being an ongoing challenge across all four provinces.[231] Moreover, comprehensive policies for young people's and the transgender community's SRHR have often largely been missing from the provincial policies around health and population welfare, of which two notable areas are the provision of CSE, and ensuring young people and transgender individuals' access to SRH services.

In youth consultations undertaken with 197 young people by RHRN Pakistan in the lead-up to the 28th session of the Universal Periodic Review (UPR), transgender youth and girls were mentioned as the two groups facing the most severe sexual health issues.[232] In effect, young people's SRHR do not feature strongly enough in the formulation and implementation of provincial health and population policies and strategies, and consequently budgets and resources are not allocated for these needs.

CSE

The incorporation of Life Skills Based Education (LSBE)[233] in mainstream curricula in secondary and higher education has been relatively included in Pakistan's education policies. However, implementation is severely limited because of a lack of capacity, political will and coordination between government sectors. The National Education Policy of 2009 contains no definition of LSBE or what particular skill is to be imparted through what curricula and at what stage. It is thus likely that skills not conforming to traditional values (such as those relating to SRHR) will not be included in any resulting curriculum and textbook reform. Moreover, in the absence of the full formulation and/or implementation of corresponding provincial policies, national policies continue to be in effect.

There have been some noteworthy NGO supported initiatives in the country, in partnership with the government, such as the LSBE programme in Punjab[234] run by SRHR NGOs, following a memorandum of agreement with the government. However, due to strong cultural and religious backlash the Punjab government cancelled the memorandum of agreement to include LSBE in the curriculum of public schools. The province's recently formulated *Adolescent Strategy and Strategic Plan (2013-2017)*[235] refers to the possibility of LSBE, but how and if it will actually be accomplished remains uncertain. In a recent positive move by the Punjab government, a decision has been taken to include a chapter on GBV in high school textbooks. This has been hailed by women's rights activists and civil society as a positive and revolutionary step forward. However, the implementation of this decision will take time. Ensuring that the content of the chapter is both comprehensive and rights-based will be crucial, and it should be accompanied by adequate teacher training.

The *Sindh Education Sector Plan 2014-18* is now set to be implemented and is pinned to fiscal reforms by the province to generate tax revenue for the social sector. The plan, approved by the Chief Minister, mentions LSBE as one of its policy actions, and the Sindh Government has made considerable progress towards the integration of LSBE in provincial curriculum. The School Education and Literacy Department along with the NGO Aahung has trained 550 master trainers on LSBE, who will be replicating trainings with 49,124 secondary school teachers across the province. In Balochistan, the government is in the process of setting up a Policy, Planning and Implementation Unit that would oversee educational reforms; and the Secondary Education Department has been collaborating with Aahung to integrate LSBE into the provincial curriculum. In Khyber Pakhtunkhwa (KP) there has not been any notable progress.

ADOLESCENT SRH SERVICES

In terms of policy formulation, some gradual progress in SRHR is being made. Two of the provinces (Punjab and KP) now have

231. The RHRN Platform in Pakistan works in the four provinces of the country: Punjab, Sindh, Balochistan and Khyber Pakhtunkhwa (KP). Because of the nature of Pakistan's government structure, RHRN work in the country is mainly focused on provincial levels, targeting decision makers in the political and administrative hierarchies.

232. Rahnuma Family Planning Association of Pakistan and SRI (2017), p. 3.

233. Locally used term for CSE.

234. Svanemyr, Joar et al (2015), "Scaling Up of LSBE in Pakistan: A Case Study," *Sex Education: Sexuality, Society and Learning* 15(3): 249-262, www.tandfonline.com/doi/full/10.1080/14681811.2014.1000454#.Vt-zw5N97BI.

235. Education & Literacy Department, Government of Sindh, *Sindh Education Sector Plan 2014-2018*, www.sindheducation.gov.pk/Contents/Menu/Final%20SESP.pdf.

youth policies that acknowledge the need to address the SRH of young people, and promote inclusivity and non-discrimination of any kind.[236] In Punjab, the *Adolescent Strategy and Strategic Plan (2013-2017)* stresses the need for developing "healthier and happy adolescents"[237] as well as empowerment and protection from all forms of abuse, violence and exploitation, while also committing to the establishment of Adolescent and Youth Friendly SRH services, LSBE, and youth-friendly training of grassroots service providers and teachers on SRH issues. In KP, the youth policy is particularly notable in that it includes many clauses related to pressing SRHR issues in Pakistan including transgender rights, access to contraceptives, counseling services, etc.[238]

Despite these positive efforts, the attention given to the SRH needs of young people remains insufficient. Provincial youth policies for both Sindh and Balochistan are still in draft form, where in Balochistan LSBE and youth-friendly SRH services are not political priorities. Moreover, the results of the RHRN youth consultations indicate that lack of awareness and information about SRHR is the most significant barrier to young people's health and wellbeing. The participants also identified the need for youth-friendly and gender-sensitive SRH services. As per the results of the surveys, 70% of the respondents were not using or accessing any Youth-Friendly Health Service (YFHS) in any form because they were either not aware of the facilities in their areas, or they did not know about YFHS. Most of the respondents stressed the role of the government in increasing access to information and services regarding SRHR.[239]

The RHRN survey further reveals that young people, transgender youth and sexual minorities suffer most from lack of information and services and are subject to stigma and discrimination.[240] Khawajasera (intersex or commonly called Transgender and/or *hijras*) were recognized as third gender in Pakistan in 2009,[241] where the Supreme Court also ordered the government to take steps to ensure that the Khawajasera community is not harassed and is provided equal opportunities for participation in the society. However, there is still widespread discrimination against transgenders at health facilities, as health providers are not sensitized and there are no special provisions for transgender individuals in the policies of health facilities. Though the exact scale of discriminatory practices against transgender individuals is unknown, the survey respondents also shared that health service providers are not trained to respond to transgender people's specific and diverse needs and lack understanding of their SRH.[242]

236. Rahnuma Family Planning Association of Pakistan and SRI (2017), p. 4.
237. Government of the Punjab Department Youth Affairs, Sports, Archaeology and Tourism, *Punjab Adolescent and Strategic Plan*, 2013-2017, www.punjab.gov.pk/pb_adolescent_strategy.
238. Rahnuma Family Planning Association of Pakistan and SRI (2017), p. 4.
239. Ibid, p. 5-7.
240. Ibid, p. 5.
241. Ghoshal, Neela and Kyle Knight (2016), *Rights in Transition: Making Legal Recognition for Transgender People a Global Priority*, Human Rights Watch, www.hrw.org/world-report/2016/rights-in-transition.
242. Rahnuma Family Planning Association of Pakistan and SRI (2017), p. 7.

RECOMMENDATIONS

CSE

- The government should take immediate measures to ensure that comprehensive programmes with adequate budget allocation for the provision of LSBE for all young people are in place, and are being effectively implemented and monitored as part of public sector education.
- National and provincial governments should work together to ensure uniform and consistent guidelines for LSBE curricula development across the provinces, where such curricula includes rights-based information and gender-sensitive content to challenge gender stereotypes, and incorporates inputs from SRHR experts and young people themselves.
- National and provincial governments should undertake awareness-raising campaigns on the importance of LSBE, to increase public support for its mainstreaming in school curricula.

ADOLESCENT SRH SERVICES

- National and provincial governments should ensure that all provinces have Youth Policies in place, which include progressive commitments regarding youth and gender-friendly SRHR information and services, and are accompanied by costed implementation plans to ensure adequate resources and budgets for their full implementation.
- National and provincial governments should take immediate measures for the sensitization of duty-bearers, teachers, and healthcare providers on youth-friendly health services, to ensure young people's access to stigma- and discrimination-free and gender-sensitive health services.
- Sexuality among young people is little researched in Pakistan, primarily owing to cultural taboos restricting open discussions on sexuality and sexual health in general. Further research and data collection is needed, in order to fully understand the barriers young people face when it comes to realizing their SRHR.

RIGHT HERE
RIGHT NOW

Africa

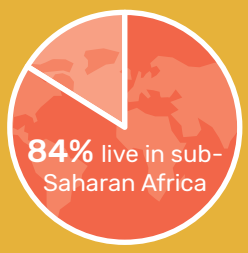
Regional level analysis

SRHR SNAPSHOT

226 million
young people are between the **ages of 15-24.**[243]

Roughly **39%** of girls in the region are married **before the age of 18.**[244]

Of the **2.1 million adolescents aged 10-19 years** living with HIV worldwide, about **1.7 million (84%) live in sub-Saharan Africa.**[245]

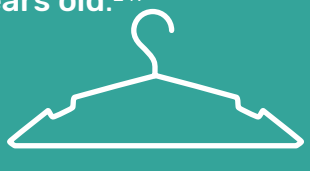


In 2016, East and Southern Africa saw **44%** of new HIV infections **worldwide.**[246]

Sub-Saharan Africa has the highest proportions of early childbearing worldwide, where birth rates among adolescents reach over **200 births per 1000 girls age 15–19.**[247]

Approximately **93% of women of reproductive age** in Africa live in countries with restrictive abortion laws.[248]

Three out of four abortions in Africa are unsafe, and every year approximately **1.4 million** unsafe abortions occur among girls **aged 15-19 years old.**[249]



243. Yahya, Mohamed (2017), *Africa's Defining Challenge*, UNDPA Africa, www.africa.undp.org/content/rba/en/home/blog/2017/8/7/africa_defining_challenge.html.
244. Girls Not Brides (2018), *Child Marriage in Sub-Saharan Africa*, www.girlsnotbrides.org/region/sub-saharan-africa/.
245. UNICEF (2018), *Turning the Tide Against AIDS Will Require More Concentrated Focus on Adolescents and Young People*, https://data.unicef.org/topic/hivaids/adolescents-young-people/#.
246. Avert (2017), *Global HIV and AIDS Statistics*, https://www.avert.org/global-hiv-and-aids-statistics .
247. UNICEF (2018), *The Highest Rates of Early Childbearing are Found in Sub-Saharan African Countries* https://data.unicef.org/topic/maternal-health/adolescent-health/.
248. Guttmacher Institute (2018), *Abortion in Africa*, www.guttmacher.org/fact-sheet/abortion-africa.
249. van Eerdewijk, Anouka et al (2018), *The State of African Women Report: Key Findings*, IPPF AR, www.ippfar.org/resource/newly-launched-state-african-women-report-key-findings, P. 46.

In terms of the region's policy framework, there are a number of synergetic opportunities to utilize in advancing ICPD related commitments outlined in the *Addis Ababa Declaration on Population and Development in Africa Beyond 2014*, in relation to CSE, adolescent-friendly SRH services, abortion, and LGBTI rights. In this sense, African states have reaffirmed their SRHR-related commitments through various human rights treaties, declarations, and sustainable development commitments at both regional and sub-regional levels.

One of the most critical commitments is the Protocol to the *African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)*. Other commitments include the *Maputo Plan of Action (2016-2030)* to further operationalize the Maputo Protocol; the *Africa Union Roadmap on Harnessing the Demographic Dividend Through Investments in Youth*, positioning investments in youth as central to achieving the *2030 Agenda* and the regional *Agenda 2063*; the *Ouagadougou Partnership*; and the *2013 Eastern and Southern Africa (ESA) Ministerial Commitment on Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People*. In addition to these government commitments, parliamentarians and health committees in the region have also built on the ICPD and made specific commitments, such as via the Network of African Parliamentary Committees of Health (NEAPACOH) Regional meeting in December 2017 and resulting *Kampala Call to Action*, and the Southern Africa Development Community (SADC) *Mahe Declaration* (reaffirming to implement commitments under CSW Resolution 60/2 on "Women, the Girl Child and HIV and AIDS").[250] Regional challenges relate to the full implementation of existing SRHR-related laws and policies; and remaining vigilant for oppositional and conservative pushback, particularly regarding CSE and LGBTI rights.

CSE

African governments have reiterated their intentions to provide CSE in a number of ways. In the *African Union Roadmap*, two of the recommended key actions and deliverables consist of adopting a life-course approach to learning that encompasses "age appropriate and culturally sensitive comprehensive education about sexual and reproductive health," and scaling up such education initiatives for both in and out of school youth.[251]

Eastern and Southern African governments have additionally reaffirmed CSE commitments through the *2013 ESA Commitment* by Ministers of Education and Health, aimed at delivering CSE in the sub-region from primary school level onwards and in alignment with agreed international standards, with two sets of targets to be achieved in 2015 and 2020 respectively.[252] In terms of 2015 targets, 15 out of 21 countries reported providing CSE/Life Skills in at least 40% of primary and secondary schools; and all 21 countries report having CSE training programmes for teachers.[253] However, a number of countries are still yet to fully integrate CSE in the curriculum at scale. Moreover, where CSE has been largely scaled up, there is still a need to strengthen the quality of the delivery and content, "to ensure that core essential topics are included and are taught early (before sexual debut). Furthermore, there is a need to strengthen programmes reaching those not enrolled in school."[254] In terms of CSE training for teachers, a 2015 report indicated that 95% of countries in the region have some form of in-service training on life skills-based HIV education for in-service teachers; but only 38% of the countries have CSE as a compulsory subject in teacher training. "This implies that teachers in some countries may not be adequately prepared to deal with every aspect of CSE in the classroom."[255]

In this sense, it is important to note that the *Maputo Plan of Action (MPoA) 2016-2030 for the Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights* touches on the provision of

250. Regional Women's Parliamentary Caucus (RWPC) of the Southern African Development Community Parliament Forum (SADC PF) (2017), *Mahe Declaration on Sustained Engagement by SADC Parliaments to Implement Resolution 60/2 of the Commission of the Status of Women on "Women, the Girl Child and HIV and AIDS,"* www.arasa.info/files/1615/1075/0690/Mahe_Declaration_by_RWPC_Women_Parliament_1_1.pdf. Also see IPPF (2017), *Access to Safe Abortion Care and Services Promoted by the Newly Inaugurated SADC Women's Parliament*, www.ippfar.org/news/access-safe-abortion-care-and-services-promoted-newly-inaugurated-sadc-womens-parliament.

251. African Union Commission (2017), p. 18-21.

252. UNESCO et al (2016), *Fulfilling Our Promise to Young People Today: 2013-2015 Progress Review: The Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People*, Paris: UNESCO, http://youngpeopletoday.net/wp-content/uploads/2016/07/ESA-Commitment-Report-Digital.pdf, P. 19.

253. Ibid. p. 18

254. Ibid, p. 13.

255. Ibid, p. 38.

comprehensive education on SRH (an issue that was unaddressed in the previous 2007-2015 Plan of Action). While this is indeed a welcome addition, it is not without shortcomings, which mainly consist of its emphasis on the role of parents and communities, thereby diverging from the UNESCO definition of CSE, and potentially inadvertently upholding CSE-related barriers stemming from parental consent requirements. Its language also inadvertently takes a step back from gains made via progressive sub-regional agreements, such as the 2013 ESA Commitment.[256] This illustrates that CSE remains an issue fraught with tension and/or inconsistencies, and the importance of staying vigilant so that region-wide, CSE is fully implemented in line with internationally agreed standards.

In effect, in many senses one cannot deny the regional trend of growing opposition to CSE, in spite of a) public health statistics that clearly illustrate high rates of teenage pregnancy, GBV, and STIs among young people, and b) increasing evidence that shows the benefits of CSE for young people's health and wellbeing. When this opposition manifests into governments' reluctance, unwillingness, or reticence to fully implement CSE related policies (because of fear of backlash from conservative groups or influential religious figures), it becomes clear that young people's health is effectively being treated as a political issue. As such, it is imperative that governments clearly indicate through policy implementation that realizing young people's SRHR cannot be subject to politics; rather, SRHR-related policies need to be fully implemented, as part of commitments under both the ICPD, and regional and human rights frameworks.

ADOLESCENT SRH SERVICES

It is encouraging to see that ensuring accessible youth-friendly SRH services is receiving increased recognition from governments. This is often via the huge regional attention given to the demographic dividend.[257] As noted in the AU Roadmap, a worryingly high adolescent fertility rate and unmet need for contraceptives could delay or jeopardize the potential benefits of the demographic dividend.[258] In this sense, the AU Roadmap's recommended key actions and deliverables include the establishment and promotion of integrated adolescent and youth friendly SRH services in public and private health facilities, school clinics and other venues; and the prioritization of national investments to ensure universal access to family planning services, and expanded use of modern contraceptives. Recommended actions also include scaling up the promotion and implementation of policies, community engagement strategies and behavioural change measures to "enhance the reproductive rights of women and adolescent girls and their access to sexual and reproductive health education, information and services."[259] But, though this focus and emphasis on youth-friendly SRH information and services is indeed welcome and needed, it is important that regional policies and frameworks keep a focus on young people as rights holders in and of themselves, and not solely as a means to ensure social and economic development in the region.

Other frameworks contain similar promising provisions in respect to adolescent SRH services. For example, the MPoA 2016-2030 places greater explicit emphasis on adolescents in addition to youth, acknowledging their distinct need to access and uptake friendly SRH services.[260,261] At sub-regional level, the *Ouagadougou Partnership* in West Africa emphasizes the importance of ensuring youth-friendly SRH services through addressing parental consent requirements, ensuring confidentiality, promoting accessibility, and training staff on adolescent issues, to ensure the non-judgmental provision of services to adolescents and young people.[262] The *2013 ESA Commitment* also includes promising reaffirmations of ensuring youth-friendly SRH services, including amending parental consent requirements, scaling up youth-friendly

256. Munyati, Bob (2016), *For Better, for Worse? In Sickness and in Health? An Investigation Into the New MPOA and Whether It Improves Accountability on SRHR in Africa*, AIDS Accountability International, www.aidsaccountability.org/wp-content/uploads/2017/06/AIDS-Accountability-International-Maputo-Plan-SRHR-Bob-Munyati-Phillipa-Tucker-2.pdf, p. 11.

257. "If countries in demographic transition make the right human capital investments and adopt policies that expand opportunities for young people, their combined demographic dividends could be enormous. In sub-Saharan Africa, for example, they would be at least US$500 billion a year, equal to about one third of the region's current GDP, for as many as 30 years." *Every Woman Every Child* (2015), p. 20.

258. African Union Commission (2017), p. 19.

259. Ibid, p. 21.

260. Munyati, Bob (2016), p. 12.

261. African Union Commission (2016), *Maputo Plan of Action 2016-2030 for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights*, https://au.int/sites/default/files/documents/24099-poa_5-_revised_clean.pdf, p. 23.

262. Ougadougou Partnership (2011), *Family Planning: Francophone West Africa on the Move: A Call to Action*, https://assets.prb.org/pdf12/ouagadougou-partnership_en.pdf, p. 16-17.

services for those in and out of school, and that such services are also non-judgmental and confidential, and include the availability of reliable and affordable SRH commodities.[263] In terms of related targets for 2015, 17 out of 21 countries reported having in-service health and social worker training programmes on the delivery of adolescent and youth-friendly SRH services, though more work is needed to ensure that such training is fully aligned with WHO standards.[264] Moreover, 15 out of 21 countries reported offering the standard minimum package of adolescent and youth-friendly SRH services; however, "the levels of alignment and implementation of national standards according to WHO guidelines vary within and among countries, and recent reviews reveal limited progress on improvements of service delivery, especially to the most vulnerable and marginalized populations."[265]

It is also important to note initiatives such as the Global Financing Facility (GFF), the intended mechanism to finance efforts for reproductive, maternal, newborn, child and adolescent health (RMNCAH) programmes and policies in support of the UN Secretary-General's *Global Strategy for Women's, Children's and Adolescents' Health (the Global Strategy)*. Among its 15 current focus countries, 12 are in Africa (Cameroon, the Democratic Republic of Congo, Ethiopia, Guinea, Kenya, Liberia, Mozambique, Nigeria, Senegal, Sierra Leone, Tanzania and Uganda). However, though GFF investment cases are supposed to be developed and implemented through engagement with a range of stakeholders, CSOs have often struggled to engage with the GFF to date (not least because while the GFF has set minimum standards for inclusiveness and transparency at the country level, there is no requirement that CSOs be included in decision-making processes). "Not only does this undermine transparency and accountability, it increases the chances that GFF priorities will not match the needs of communities."[266]

ABORTION

Like adolescent-friendly SRH services, abortion is an area where there has been some notable progress in the region. Above all stands the Maputo Protocol, through which there is clear guidance for liberalizing abortion laws, as well as government commitment at regional level via Article 14.2.c, where states agreed to "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus."[267] In this sense it is commendably the "first protocol to recognize women and girls' access to safe abortion under specific conditions as a human right."[268] The overarching challenge regarding decriminalization of abortion in the region is the lack of follow-up in many countries, as well as some governments' reservations to Maputo Article 14.2.c.[269]

In this respect, the MPoA 2016-2030 has both pros and cons. In one sense, it makes progress in that it includes "2.3 Implement national policies, strategies and action plans to end unintended pregnancies and unsafe abortion," thus explicitly calling on governments to end unsafe abortion. However, it has weaker language specifically on abortion laws, stating governments should "ensure access to safe abortions to the full extent of national laws and policies," a shift from the MPoA 2007-2015's "Review and amend laws and regulations with the view to creating an enabling environment for preventing unsafe abortions."[270] This shift in language is unfortunately a step back, particularly since the overwhelming majority of women of reproductive age in Africa live in countries with restrictive abortion laws. As such, it is important at the regional level to not shy away from calling on governments to expand the legal grounds for safe abortion services.

Moreover, even in countries where abortion is legally permitted under certain circumstances, it is likely that many women are unable to obtain a safe, legal procedure.[271] As illustrated by the example of Ethiopia, adolescents are currently benefiting from the expanded abortion law that grants them the legal right to obtain safe abortion

263. UNESCO et al (2016), p. 19.
264. Ibid, p. 13
265. Ibid, p. 12-13.
266. Bretton Woods Project (2017), *GFF Falls Short on Family Planning*, www.brettonwoodsproject.org/2017/01/gff-falls-short-family-planning/ .
267. African Commission on Human and Peoples' Rights (2003), *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, www.achpr.org/instruments/women-protocol/#14.
268. van Eerdewijk, Anouka et al (2018), p. 17.
269. See van Eerdewijk, Anouka et al (2018).
270. Munyati, Bob (2016), p. 9.
271. Guttmacher Institute (2018), *Abortion in Africa*.

care. Nevertheless, in 2014 one-third of abortions among adolescents in Ethiopia were clandestine and thus potentially unsafe.[272] Similarly in South Africa, a country with one of the most liberal abortion laws in the region and world, long waits and limited numbers of trained service providers entail that many women are still forced to opt for illegal and potentially unsafe procedures.[273] These cases illustrate that liberalizing abortion laws is important but not enough; "service provision guidelines must be adopted and disseminated, providers must be trained, and governments must be committed to ensuring that safe abortions are available."[274]

LGBTI RIGHTS

Notably, in 2014 the African Commission on Human and Peoples Rights (ACHPR) issued Resolution 275 regarding the *Protection Against Violence and Other Human Rights Violations Against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity*. In this resolution, the ACHPR called on States:

> *to end all acts of violence and abuse, whether committed by State or non-state actors, including by enacting and effectively applying appropriate laws prohibiting and punishing all forms of violence including those targeting persons on the basis of their imputed or real sexual orientation or gender identities, ensuring proper investigation and diligent prosecution of perpetrators, and establishing judicial procedures responsive to the needs of victims.*[275]

However, LGBTI rights remain a contentious issue in the region as a whole, with significant steps backward and backlash from the opposition, including the passing of anti-gay bills and laws.[276] In effect, though ongoing discrimination and violence towards LGBTI people is a challenge worldwide, "a range of factors have meant that over the past decade, in many countries in the region, these attitudes and actions directed towards LGBTI people have become particularly acute, and some politicians and other public figures are expressing homophobic and transphobic views for political gain."[277]

As such, this is an area that has been very challenging to advance on in the region. This can be seen in one of the shortcomings of the MPoA 2016-2030, where it refrains from defining vulnerable and marginalized groups, leaving them to be defined within the national context. This provision entails that the most vulnerable persons' SRHR and access to services may be compromised, in that key populations such as LGBTI may be left out when it comes to formulating and implementing national policy,[278] particularly in the context of rising opposition against LGBTI rights. In this sense, much remains to be done in terms of ensuring that States' human rights related commitments towards LGBTI populations are translated into action.

RECOMMENDATIONS

Overall, in terms of regional policy formulation and declarations, while some formulations such as the MPoA 2016-2030 are weaker in certain language, it is nonetheless important to see these developments as at least a commitment to move forward. In a context of mobilized opposition, that these policies and declarations are renewals of prior commitments is arguably a win in and of itself, and an important point of departure. In this respect, it also remains integral to work within the existing rights and legally binding frameworks, such as the Maputo Protocol itself, while seeing the MPoA as a strategy for moving that Protocol and related commitments forward.

Furthermore, in order to counter general threats of regression, it is important to think beyond SRHR terminology, and focus on the content and implicated rights. For example, a lot of resistance towards CSE stems from the term itself; as such, if countries are able to move forward by calling it a different name, but ensuring that the content is in line with internationally agreed standards and commitments on CSE, then that could provide a potential way

272. Ipas and Guttmacher Institute (2018), *Induced Abortion and Postabortion Care Among Adolescents in Ethiopia*, www.guttmacher.org/fact-sheet/adolescent-abortion-ethiopia.

273. Moore, Jina and Estelle Ellis (2012), "In South Africa, A Liberal Abortion Law Doesn't Guarantee Access," *The Nation*, www.thenation.com/article/south-africa-liberal-abortion-law-doesnt-guarantee-access/.

274. Guttmacher Institute (2018), *Abortion in Africa*.

275. African Commission on Human and People's Rights (2014), *275: Resolution on Protection Against Violence and Other Human Rights Violations Against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity*, www.achpr.org/sessions/55th/resolutions/275/.

276. Amnesty International (2018), *Mapping Anti-Gay Laws in Africa*, www.amnesty.org.uk/lgbti-lgbt-gay-human-rights-law-africa-uganda-kenya-nigeria-cameroon.

277. Amnesty International (2014), *Speaking Out: Advocacy Experiences and Tools of LGBTI Activists in Sub-Saharan Africa*, www.amnesty.org/download/Documents/4000/afr010012014en.pdf, London: Amnesty International, p. 5.

278. Munyati, Bob (2016), p. 8.

forward to further advance youth SRHR issues. What is most important is ensuring access, and that rights are observed. Also needed, given the current unmet need of young people's SRHR in the region, is the political will to scale up the level of response, and take bold rather than small steps to tackle huge challenges. Current constraints on the realization of SRHR-related commitments include "weak political commitment and leadership, inadequate financing for health and high donor dependency."[279] As such, assertive policies with adequate financing need to be put in place, and politicians must separate religion and morality from women and adolescents' health, in order for governments to take the ambitious commitments outlined on paper into action.

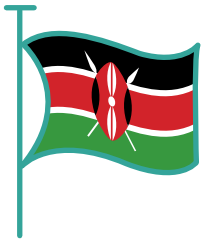
Our regional recommendations in regards to achieving the Addis Ababa Declaration are thus as follows:

- Prioritize young people's SRHR through increasing domestic financing for health, and in particular SRH, while reducing overreliance on foreign financing for health, in order to accelerate the realization of the region's ICPD Beyond 2014 related commitments. In this regard, governments should allocate at least 15% of their annual budget to health, as agreed in the AU *Abuja Declaration*.[280]
- Urge member states of the African Union to sign, ratify and fully implement the Maputo Protocol, as well as remove reservations in relation to SRHR, access to abortion and women and girls' rights.
- Ensure strong monitoring and accountability mechanisms at the African Union to monitor progress and promote learning across countries and Regional Economic Communities (RECs), focused on implementing the MPoA 2016-2030 and advancing the SRHR of all adolescents, women and girls.
- Address CSE as a vital component of improving the health and rights of adolescents and youth, recognizing its critical contribution to realizing *Agenda 2063*, the *Addis Ababa Declaration* and sustainable development.
- Fully implement ACHPR Resolution 275 throughout the continent, in order to address the ongoing discrimination and violence faced by LGBTI individuals region-wide.

279. van Eerdewijk, Anouka et al (2018), p. 18.

280. "In the Abuja Declaration, already adopted by the AU in 2001, African states pledged to allocate a minimum of 15% of their annual budget to strengthening the health sector." Ibid.

Kenya



SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

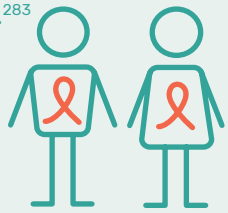
	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1972	1972	1984	1997	1990	2008
Date of last review	2012	2016	2017	2013	2016	2015
Next report due date	Report was due in 2015	Report is due in 2021	Report is due in 2021	Report was due in 2017	Report is due in 2021	Report is due in 2022

SRHR SNAPSHOT

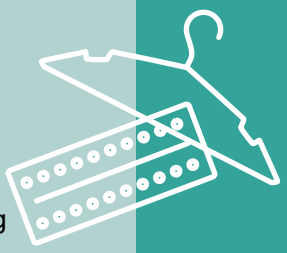
Young people aged 15-24 make up approximately 21% of Kenya's total population.[281]

23% of girls in Kenya are married before the age of 18.[282]

In 2015, more than half (51%) of all new HIV infections in the country occurred among adolescents and young people aged 15-24.[283]

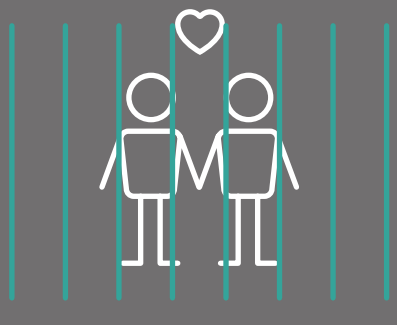


In 2012, approximately 465,000 abortions occurred in Kenya, translating to one of the highest national abortion rates in the world; and with the abortion rate being highest among young women aged 20-24.[284]



Of this figure, 120,000 women received care in health facilities for complications from unsafe abortion, and more than three-quarters of those treated had moderate or severe complications, with young women aged 19 and younger disproportionately affected.[285]

Homosexuality is criminalized by the Penal Code under sections 162, 163 and 165.



281. National Council for Population and Development (NCPD) (2013), *Kenya Population Situation Analysis, Nairobi: Government of Kenya*, www.unfpa.org/sites/default/files/admin-resource/FINALPSAREPORT_0.pdf, p. 124.
282. Girls Not Brides (2018), *Child Marriage Around the World: Kenya*, www.girlsnotbrides.org/child-marriage/kenya/.
283. Avert (2018), *HIV and AIDS in Kenya*, www.avert.org/professionals/hiv-around-world/sub-saharan-africa/kenya.
284. Mohamed, Shukri F. et al (2015), "The Estimated Incidence of Induced Abortion in Kenya: A Cross-Sectional Study," *BMC Pregnancy and Childbirth* 15:185, https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0621-1.
285. Ibid.

Young people's SRHR, particularly in terms of their access to SRH information and services, is supported by a number of health and education policies in Kenya.[286] Yet the SRHR-related policy and legal framework presents several shortcomings, which in turn hinder the full implementation of SRHR-related policies, and contribute to the persistence of barriers to the realization of young people's SRHR, particularly for adolescent girls and LGBTI youth.

CSE

The government has indicated its commitment to provide sexuality education, evident in the development and revisions of various adolescent SRH-related policies and curricula.[287] Moreover, in relation to the *2013 ESA Commitment*, Kenya reported meeting all of the CSE-related targets for 2015, namely providing CSE/Life Skills in at least 40% of primary and secondary schools, and having CSE training programmes for teachers.[288] "Yet challenges remain – from the national policy-making and programme-planning level down to the classroom implementation level."[289]

The *National School Health Policy* is meant to provide guidelines on CSE. Though it includes some language related to gender and health, as well as ending harmful gender-related cultural practices, this language is often vague and lacking specificity on SRHR. The language in the policy itself could thus be strengthened. Moreover, in terms of implementation, sexuality education is often not comprehensive in nature. In a 2017 study[290] with 78 schools in Nairobi, Mombasa, and Homa Bay counties, only 2% of students reported learning about all of the topics that constitute a CSE programme as defined by international standards. Students reported learned about topics in relation to sexual and reproductive physiology and HIV/STI prevention, but considerably less in relation to values and interpersonal skills, gender and SRH rights, contraceptive methods and unintended pregnancy. Student assessments also tended to focus more on knowledge than on attitudes and practical skills. In addition, messages conveyed by teachers were often conservative in nature and focused on abstinence, where rather than promoting a more positive view of sexuality, teachers often relayed CSE-related messages in a moralistic, judgmental, and fear-inducing way. Teachers in turn reported the main barriers to teaching sexuality education being a lack of teaching materials, time or training, and embarrassment about certain topics.[291]

The provision of CSE at primary school level also remains very limited. In the aforementioned study, most students in Forms 2 and 3 (96%) had received some sexuality education by the time they completed primary school, but the information received was very basic and did not include information on safer sex. This is problematic, for while 86% of adolescents attend primary school in Kenya, only 33% continue on to secondary school, entailing their limited receipt of CSE-related initiatives. Moreover, CSE is not currently included as a stand-alone, examinable subject in the Kenya national curriculum; rather, some topics related to SRH education are incorporated in different subjects, such as Christian religious education, biology, and life skills. While life skills is the most comprehensive of these subject areas and is compulsory, it is not examinable, entailing that it is assigned less importance than other subjects by both teachers and students alike.[292]

There is also increased opposition to CSE and reviewing the *National School Health Policy* from specific influential religious and cultural groups, who portray CSE as synonymous with sexual immorality, homosexuality, and abortion. Opposition groups have delivered petitions to the Ministry of Education and erected billboards claiming that CSE is "dangerous," interferes with parental responsibilities and calling on parents to reject it, thereby contributing towards an increasingly hostile environment regarding CSE.

ADOLESCENT SRH SERVICES

Article 43(a) of the Kenya Constitution states that every person has the right to the highest attainable standard of health, including the right to reproductive health care services. In

286. Among these policies are the *2003 Adolescent Reproductive Health Policy*; the *2005 National Guideline for the Provision of Youth-Friendly Services*; *2009 National School Health Policy*; and the *2015 National Adolescent Sexual and Reproductive Health Policy*, among others. Sidze, Estelle M. et al (2017).
287. Sidze, Estelle M. et al (2017).
288. UNESCO et al (2016), p. 12.
289. Sidze, Estelle M. et al (2017).
290. Ibid.
291. Ibid.
292. Ibid.

terms of adolescents' access to SRH services, the 2015 *Adolescent Sexual and Reproductive Health (ASRH) Policy* is in place. As per this policy, the Ministry of Health at the national level has a responsibility to oversee and facilitate implementation of the Policy at national and county levels; ensure that there is adequate capacity in terms of staffing, equipment and supplies; disseminate the ASRH Policy; and develop a comprehensive Plan of Action for its implementation. The Ministry of Health is also meant to set standards and regulatory mechanisms for this policy; regulate and co-ordinate ASRH training, information sharing and service delivery; co-ordinate activities supported by development partners; mobilize and allocate resources for ASRH programmes; facilitate adolescent data disaggregation; and strengthen the school health programme. However, as with the *National School Health Policy*, implementation of the ASRH policy is weak, particularly at the county level. As such, young people's access to and uptake of SRH services and commodities remains limited, as these services are often characterized by prohibitive costs, insecurity and inflexible availability. In effect, as per the Kenya Service Availability and Readiness Assessment Measure, nationally only one out of ten public health facilities offer comprehensive youth friendly services.[293] Young women and girls are thus limited in accessing healthcare information and services including contraceptives. This is further aggravated by inadequate service providers, who hold poor attitudes towards young people's SRHR, indicating an urgent need for better service provider training on youth-friendly services.[294]

In turn, adolescent health indicators are still poor in Kenya. Teenage pregnancy is high while contraceptive use among young people is still low; where although 96% of all adolescent females have heard of at least one modern method, only 41% of sexually active 15–19-year-olds are currently using any contraceptive method, and 37% are using a modern one.[295] Young LGBTI individuals also face challenges in accessing SRH services, because of additional barriers relating to homophobia and transphobia. While the Kenya *Health Policy 2014-2030* stresses the importance of inclusiveness, nondiscrimination, social accountability, and gender equality regarding the provision of health services, LGBTI individuals still face hurdles in regards to their right to healthcare services. In a report by UHAI – the East African Sexual Health and Rights Initiative, roughly 4 out of 10 LGBTI persons in East Africa responded that they were denied health services because of their gender identity, while 46% responded that they were denied services because of their sexual orientation. Furthermore, about 4 out of 10 respondents confirmed refraining from accessing health services due to their sexual orientation, and risk of stigma and discrimination.[296]

ABORTION

Until the late 2000s the abortion law in Kenya was highly restrictive, only permitting abortion to save the life of the woman. A positive development occurred in 2010, where as part of efforts to reduce the country's high rates of maternal mortality and morbidity resulting from unsafe abortion, the new Constitution expanded the grounds for abortion access, stating under article 26(4) that abortion is permitted if the life or health of the woman is in danger, to "protect the woman's health," and in cases of emergency, allowing for quite liberal interpretations of the law.[297,298,299] Subsequently, in September 2012 the Ministry of Health launched the *Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion*, providing a framework for implementation. However a huge setback was experienced in December 2013, when the Director of Medical Services suspended the Guidelines indefinitely, and implemented a ban on safe abortion trainings for healthcare professionals, resulting in great confusion as to when legal abortions can be provided.[300] To date, there is no framework for the implementation of article 26(4); training for healthcare providers on comprehensive abortion care is lacking and, in a context of legal restriction and challenging societal and religious attitudes, medical practitioners are vulnerable and afraid, uncertain of whether they

293. Network for Adolescents and Youth of Africa (NAYA Kenya) et al (2017), *Supplementary information on the Kenya State Report for Consideration by the Committee on the Convention on the Elimination of All Forms of Discrimination Against Women at the 68th session*, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/KEN/INT_CEDAW_NGO_KEN_28991_E.pdf.

294. Ibid.

295. Sidze, Estelle M. et al (2017).

296. Network for Adolescents and Youth of Africa (NAYA Kenya) et al (2017).

297. Center for Reproductive Rights (2018), *Kenya's Abortion Provisions*, www.reproductiverights.org/world-abortion-laws/kenyas-abortion-provisions.

298. Center for Reproductive Rights (2016), *U.N. Committee: Kenya Should Decriminalize Abortion in All Circumstances, Ensure Reproductive Health Services for Adolescents*, www.reproductiverights.org/press-room/un-committee-kenya-should-decriminalize-abortion-in-all-circumstances.

299. Mohamed, Shukfri F. et al (2015).

300. Center for Reproductive Rights (2016).

would be legally protected if they were to provide abortions under the respective clauses of the new Constitution. Additionally, women seeking abortions are often not aware of conditions under which abortion may now be deemed legal in Kenya.[301]

As a result, unsafe and clandestine abortions continue to be prevalent, where it is estimated that roughly a fifth of all pregnancies in the country are ended through illegal and unsafe procedures.[302] There is also evidence that adolescents are particularly vulnerable to severe complications from unsafe abortions, where "a 2013 study indicated that 10–19-year-olds accounted for 17% of all women who sought post-abortion care in public facilities, and that 74% of the moderate or severe complication cases were among this group, partly because of their use of less-skilled providers."[303]

RECOMMENDATIONS

CSE

- Finalize the *National School Health Policy*, aligning it with the 2013 *ESA Commitment*, and ensuring that it is both inclusive and explicitly includes progressive language on adolescent SRHR; and expedite its full implementation in both primary and secondary schools.
- Ensure that the Ministry of Education, through its review and finalization of the *National School Health Policy* and technical guidelines on CSE, meaningfully and inclusively involves young people and adolescents.

ADOLESCENT SRH SERVICES

- Strengthen the full implementation of the ASRH Policy for improved access to SRH services by all youth, including LGBTI youth.
- Ensure that adolescents and youth are effectively engaged in the rollout of the ASRH Policy.

ABORTION

- Expedite the reinstatement and implementation of the suspended 2012 *Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya*.
- Resume and promote safe abortion trainings for service providers.

301. Mohamed, Shukri F. et al (2015).
302. East African Centre for Law and Justice (2015), *Abortion in Kenya*, http://eaclj.org/about-us/7-fida-and-kclf-landscaped-comparison.html.
303. Sidze, Estelle M. et al (2017).

Senegal

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

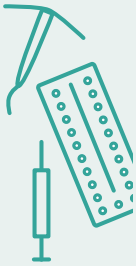
	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1978	1978	1985	1986	1990	2010
Date of last review	1997	2001	2015	2013	2016	N/A
Next report due date	Review planned in 2018	Report was due in 2003	Report due in 2019	Reviewed in 2018	Report due in 2021	Report submitted in 2015

SRHR SNAPSHOT

63% of the Senegalese population is under 25 years old.[304]

Only 27% of young women and 33% of young men between the ages of 15-24 have a comprehensive understanding of HIV.[305]

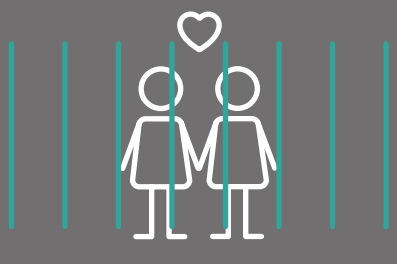
While approximately 90.4% of adolescents between 15-19 years old and 98.4% of young women 20-24 years old know of at least one modern contraceptive method, contraceptive prevalence rates among these age groups are only 5.5% and 17.9% respectively.[306]



In spite of the country's highly restrictive abortion law, an estimated 51,500 induced abortions occurred in Senegal in 2012, of which nearly all these procedures were clandestine and unsafe.[307]

Senegal being a predominantly conservative and patriarchal society, speaking about sexuality is taboo, and it is much more pronounced when it comes to adolescents and young people.[308]

Article 319 of the Senegalese Penal Code of 1965 punishes acts "against nature" or "immodesty" between persons of the same sex.[309]



304. Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF (2017), *Sénégal: Enquête Démographique et de Santé Continue (EDS-Continue 2016)*, Rockville: ANSD et ICF, www.ansd.sn/ressources/publications/EDS-C%202016.pdf, p. 17.
305. RHRN du Sénégal (2018), *Rapport Parallèle de la Plateforme Right Here, Right Now (RHRN) du Sénégal, Examen Périodique Universel du Sénégal, 31e Session*, www.sexualrightsinitiative.com/wp-content/uploads/RAPPORT-PARALLELE-EPU-RHRN-SENEGAL-2018-FINAL.pdf, p. 4.
306. Ibid, p. 4-5.
307. Sedge, Gilda et al (2015), "Estimates of the Incidence of Induced Abortion and Consequences of Unsafe Abortion in Senegal," *International Perspectives on Sexual and Reproductive Health* 41(1): 11-19, www.guttmacher.org/journals/ipsrh/2015/03/estimates-incidence-induced-abortion-and-consequences-unsafe-abortion-senegal.
308. RHRN du Sénégal (2018), p. 3.
309. Ibid, p. 12.

Senegal has a number of youth-related policies in place, among them the *Strategic Plan 2014-2018*, the Ministry of Health's 2018-2022 SRMNEA Plan (*Santé de la Reproduction de la Mère, du Nouveau-né, de l'Enfant et de l'Adolescent*), the Ministry of the Family's *National Strategy for Equity and Gender Equality*, and the Ministry of Youth's 2018-2022 Sector Policy. However, shortcomings in implementation entail that young people's access to SRH information and services remains unachieved. Moreover, certain issues such as sexual orientation and the rights of LGBTI persons remain highly sensitive in Senegal, where the current context is characterized by strong resistance from religious circles and homophobia among the general population, resulting in rights violations of LGBTI individuals.

ADOLESCENT SRH SERVICES

Senegal's 2005 Reproductive Health Law[310] recognizes that the right to reproductive health is a fundamental human right and universally guaranteed to all, without discrimination based on age, sex, income, religion, race, ethnicity, marital status or any other grounds. There is also no legal restriction regarding young people's access to contraceptives and other basic health services such as pregnancy tests and STI screenings, though one must be at least 15 years old to consent to an HIV test.[311]

Senegal has also made notable efforts regarding young people's access to health services, via the implementation of a 2014-2018 Strategic Plan. In this strategic national plan, the main goals are to contribute to the health and well-being of adolescents/youths from 10-24 years old; to promote adolescent/youth SRH; and to increase adolescents and young people's use of SRH services by 80%, through communication, advocacy, capacity-strengthening, sexual health education, and the provision of user-friendly services. The Ministry of Health also developed a document entitled *Health Services Tailored to the Needs of Adolescents and Youth,* which includes the following five focus areas:

- information;
- reorganizing service delivery points to tailor them to the needs of adolescents and youths for friendly and quality services;
- strengthening the youth-friendly skills and attitudes of service providers;
- community participation (youth, families, religious leaders, etc.);
- adapted management of these service delivery points by integrating adolescent/youth reproductive health services.

The integrated 2018-2022 Plan SRMNEA (*Santé de la Reproduction, de la Mère, du Nouveau-né, de l'Enfant et de l'Adolescent*) has also been validated by the government, and has an associated budget line (in addition to being partially financed by the GFF). The adolescent-youth component of this plan, however, remains considerably under-funded.[312] In effect, the government does not have specific budget lines associated with young people's access to SRH services. As such, despite the efforts made in terms of policy development, the health system does not yet allow equitable access to SRH service packages, indicating that young people and adolescents' SRH is not yet a strong priority in Senegal.[313] This is further illustrated based on the distribution of funds in the national investment report for SRMNEA, where only 62,206,100 CFA from the estimated 2018-2022 budget are allotted towards priority 3 (improving the health of adolescent youth); and only 2,204,586,000 CFA are allotted from the estimated 2018-2022 investment portfolio.[314] Moreover, sufficient funds for adolescents' SRH financing continue to be unavailable at the level of local authorities; this in turn contributes to insufficient dissemination and implementation of government plans and strategies at the local level. Additionally, the involvement of other ministries such as Justice, Education, Youth, and Finance in the implementation of these SRH policies is low, thereby reducing the likelihood of addressing young people's SRHR in a cross-cutting, comprehensive manner.[315]

310. "Law No. 2005-18 of 5 August 2005 on Reproductive Health Care and Services, Reproductive Health Personnel, Reproductive Health Rights, Voluntary Termination of Pregnancy and Voluntary Transmission of HIV/AIDS." RHRN du Sénégal (2018), p. 6.
311. Ibid, p. 7.
312. Ibid.
313. Ibid, p. 5.
314. Ibid, p. 6.
315. Ibid, p. 8.

GBV AND LGBTI RIGHTS

In regards to gender-based violence (GBV) and LGBTI rights, Article 13 of the 2005 Reproductive Health Law states that "all forms of violence, sexual abuse or inhuman or degrading treatment shall be punishable in accordance with the penal provisions in force." Likewise, the Constitution states that it is the responsibility of the State to protect all persons in Senegal, and guarantees fundamental rights and freedoms to all citizens, including the rights to security and equality before the law, the inviolability of the home and the freedoms of expression and association.[316]

The persistence of violence and abuses against LGBTI individuals is effectively caused by a misinterpretation of Article 319 of the Senegalese Penal Code, which punishes acts "against nature" or "immodesty" between persons of the same sex. However, the law provides no explanation as to what constitutes an unnatural or shameless act and does not explicitly address the issue of the application of this article. Moreover, the law penalizes acts and not identities or orientation. Yet this misinterpretation of Article 319, alongside the non-application of Article 13 of the 2005 Reproductive Health Law, contributes towards a hostile environment for LGBTI individuals, where they are stigmatized and face discrimination and violence. According to Human Rights Watch's confidential report released in June 2016, there were 39 cases of arbitrary arrest from 2011 to 2016 when the police arrested individuals suspected of "homosexuality" or of having committed acts "against nature." This is then exacerbated by the propensity of the Senegalese media to selectively and/or sensationally report on LGBTI issues and arrests, which further reinforces homophobia among the general population. Added to this is the manipulation of LGBTI issues for political purposes, the results of which are several homophobic movements that pose a real threat to LGBTI people and human rights organizations. These movements include the non-homosexual collective and the student movement against homosexuality.[317]

RECOMMENDATIONS

YOUTH-FRIENDLY SRH SERVICES

- Strengthen policy implementation by creating a budget line exclusively for the Reproductive Health of Adolescents and Youth at the level of the Ministry of Health, and increasing the financing of Reproductive Health of Adolescents and Youth (SRAJ) in the investment plan of the GFF. Set up a high-level coordination committee bringing together all the ministries concerned to monitor related implementation.
- Invest in local service provision for adolescent and youth SRH services, including a costed plan for decentralizing these services.
- Consult with youth to improve the friendliness and accessibility of SRH services, while strengthening their skills and capacities to meaningfully engage in related policy-making and implementation processes.

GBV AND LGBTI RIGHTS

- Align Article 319 of the Penal Code with the Constitution (Article 1, 7, 8, and 16), stating that the law does not allow discrimination and violence based on any basis, including sexual orientation or gender identity.
- Repeal all provisions which may give rise to discrimination and violence based on SOGIE, and guarantee respect for the rights and fundamental freedoms of all citizens.
- Fully implement Article 13 of the 2005 Reproductive Health Law, to address high rates of violence based on or associated with gender. Allocate adequate budgetary resources for the legal and psychological assistance of GBV victims.

316. *Constitution of the Republic of Senegal* (2009), www.constituteproject.org/constitution/Senegal_2009, Articles 1, 7, 8, and 16.
317. RHRN du Sénégal (2018), p. 12.

Uganda

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1995	1987	1985	1986	1990	2008
Date of last review	2004	2015	2010	2005	2005	2016
Next report due date	Report was due in 2008	Report due in 2020	Report was due in 2014	Report was due 2008	Report was due in 2011	Report due in 2022

SRHR SNAPSHOT

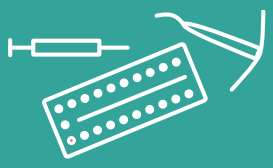
78% of Ugandans are under the age of 30 years old, with 52% below 15 years old.[318]

As of 2017, 33% of young women aged 20-24 gave birth before the age of 18.[319]

Unintended pregnancies have been linked to unsafe abortions that constitute nearly one third of maternal deaths among young people in the country.[320]

In 2014, only 38.5% of young women and men aged 15-24 accurately identified ways to prevent HIV transmission and rejected related misconceptions.[321]

Only 24% of people between 15-29 years use any modern contraception method.[322]



One of the most common reasons that unmarried, sexually active 15–24-year-old women cite for not using a method is that they are not married, illustrating the impact of the stigma surrounding sex outside of marriage in Uganda.[323]

318. Population Secretariat (2013), *State of Uganda of Population Report: Population and Social Transformation: Addressing the needs of Special Interest Groups*, http://npcsec.go.ug/wp-content/uploads/2013/06/State-of-Uganda-Population-Report-2013.pdf, p. 84.
319. Nozawa, Mina (2017), *What's Life Like for Vulnerable Adolescent Girls in Northern Uganda?* UNFPA Uganda, http://uganda.unfpa.org/en/news/what%E2%80%99s-life-vulnerable-adolescent-girls-northern-uganda.
320. Gorette, Nalwadda et al (2009), "The Abortion Paradox in Uganda: Fertility Regulator or Cause of Maternal Mortality," *Journal of Obstetrics and Gynaecology* 25(8): 776-780, www.ncbi.nlm.nih.gov/pubmed/16368584.
321. Avert (2018), *HIV and AIDS in Uganda*, www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda.
322. Vlassoff, Michael et al (2009), *Benefits of Meeting the Contraceptive Needs of Uganda Women*, Guttmacher Institute, www.guttmacher.org/report/benefits-meeting-contraceptive-needs-ugandan-women.
323. Guttmacher Institute (2017), *Contraception and Unintended Pregnancy in Uganda*, www.guttmacher.org/fact-sheet/contraception-and-unintended-pregnancy-uganda.

In general terms, access to youth friendly and comprehensive SRH services in Uganda is limited for many young people and as a result, they lack the required life skills and knowledge to make informed choices about their health and wellbeing. Uganda also lacks an enabling legal environment for the SRHR for young people, and where there are policies in place, these largely remain un-disseminated and/or un-implemented. There has also been increasing opposition to SRHR in the country, further hindering progress and Uganda's implementation of SRHR-related laws and policies.

CSE

In Uganda, sexuality education has rarely been comprehensive and not at all or not systematically provided at school level. In 2013, Uganda became signatory to the *ESA Commitment*. It also reported meeting both of its CSE-related targets for 2015, namely providing CSE/Life Skills in at least 40% of primary and secondary schools; as well as having CSE training programmes for teachers.[324] This, however, was then followed in August 2016 by a parliamentary resolution banning CSE in schools, further upheld by a ministerial statement from the Ministry of Gender, Labour and Social Development in October 2016, portraying CSE as promoting indecent behaviour and practices inconsistent with national values.[325]

The CSE ban effectively undermined any previous progress gained; however, some positive news is that since 2016, and the launch of a civil society lawsuit calling on the government to lift the ban,[326] there have been efforts to expedite the process of reviewing and passing both the draft School Health Policy, and the *Sexuality Education Framework*, drafted by the HIV technical working group in the Ministry of Education and Sports. The *Sexuality Education Framework* was launched in May 2018,[327] whereas the Draft School Health Policy has undergone review and approval by the Senior Management Team at the Ministry of Education and Sports, and awaits to be launched in 2018 as well. Notably, the draft School Health Policy includes a number of recommendations made by CSOs including the Uganda RHRN partnership, such as ensuring a rights-based approach; and that the content includes gender, special needs, sexual health, HIV, sexuality, relationships, communication and negotiation skills, self-respect, non-discriminatory attitudes, IPV, contraception, and unsafe abortion, among other important topics. The policy also calls for school health programmes to be well integrated within existing planning and budgeting mechanisms, and receive adequate funding. Moreover, the implementation of sexuality education as envisaged in the Framework will be mainstreamed into the delivery of curricular, extra-curricular and co-curricular activities in and outside the classroom. Integration of the Framework will also be achieved through ensuring that sexuality education is an integral part of school policies and practices, and in the partnerships the school develops with the local community, founding bodies, affiliated religious institutions and parents, further indicating the Framework's potential to create significant inroads regarding the provision of sexuality education for young people in Uganda.

ADOLESCENT SRH SERVICES

Young people's health indicators continue to be poor in Uganda, with an annual adolescent pregnancy rate of 25% among 15-19 year-olds.[328] Early marriage in Uganda also remains common, where almost 1 in 2 girls is married before turning 18 years old.[329] Moreover, 30.4% of young women and girls report an unmet need for contraception.[330] The poor SRHR status of young people in Uganda is caused by lack of availability of and restricted access to SRH services and information and non-supportive environment for

324. UNESCO et al (2016), p. 12.
325. To learn more about the ban see Bbosa, Denis (2017).
326. Fallon, Amy (2017).
327. Ahimbisibwe, Patience (2018), "Govt to Launch Sexuality Education Guidelines Today," *Daily Monitor*, www.monitor.co.ug/News/National/Govt-launch-sexuality-education-guidelines-today/688334-4555728-q0wx2e/index.html .
328. Uganda Bureau of Statistics (UBOS) and ICF (2017), *Uganda Demographic and Health Survey 2016: Key Indicators Report*, Kampala & Rockville: UBOS and ICF, www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/Uganda_DHS_2016_KIR.pdf.
329. Girls Not Brides (2018), *Child Marriage Around the World: Uganda*, www.girlsnotbrides.org/child-marriage/uganda/.
330. UNFPA Uganda (2017), *Family Planning Investment Case for Uganda*, http://uganda.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Family%20Planning%20Investment%20Case%20Sept%2026%202017.pdf.

young people´s sexuality. The majority of current SRH services do not qualify as "youth friendly," especially in rural areas. For example, with a national average of 5%, only 2-3% of facilities offer youth-friendly HIV counseling and testing services in the Eastern Region.[331] Another barrier to adolescents accessing SRH services is the negative attitudes of providers, where they are often judgmental towards sexually active adolescents, and/or deny them services. The health sector also lacks financial efficiency, resulting in low quality SRH services and lack of information for most of the population.

Some positive developments have been in regards to budget allocation for family planning, where in 2012, the Government committed to increase its allocated budget by 30% and raised its allocation for family planning supplies from US $3.3 million to US $5 million over the next five years. In the 2013-2014 fiscal year, the government further allocated USD $6.9 million, with total expenditure on family planning in 2015 by the government and development partners reaching an estimated $18.0 million.[332] The government has also made changes in the National Reproductive Health Commodity Distribution Strategy, where free family planning commodities are now distributed via the Alternative Distribution Mechanism in the private sector, thereby increasing availability of commodities in rural and hard to reach areas.[333] The Ministry of Health has also developed some guidelines and strategies surrounding adolescent SRH, including a review of the National Adolescent Health Policy, but approval and/or implementation is weak because of poor prioritization of adolescent health; lack of consensus regarding stigmatized issues such as young people's access to contraceptives; inadequate collaboration and lack of alignment between government, donors and decentralized public and private health providers. In effect, in a disappointing turn of events, during the 2nd National Family Planning Conference in September 2017 the Minister of Health refused to launch the country's SRHR service standards and guidelines, even though all efforts to review the document had been completed.

ABORTION

Ugandan law explicitly allows abortion to save a woman's life. However, the 2006 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights* go even further – permitting abortion under additional circumstances, including in cases of fetal anomaly, rape and incest, or if the woman is HIV-positive.[334] Regrettably the 2006 policy, along with the accompanying standards and guidelines, were shelved almost immediately after they were passed, due to resistance from the opposition – stalling their implementation. Existing abortion-related laws and policies are thus currently interpreted inconsistently by law enforcement and the judicial system, making it difficult for women and the medical community to understand when abortion is permitted. Because of this ambiguity, medical providers are often reluctant to perform an abortion for any reason, out of fear of legal consequences.[335]

To date, the process of reviewing and reinstating the shelved standards and guidelines has stalled, though the Minister of State Primary Health has expressed willingness to initiate discussions and further reviews of the standards and guidelines as soon as possible. In this regard the Ministry of Health and CSOs have been having ongoing discussions.

LGBTI RIGHTS

Trends regarding LGBTI rights in Uganda have been mixed. While same sex marriage is still illegal in Uganda, some politicians and policy makers are adamant on developing and implementing more progressive national laws and policies that conform with international standards. However there are highly inflammatory statements coming from politicians against LGBTI communities, such as from the country's Speaker of Parliament.[336] There is also a push in Uganda's parliament to reinstate the anti-homosexuality bill,[337] which included the banning of the "promotion of

331. Darabi, Leila et al (2008), *Protecting the Next Generation in Uganda: New Evidence on Adolescent Sexual and Reproductive Health Needs*, Guttmacher Institute, www.guttmacher.org/sites/default/files/report_pdf/png_uganda_mono.pdf.

332. UNFPA Uganda (2017).

333. Ibid.

334. Guttmacher Institute (2017), *Abortion and Postabortion Care in Uganda*, www.guttmacher.org/fact-sheet/abortion-and-postabortion-care-uganda.

335. Ibid.

336. "Uganda's Speaker of Parliament Blasts Efforts to Protect LGBT Refugees" (2018), *Mamba*, www.mambaonline.com/2018/03/31/uganda-speaker-parliament-blasts-efforts-protect-lgbt-refugees/.

337. "MPs Want Anti-Homosexuality Bill Returned to Parliament" (2018), *The Insider*, http://theinsider.ug/index.php/2018/04/11/mps-want-anti-homosexuality-bill-returned-to-parliament/.

homosexuality" and life imprisonment for "aggravated homosexuality," and was first signed into law in 2014 but then later annulled by the Constitutional Court over a technicality.[338,339] In general, LGBTI individuals still stand to be at grave risk of harm and threats if they openly express their SOGIE in Uganda.

However there have been some positive trends, including a willingness on the part of the police to be trained on SOGIE issues as well as the ACHPR Resolution 275; service providers in most public health facilities do not turn away LGBTI persons who seek help; and the participation of some SOGIE groups in some government spaces, including the Uganda Human Rights Commission and Equal Opportunity Commission. Human rights defenders and LGBTI groups have also been undertaking media advocacy to bring attention to challenges they face; and there has been the documentation and submission of alternative reports to the Universal Periodic Review, the IESCR, and the ACHPR (which are then used to push advocacy and change at national level).

RECOMMENDATIONS

CSE

- Ensure the expedited approval, launch and implementation of the National School Health Policy, as well as the dissemination and implementation of the Sexuality Education Framework.
- Domesticate ESA commitments into national policies, and approve an accountability and reporting framework for these commitments.

ADOLESCENT SRH SERVICES

- Ensure the expedited approval, launch, dissemination and implementation of an inclusive National Adolescent Health Policy (NAHP).
- The Ministry of Health should allocate sufficient resources for SRHR within the Health Budget code.

ABORTION

- The Ministry of Health should expedite the process of the approval, launch, dissemination and implementation of the SRHR service standards and guidelines.
- Building on the efforts related to the School Health Policy and National Adolescent Health Policy, the Ministry of Health should include young people and CSOs in the review process of the stayed SRHR service standards and guidelines.
- The government should undertake awareness-raising initiatives in order to increase clarity among service providers and the greater public regarding the laws and policies around abortion.[340]

LGBTI RIGHTS

- Uganda should implement the ACHPR Resolution 275 on *Protection Against Violence and other Human Rights Violations Against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity*.
- SRHR policies and services should be more inclusive of LGBTI individuals.

338. "Uganda Court Annuls Anti-Homosexuality Law" (2014), *BBC News*, www.bbc.com/news/world-africa-28605400.

339. Fallon, Amy (2017).

340. Prada, Elena et al (2016), "Incidence of Induced Abortion in Uganda, 2013: New Estimates since 2003," *PLoS ONE* 11(11), http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0165812.

Zimbabwe

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

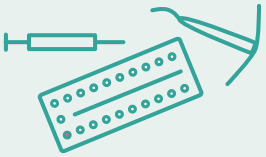
	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1991	1991	1991		1990	2013
Date of last review	1998	1997	2012		2016	N/A
Next report due date	Report was due in 2002	Report was due in 1998	Report submitted in 2018		Report is due in 2021	Report was due in 2015

SRHR SNAPSHOT

62% of Zimbabwe's population is under 25 years old.[341]

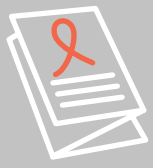
Nearly one-quarter of all 15–19-year-old Zimbabwean women (23%) are currently married or in an informal union.[342]

As of 2011, 62% of 15–19-year-olds had an unmet need for modern contraceptives, a level three times higher than that of their married peers.[343]



24% of Zimbabwe's maternal deaths are among adolescents aged 15-19.[344]

Only 41% of teenage boys and girls between the ages of 15-19 indicated comprehensive knowledge of HIV and AIDS.[345]



Strong taboos against premarital sexual activity, as well as widespread misconceptions regarding legal restrictions on adolescents' access to contraceptives, make it difficult for single, sexually active adolescents to obtain the effective methods they need to prevent unwanted pregnancy.[346]

More than 70,000 women every year resort to unsafe abortion.[347]

341. UNFPA Zimbabwe, *Young People*, http://zimbabwe.unfpa.org/en/topics/young-people-2.
342. Guttmacher Institute (2014), *Meeting the Sexual and Reproductive Health Needs of Adolescents in Zimbabwe*, www.guttmacher.org/fact-sheet/meeting-sexual-and-reproductive-health-needs-adolescents-zimbabwe.
343. Ibid.
344. Ibid.
345. Zimbabwe Ministry of Health and Child Care (2016), *National Adolescent and Youth Sexual and Reproductive Health Strategy II, 2016-2020*.
346. Guttmacher Institute (2017), *In Zimbabwe Adolescents Lack Access to Essential Reproductive Health Information and Services*, www.guttmacher.org/news-release/2014/zimbabwe-adolescents-lack-access-essential-reproductive-health-information-and.
347. Marie Stopes International (2018), *Zimbabwe*, https://mariestopes.org/where-we-work/zimbabwe/.

Zimbabwe has some youth-related policies and guidelines for youth-friendly services in place, such as the *National Adolescent and Youth Sexual and Reproductive Health Strategy II 2016–2020 (ASRH Strategy II)*, the 2016 *National Guidelines on Clinical Adolescents and Youth Friendly Sexual and Reproductive Health Services Provision* and the *Extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020 (ZNASP III)*. On paper, these documents acknowledge that young people are not a homogenous group and therefore have different needs. In particular, the National Guidelines refer to LGBTI youth by breaking down adolescents and young people to include those with different sexual orientations, those living with HIV, disabilities, those in conflict with the law, etc.[348] The ZNASP III also highlights gay men, men having sex with men (MSM) and transgender people as among the four main groups considered as key populations within the policy.

In practice, however, the legislative context (where the current constitution outlaws same-sex marriages and supportive legislation criminalizes MSM), combined with a cultural context that is often hostile to LGBTI rights, make it difficult for LGBTI youth to realize their SRHR. National policies, strategies and key documents that govern public health also do not have a sufficiently clear or inclusive definition of minority groups such as LGBTIs, and/or particularly leave out lesbians, bi-sexual and intersexual youth; entailing that their health needs and rights are often unaccounted for and unmet.

CSE

As a signatory to the 2013 ESA Commitment, Zimbabwe has indicated its commitment to ensure the provision of CSE for adolescents and youth. Zimbabwe reported meeting all of the CSE-related targets for 2015, namely providing CSE/Life Skills in at least 40% of primary and secondary schools, and having CSE training programmes for teachers.[349] Several policies and strategies have supported Zimbabwe's CSE efforts, such as the Life Skills, Sexuality and HIV and AIDS Education Strategic Plan (2012-2015), which caters for children, adolescents and young people from ages 4-18, both in and out of school. Zimbabwe had also completed a national curriculum review process in the following subjects: Guidance and Counselling, Life Skills, Sexuality, and HIV and AIDS. These are compulsory subjects in both the primary and secondary schools curricula and as of 2016, are meant to be examinable at "O" level. Discussions are reportedly ongoing on how to handle assessment at primary education level. For out of school youth, community-based sexuality education programmes targeting this population are being implemented through government and NGOs.[350]

In terms of teacher training, Zimbabwe reported in 2015 that all pre-service teachers from teachers' colleges in the country were trained in CSE, accounting for over 25,200 pre-service teachers, and a more systematic programme of training was implemented for in-service teachers, training 3,693 primary school and 7,720 secondary school teachers. "Zimbabwe's 14 teacher training colleges provide compulsory CSE under the Health and Life Skills Education subject and as a result of the newly developed Zimbabwe Curriculum Framework (2015-2022), the Ministry of Primary and Secondary Education recently put together a comprehensive syllabus and teachers' manual on life skills, sexuality, and HIV & AIDS education, in line with regional and international standards."[351]

However, there are still significant shortcomings, both in terms of policy implementation, and the scope of the policies themselves. For example, although the government has recently launched the *School Health Policy*, it has yet to be implemented. The policy defines CSE, however it does not go into further detail about it nor does it explicitly include it among the 8 components of the Comprehensive

348. Zimbabwe Ministry of Health and Childcare (2016), *National Guidelines on Clinical Adolescent and Youth Friendly Sexual Reproductive Health Service Provision*, p. 25.

349. UNESCO et al (2016), p. 12.

350. Ibid, p. 94.

351. Ibid.

School health package that is a standard for all schools. There are, therefore, still gaps in actually delivering CSE. The subject also still largely remains non-examinable and is broadly regarded as an extra curriculum activity, entailing that it is not assigned as much importance as other subject matters, by both teachers and students. Additionally, the *School Health Policy* is not inclusive of diverse populations, such as LGBTI groups; consequently, curriculum responses are heteronormative and in turn inadequate in empowering diverse groups of young people to make informed choices about their SRHR.

ADOLESCENT SRH SERVICES

The provision of youth-friendly health services in Zimbabwe is guided by the *National Adolescent and Youth Sexual and Reproductive Health Strategy II 2016–2020 (ASRH Strategy II)*, the 2016 *National Guidelines on Clinical Adolescents and Youth Friendly Sexual and Reproductive Health Services Provision* and the *Extended Zimbabwe National HIV and AIDS Strategic Plan 2015-2020 (ZNASP III)*. However, most of the policies, such as the ASRH Strategy II are not fully funded by the Ministry of Healthy And Child Care, thus failing to address the SRH needs of young people. Health in general is under-budgeted in Zimbabwe, where it is currently budgeted for approximately 7% of government spending, significantly less than the 15% required under the *Abuja Declaration*. Of the 7% budgeted for health, it is unclear how much is directed towards ASRH.

In terms of training health workers to deliver youth-friendly services, under the *ESA Commitment* Zimbabwe reported in 2016 that it had developed a *Standard National Adolescent Sexual and Reproductive Health Training Manual for Service Providers*, "to guide facilitators in preparing, delivering, and evaluating standard training in youth-friendly SRH service provision for service providers (both pre- and in-service)." Zimbabwe also reported establishing community level ASRH committees "to support and stimulate community participation, leadership, and ownership of ASRH programmes." However, no reliable data is available regarding the number of healthcare professionals who were trained between 2013 and 2015.[352] The quality of youth-friendly SRH services also currently varies from facility to facility, depending on the service provider or the financial resources available.[353] In effect, "strong taboos against premarital sexual activity, as well as widespread misconceptions regarding legal restrictions on adolescents' access to contraceptives, make it difficult for single, sexually active adolescents to obtain the effective methods they need to prevent unwanted pregnancy."[354] Young women also often report perceiving existing SRH services as not "girl-friendly."[355] Moreover, though the ASRH Strategy II and National Guidelines are inclusive of LGBTI individuals on paper, in practice individuals of diverse SOGIE still face discrimination when accessing SRH services and information in health institutions.

ABORTION

Currently, the Termination of Pregnancy Act (No. 29 of 1977) in Zimbabwe conditionally permits abortion on the grounds of saving the life of the woman, to preserve her physical health, in cases of rape or incest, and in the case of fetal impairment. Outside of these grounds, however, abortion is criminalized, liable to a fine and/or imprisonment.[356,357] Moreover, implementation is still a big challenge, in that even when the above conditions are met, bureaucracy and red-tape make it difficult for women and particularly for young women and adolescent girls to access this service. Sometimes the justice system is comprised of anti-choice judges who preside over sexual abuse or incest cases; these judges may then deliberately delay a ruling beyond when the needed abortion can be done. In cases of health risk, the patient is required to have two forms from doctors working in different healthcare facilities. These forms should then be submitted to a medical superintendent who will then issue a

352. Ibid.
353. Ibid.
354. Guttmacher Institute (2014), *Meeting the Sexual and Reproductive Health Needs of Adolescents in Zimbabwe*.
355. Ibid.
356. Women on Waves, *Zimbabwe, Abortion Law*, www.womenonwaves.org/en/page/5560/zimbabwe--abortion-law.
357. Guttmacher Institute (2014), *Meeting the Sexual and Reproductive Health Needs of Adolescents in Zimbabwe*.

written consent. For marginalized groups or areas this is difficult due to high consultation fees one has to bear, and in some areas hospitals are not located closely together, making it difficult to visit more than one health institution. In its current state the ToP Act thus limits women's ability to access safe abortion, entailing that most women and girls opt for unsafe options, putting them at risk of death, disability, infertility and other health issues, and compromising their socio-economic development, health, and rights. Of note is the 2014 ruling of the Supreme Court in the case of *Mildred Mapingure v. Minister Of Home Affairs and 2 Others*, where the Court held that the current ToP Act lacks a clear procedural guideline regarding how to access safe abortion services, and that further clarification regarding the law is needed.[358] However, such guidelines are yet to be fully developed, disseminated or implemented.

RECOMMENDATIONS

CSE

- The Ministry of Primary and Secondary Education should strengthen the School Health Policy (SHP) by making it explicitly more inclusive of diverse populations, such as LGBTI individuals, in order to uphold the rights of those who are most marginalized.
- The Ministry should then expedite the implementation of the SHP, guaranteeing a mechanism to ensure its full implementation in both primary and secondary schools.

YOUTH FRIENDLY SERVICES

- The government should fully fund and implement the ASRH Strategy II.
- The government should undertake outreach to service providers and strengthen youth-friendly training among service providers, "to dispel the common misperceptions that age restrictions and parental or spousal consent requirements exist for receiving family planning and HIV services."[359]
- Youth-friendly health service training for providers should emphasize the importance of service providers maintaining confidentiality and having nonjudgmental attitudes, so that fear of disclosure or ill-treatment does not deter adolescents from seeking the SRH services they need.[360]

ABORTION

- The government should ensure that the review of the Termination of Pregnancy Act is prioritized, that it expands grounds for abortion access in Zimbabwe, and accelerate its full implementation.
- In reviewing the ToP Act, the Minister of Health and Child Care should ensure meaningful CSO and youth participation in the process, in order to ensure that amendments to the ToP Act are in line with women and young people's realities.
- The government should also ensure that the ToP Act is accompanied by clear procedural guidelines that enable women to access safe abortion services in a timely way.

358. Center for Reproductive Rights et al, (2017), *Legal Grounds: Reproductive and Sexual Rights in Sub-Saharan African Courts Volume III, Pretoria*: Pretoria University Law Press, www.reproductiverights.org/sites/crr.civicactions.net/files/documents/ONLINE-GLP-LegalGround.pdf, p. 81-85.

359. Guttmacher Institute (2014), *Meeting the Sexual and Reproductive Health Needs of Adolescents in Zimbabwe*.

360. Ibid.

RIGHT HERE
RIGHT NOW

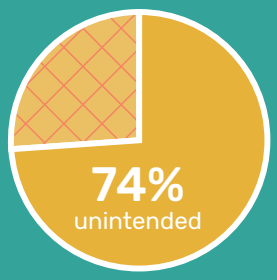
Latin America and the Caribbean

Regional level analysis

SRHR SNAPSHOT

About **106 million** young people are between the **ages of 15 and 24**, making up **20%** of the region's total population.[361]

The region has the **second highest** adolescent pregnancy rate in the world,[362] while **74%** of adolescent pregnancies are unintended.[363]



Latin America and the Caribbean is the only region in the world where rates of child marriage and early unions **are not declining**, but are in fact **increasing along with the number of births to girls under 15**.[364]

Maternal mortality is **one of the leading causes of death** among adolescents and youth **aged 15-24 years**.[365]

More than **97%** of **women of reproductive age** live in countries with restrictive abortion laws.[366]

Principles of **heteronormativity, cisnormativity, and the sex and gender binaries** are highly prevalent across the region, which fuel **prejudice and discrimination** against LGBTI communities.[367]

361. United Nations, *Regional Overview: Latin America and the Caribbean*, www.un.org/esa/socdev/documents/youth/fact-sheets/youth-regional-eclac.pdf.
362. Pan American Health Organization (PAHO) (2018), *Latin America and the Caribbean Have the Second Highest Adolescent Pregnancy Rates in the World*, www.paho.org/hq/index.php?option=com_content&view=article&id=14163&Itemid=1926&lang=pt.
363. Starrs, Ann M. et al (2018), p. 2667.
364. Organization of American States (OAS) (2017), *Let Them Be Children: Combating Child and Early Marriage and Union in the Americas*, www.oas.org/en/media_center/press_release.asp?sCodigo=E-031/17.
365. Pan American Health Organization (PAHO) (2018).
366. Guttmacher Institute (2018), *Abortion in Latin America and the Caribbean*, www.guttmacher.org/fact-sheet/abortion-latin-america-and-caribbean.
367. Inter-American Commission on Human Rights (IACHR) (2015), *Violence Against Lesbian, Gay, Bisexual, Trans and Intersex Persons in the Americas*, OAS/Ser.L/V/II.rev.1, www.oas.org/en/iachr/reports/pdfs/violencelgbtipersons.pdf, p. 265.

Latin America and the Caribbean is characterized by markedly progressive regional human rights norm-setting regarding SRHR, both in terms of human rights instruments, such as the 1994 *Belém do Pará Convention*, as well as declarations from Human Rights bodies, such as the Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention (MESECVI),[368] and the Inter-American Commission on Human Rights (IACHR).[369] In this sense the *Montevideo Consensus* is similarly progressive, containing holistic and ambitious language regarding sexual rights, young people's SRHR, CSE, youth-friendly services, and abortion, among other ICPD topics.

There have also been some efforts undertaken towards ensuring its realization, in terms of the development of the *Operational Guide for Implementation and Follow up of the Consensus*, as well as civil society efforts to monitor the implementation of the Consensus, such as the social monitoring tools *Mira que te Miro* and *ISOMontevideo*. Overall challenges relate to meaningful follow-up and operationalization of the Consensus, in that a number of governments in the region are either not prioritizing the Consensus and/or attempting to distance themselves from it; as well as a resurgence of religious fundamentalist groups across the region.

CSE AND ADOLESCENT SRH SERVICES

The realities outlined in the above SRHR Snapshot for the region illustrate the urgent need for both increased provision of CSE, and young people's access to SRH services. In terms of regional norm-setting, there have been some promising developments in human rights forums, further reaffirming governments' youth SRHR-related commitments as part of their human rights commitments. For example, the Committee of Experts of the Follow-up Mechanism to the Belém do Pará Convention (MESECVI) noted in its 2014 *Declaration on Violence Against Women, Girls, and Adolescents and their Sexual and Reproductive Rights*, that "States have the obligation to guarantee education on sexual and reproductive rights in the education system."[370] The Committee also recommended that States party to the *Belém do Pará Convention* guarantee "age-appropriate education on sexual and reproductive health and rights, including HIV/AIDS and STIs, in school curricula at all levels."[371] Similarly, in regards to adolescent SRH services MESECVI has recommended that states guarantee "that women and adolescents have immediate access to affordable contraceptives, including emergency oral contraceptives, thereby eliminating the discriminatory effects on women of denying them services on the basis of stereotypes that reduce the primary role of women to motherhood and prevent them from making decisions about their sexuality and reproduction."[372]

In practice, however, the issues of CSE and youth-friendly SRH services have generally been subject to ongoing resistance and vehement action on the part of the anti-rights sectors, obstructing the meaningful implementation of governments' related commitments. Booklets, guides, materials or sexual education initiatives for young people that have been prepared by governments have frequently been subject to attacks initiated by fundamentalist religious and conservative groups, including mass marches, burning of materials and the dismissal of affiliated political officials. These attacks position efforts to provide CSE and adolescent SRH services as attempts to upend the traditional family and overthrow the "natural order" of society.[373,374] The rise of anti-CSE campaigns across various countries under versions of the slogan *Con mis hijas no se metan* ("Do not mess with my kids")[375] illustrates

368. Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2014), *Declaration on Violence Against Women, Girls, and Adolescents and Their Sexual and Reproductive Rights*, OEA/Ser.L/II.7.10, www.oas.org/es/mesecvi/docs/declaracionderechos-en.pdf.

369. IACHR (2017), *IACHR Urges All States to Adopt Comprehensive, Immediate Measures to Respect and Protect Women's Sexual and Reproductive Rights*, https://mailchi.mp/dist/iachr-urges-all-states-to-adopt-comprehensive-immediate-measures-to-respect-and-protect-womens-sexual-and-reproductive-rights?e=07a43d57e2.

370. Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2014), p. 7.

371. Ibid, p. 16.

372. Ibid.

373. "Latin America's Battle Over 'Gender Ideology'" (2017), *The Economist*, www.economist.com/the-americas/2017/09/30/latin-americas-battle-over-gender-ideology.

374. Kane, Gillian (2018), "'Gender Ideology': Big, Bogus and Coming to a Fear Campaign Near You," *The Guardian*, www.theguardian.com/global-development/2018/mar/30/gender-ideology-big-bogus-and-coming-to-a-fear-campaign-near-you.

375. "Latin America's Battle Over 'Gender Ideology'" (2017).

the fervent opposition to and hostile environment for advancing on CSE and adolescent SRH services. This opposition is stoked by groups from the religious right, emphasizing abstinence until marriage and strict adherence to heteronormativity. In this sense it can be said that, in terms of implementation, lamentably no significant regional progress has been made regarding CSE and adolescent SRH services, as they are often highly loaded political issues few government officials are willing to champion, for fear of the potential political repercussions.

ABORTION

Latin America and the Caribbean is characterized by some of the most restrictive abortion laws in the world. Abortion is still completely criminalized in six countries,[376] where in some countries such as El Salvador "many women have been prosecuted on abortion charges, and some, accused of aggravated homicide, are serving prison terms of up to 40 years."[377] Nine other countries in the region permit abortion almost exclusively on the grounds to save the woman's life, with some countries offering limited exceptions for rape (e.g. Brazil, Bolivia, Chile, Colombia, Mexico and Panama) and unviability of the fetus (e.g. Chile, Colombia, Panama and almost half of the states of Mexico).[378] "Fewer than 3% of the region's women live in countries where abortion is broadly legal – that is, permitted either without restriction as to reason or on socioeconomic grounds."[379] Notably, abortion is legal on request in Cuba,[380] Uruguay,[381] and in the Federal District of Mexico.[382]

As with CSE and adolescent SRH services, there have been some promising developments regarding regional human rights norm-setting, in terms of recommendations from regional Human Rights bodies. Taking into consideration the high rates of sexual violence characterizing the region, particularly towards young women and girls,[383] the MESECVI Committee in its 2014 Declaration noted that laws which restrict safe abortion access or completely prohibit abortion effectively re-victimize and perpetuate violence against women, girls, and adolescents.[384] In its second Hemispheric Follow-Up Report regarding the implementation of the *Belém do Pará Convention*, MESECVI affirmed that "forcing a woman to continue with a pregnancy, especially when such pregnancy is the result of a rape or when the life or health of the woman is at risk, represents a form of institutional violence and may constitute a form of torture, violating Article 4 of the *Belém do Pará Convention*."[385] MESECVI has also recommended that States guarantee "the sexual and reproductive health of women and their right to life, eliminating unsafe abortion and establishing laws and policies that enable the termination of pregnancy, at the very least in the following cases: i) risk to the life or health of the woman; ii) inability of the fetus to survive; and iii) sexual violence, incest and forced insemination."[386]

In practical terms, however, ongoing challenges remain, in the form of strong opposition from conservative and religious fundamentalist groups across the region, abortion-related stigma, ensuring access to safe abortion services in rural/remote areas,[387] and bureaucratic hurdles to accessing abortion even on permitted grounds. In specific, the impetus to decriminalize abortion has generally stagnated in the region. Fundamentalist groups have essentially achieved that the issue of abortion has a very high political cost that no government wants to assume. There have been some successes, such as the liberalization of the abortion law in Chile permitting abortion in limited cases,[388] and the advancement of public debates on expanding

376. Guttmacher Institute (2018). *Abortion in Latin America and the Caribbean*.
377. Office of the United Nations High Commissioner for Human Rights (OHCHR) (2017), *El Salvador: UN Experts Urge Congress to Allow Termination of Pregnancy in Specific Circumstances*, www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21595&LangID=E .
378. Guttmacher Institute (2018). *Abortion in Latin America and the Caribbean*.
379. Ibid.
380. Women on Waves, *Abortion Law Cuba*, www.womenonwaves.org/en/page/4915/abortion-law-cuba.
381. Women on Waves, *Abortion Law Uruguay*, www.womenonwaves.org/en/page/4954/abortion-law-uruguay.
382. Women on Waves, *Mexico*, www.womenonwaves.org/en/page/3106/mexico.
383. The Pan American Health Organization (PAHO) has estimated that 11-20% of pregnancies in girls and adolescents are the result of sexual violence, and in the case of 60% of girls who had begun sexual activity before turning 15 years old, these were non-consensual relations with men older than them in age by an average of 6 years. Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2016), *Hemispheric Report on Child Pregnancy in the States Party to the Belém do Pará Convention*, OEA/Ser.L/II, Washington DC: Follow-Up Mechanism to the Belém do Pará Convention (MESECVI), www.oas.org/es/mesecvi/docs/MESECVI-EmbarazoInfantil-EN.pdf, p. 11 .
384. Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2014), p. 8.
385. Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2016), p. 42.
386. Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention (MESECVI) (2014), p. 16.
387. Guttmacher Institute (2018). *Abortion in Latin America and the Caribbean*.
388. Reuters Staff (2017), "Chile Court Ruling Ends Abortion Ban; New Law Allows in Limited Cases," *Reuters*.
389. Peker, Luciana (2018), "Más Cerca de la Ley," *Página/12*, www.pagina12.com.ar/105977-mas-cerca-de-la-ley.

abortion laws in Argentina,[389] including the historic step taken by the lower house of congress in narrowly approving a bill that would legalize abortion in the first 14 weeks of pregnancy.[390] With the exception of such very specific cases, however, the decriminalization of abortion has once again become a taboo subject in governmental and legislative spheres. In pre-electoral moments, political parties and candidates (including those that are leftist or progressive) often avoid any mention or reference on this matter; in the initial moments of newly elected governments, the issue is also avoided because of the fear of generating situations of internal ungovernability. In times of internal political crisis, moreover, it is also avoided because governments weakened by many other factors are afraid of generating ruptures with business sectors and/or churches.

Considering that the democracies of Latin America and the Caribbean are unstable and highly volatile, it could be said that, very exceptionally, there are favorable situations to incorporate this issue into the political agenda of the countries, as was the case in Chile. However, the cases of El Salvador[391] and Bolivia regrettably confirm this hypothesis of stalled progress and lack of political appetite, even with governments of the left. In this sense it can be said that, in terms of implementation, no significant regional progress has been made regarding abortion.

LGBTI RIGHTS

In regards to LGBTI rights, there have been some positive developments, again in terms of regional norm setting via Human Rights bodies. In January 2018 the Inter-American Court of Human Rights (IHRC)'s affirmed that same-sex marriages should be recognized, a ruling which applies to countries which have signed the *American Convention on Human Rights*.[392] Moreover, although there is still significant pushback regarding LGBTI rights fueled by religious conservatisms,[393] there have been a number of legislative advances regarding LGBTI rights in the countries of the region, such as the repeal of anti-gay laws in the Caribbean,[394,395] as well as the development of laws that recognize the rights to same-sex unions[396] and legal change of name and gender marker on identity documents,[397,398] among others.

The challenge that arises in this area relates to reactions from the public, as evidenced by the high levels of violence and attacks that LGBTI communities continue to experience,[399] as well as public backlash to progressive legislative developments or attempts to block recognition of LGBTI rights, such as in Bolivia, Brazil, Colombia, Mexico, Guatemala, Peru, and Belize.[400] These trends illustrate the limitations of implementing progressive public policies without also undertaking education and citizen awareness campaigns. As a result, individuals who presume it safe to openly identify as LGBTI continue to risk social sanctions and violent punishment by some fundamentalist sectors, even in countries where there have been notable advances in LGBTI rights-related policy and law. There also continues to be a lack of adoption by States of meaningful measures to prevent, investigate, sanction and provide reparations for acts of violence against LGBTI individuals.[401] This inaction on the part of States then effectively condones and perpetuates an enabling environment for violence and discrimination towards LGBTI communities.

390. Goñi, Uki (2018).
391. International Planned Parenthood Federation Western Hemisphere (IPPF/WHR) (2018), International Planned Parenthood Federation Western Hemisphere (IPPF/WHR) *Statement on Salvadoran Legislative Assembly Decision to Ignore Draconian Abortion Ban*, www.ippfwhr.org/en/news-room/international-planned-parenthood-federation-western-hemisphere-ippfwhr-statement-on.
392. "Inter-American Human Rights Court Backs Same-Sex Marriage" (2018), *BBC News*, www.bbc.com/news/world-latin-america-42633891.
393. See for example the cases of Mexico ("Diputados del PAN, PRI y Verde Rechazan la Iniciativa de Peña Nieto sobre Matrimonio Igualitario" (2016), *Animal Político*, www.animalpolitico.com/2016/11/diputados-matrimonio-igualitario/); Peru ("Latin America's Battle Over 'Gender Ideology'" (2017), *The Economist*, www.economist.com/the-americas/2017/09/30/latin-americas-battle-over-gender-ideology), and Ecuador ("Marcha por la Familia y Contra la Ley Para Erradicar Violencia Contra Mujeres" (2017), *El Universo*, www.eluniverso.com/noticias/2017/10/14/nota/6429238/marcha-familia-contra-ley).
394. Zeldin, Wendy (2016), "Belize: Anti-Homosexuality Legal Provision Struck Down for First Time in Caribbean," *The Library of Congress*, www.loc.gov/law/foreign-news/article/belize-anti-homosexuality-legal-provision-struck-down-for-first-time-in-caribbean/.
395. Brown, Desmond (2018), "PANCAP Says Trinidad Court Ruling on Buggery Law Affirms the Right to Human Dignity by All," *Caribbean News Service*, https://caribbeannewsservice.com/now/guyana-pancap-says-trinidad-court-ruling-on-buggery-law-affirms-the-right-to-human-dignity-by-all/.
396. "Colombia Legalizes Gay Marriage" (2016), *BBC News*, www.bbc.com/news/world-latin-america-36166888.
397. El Senado y Cámara de Diputados de la Nacíon Argentina (2012), *Identidad de Genero Ley 26.743*, www.tgeu.org/sites/default/files/ley_26743.pdf.
398. Ministerio de Justicia y del Derecho [Colombia] (2015), *Decreto 1227 de 2015*, www.minjusticia.gov.co/Portals/0/Ministerio/decreto%20unico/%23%20decretos/1.%20DECRETO%202015-1227%20sexo%20c%C3%A9dula.pdf.
399. Inter-American Commission on Human Rights (IACHR) (2015).
400. Carroll, Aengus and Lucas Ramón Mendos (2017), p. 161.
401. Inter-American Commission on Human Rights (IACHR) (2015), p. 11.

RECOMMENDATIONS

With the above challenges in mind, it becomes clear that although Latin America and the Caribbean has some laudable regional commitments in place via the *Montevideo Consensus*, significant hurdles remain in terms of its implementation, for which in general, there is not much political will. Uruguay could be considered as an exception to this regional trend, in that it has taken significant steps towards implementation.[402] However countries with a clear conservative tendency, either with right-wing governments (e.g. Chile) or religious-based governments (e.g. Brazil), or governments composed of ex-military (e.g. Guatemala) or constituted by democratic breaks or coups d'état (e.g. Honduras or Paraguay) are generally unsupportive of the *Montevideo Consensus*, and will effectively try to undermine it. In turn, so-called leftist or progressive governments have for the most part, not made efforts for the implementation of the Consensus (e.g. Ecuador, Venezuela, El Salvador, Nicaragua). There is another group of countries with challenges or internal conflicts that occupy all the efforts of the government and civil society, where when under pressure to sacrifice implementation of the Montevideo agenda, they have done so without hesitation, as is the case with the Peace agreements of Colombia. As such, there is a critical need for governments to illustrate their reinforced commitment towards the implementation of the Consensus, in order to ensure that it does not remain solely "on paper."

Moreover, given the strong foothold of religious fundamentalist groups in the region, and their ability to obstruct the advance of SRHR-related commitments, it is also clear that substantial efforts are needed by governments, UN agencies, and CSOs to strengthen the separation of Church and State. This is one of the first critical steps to preventing any fundamentalist interventions in the development and implementation of public policies meant to guarantee equal rights for all people.

Our regional recommendations are the following:

- Resume and/or increase efforts to fully implement the *Montevideo Consensus*, in line with governments regional and international human rights commitments.
- Strengthen the separation of Church and State, in line with the reaffirmation "that a secular State is one of the elements fundamental to the full exercise of human rights, the deepening of democracy and the elimination of all forms of discrimination."[403]
- Ensure that public policies intended to address forced child pregnancy, unplanned and unwanted pregnancy, and maternal mortality, include urgent measures to guarantee the availability of and access to modern contraceptive methods.
- Renew and ensure region-wide efforts towards amending abortion-related laws, regulations, and policies "in order to protect the lives and health of women and adolescent girls [and] improve their quality of life,"[404] as outlined in the *Montevideo Consensus*.
- Advances in ensuring access to abortion should also go beyond expanding the legal grounds for the procedure. It is also necessary to advance the social acceptance of abortion. To do this, governments must provide factual information and eliminate stigmatizing language and practice surrounding the procedure, in order to reduce potential pushback or resistance to its decriminalization.
- Ensure the implementation of education and public awareness campaigns in tandem with implementing LGBTI rights laws, as well as positive public statements by State authorities,[405] in order to combat the stigmatization of LGBTI persons, and foster a receptive environment for advancing LGBTI rights both in policy and practice, in line with recommendations by the IACHR.[406]

402. This can be seen in the country's 2012 decriminalization of abortion, advances made in the provision of CSE, and its recognition of SRHR. It can also be seen via Uruguay's leadership and positioning in intergovernmental spaces, such as sessions of the Commission on Population and Development.

403. United Nations ECLAC (2013), p. 13.

404. Ibid, para. 42.

405. Inter-American Commission on Human Rights (IACHR) (2015), p. 269.

406. Ibid, p. 265-283.

Bolivia

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1982	1982	1990	1999	1990	2009
Date of last review	2013	2008	2015	2013	2009	2016
Next report due date	Report due in 2018	Report was due in 2010	Report is due in 2019	Report was due in 2017	Report was due in 2015	Report is due in 2023

SRHR SNAPSHOT

Young people aged 15-29 years old comprise 27.2% of Bolivia's total population.[407]

22% of girls are married before turning 18 years old.[408]

Teenage pregnancy accounts for approximately 23% of all pregnancies in the country.[409]

Maternal mortality in the country is 160 per 100,000 live births, which is triple the average of the Latin American region.[410]

The third leading cause of maternal mortality in the country is unsafe abortion.[411]

An estimated 60,000 abortions are performed each year in unsafe and clandestine conditions.[412]

407. Instituto Nacional de Estadistica [Bolivia] (2017), *La Poblacíon de Bolivia se Mantiene Joven*, www.ine.gob.bo/index.php/principales-indicadores/item/732-la-poblacion-de-bolivia-se-mantiene-joven.
408. Girls Not Brides (2018), *Child Marriage Around the World: Bolivia*, www.girlsnotbrides.org/child-marriage/bolivia/.
409. "Bolivia Registra Alta Tasa de Embarazo Adolescente" (2016), *Los Tiempos*, www.lostiempos.com/actualidad/nacional/20160825/bolivia-registra-alta-tasa-embarazo-adolescente.
410. Ministerio de Salud [Bolivia] (2016), *Estudio Nacional de Mortalidad Maternal 2011 Bolivia: Resumen Ejecutivo, 2016*, La Paz: Ministerio de Salud del Estado Plurinacional de Bolivia, https://data.miraquetemiro.org/sites/default/files/documentos/EstudioNacionaldeMortalidadMaterna2011Resumenejecutivo.pdf.
411. Ibid.
412. Calle, Guiomara (2015), "Cuatro de Cada Diez Embarazos Adolescentes Terminan en Aborto," *La Razón*, www.la-razon.com/sociedad/Informe-embarazos-adolescentes-terminan-aborto_0_2367963182.html.

In Bolivia's national legal and policy framework, there are a number of notable commitments which are favourable to young people, and which obligate the State to implement public policies on sexual and reproductive rights.

Challenges largely relate to their implementation, while further complicating the context towards the end of 2017 has been the Plurinational Legislative Assembly's review of the National Penal System Code, undertaken over the past 3 years. While the newly drafted and approved Penal System Code included some progressive SRHR-related amendments, in early 2018 the government announced the repeal of the Code in its entirety,[413] which regrettably will further complicate both needed changes in SRHR-related laws and policies, as well as their full implementation.

ADOLESCENT SRH SERVICES

Bolivia has made some promising progress and improvements within its policy and legal framework regarding the rights of young people. These include specific provisions in the National Constitution; the *National Law of Youth* (Law 342)[414] which has several articles on the SRH of young people; and the *Plurinational Plan for the Prevention of Pregnancies in Adolescents and Young People (2015-2020)*. Although these regulations demonstrate progress in the improvement of the current legal framework regarding the rights of young people, there are still serious challenges in their implementation, especially in terms of SRHR. Over the past few years, the Ministry of Health has been in the process of reviewing and strengthening the implementation of the *National Strategic Plan for Sexual and Reproductive Health*. This process has also been linked with the Plurinational Legislative Assembly's review of the National Penal System Code, as the Code is intended to give basic guidelines to SRH policies in Bolivia, including the aforementioned Plan. However, the review process of the *National Strategic Plan for SRH* has been impeded, as several ministries, including the Ministry of Health, were working on the aforementioned Code, entailing that presently, full implementation is hindered and at a standstill.

ABORTION

Significantly, there has been notable progress in Bolivia in terms of expanding access to safe abortion. In 2014, a Constitutional Judgment (206/2014)[415] was passed which decriminalizes access to legal abortion in cases of rape or incest, risk to the life or health of the mother. The Ministry of Health also developed a Technical Procedure for ILE (Legal Interruption of Pregnancy)[416] that operationalizes this Constitutional Judgment, of which one of its most interesting aspects is establishing a 24-hour period for carrying out an abortion from the moment of the request of the woman, with the presentation of the copy of the complaint in cases of sexual violence or rape, and/or a medical report in cases of risk to the health or life of the mother and in cases of severe fetal malformation. The Constitutional Judgement also defines conscientious objection as personal and not institutional, thus guaranteeing access to this right for women. As such, access to abortion in the country is currently permitted in cases of risk to the woman's life; to preserve woman's health; congenital diseases or fetal malformation; rape or incest.[417] In a regional context of highly restrictive abortion laws, the expansion of abortion access in Bolivia is commendable; though this same Constitutional Judgment effectively reinforced the criminalization of abortion outside of these grounds. Moreover, in the absence of an official comprehensive understanding of the concept of health, women and girls continue to face challenges in accessing abortion for health reasons.

Notably, the revised Penal System Code that was repealed in January 2018 included Article 157, further expanding the decriminalization of abortion, and effectively permitting abortion on demand up to 8

413. "Morales Anuncia la Abrogacíon del Código del Sistema Penal" (2018), *Los Tiempos*, www.lostiempos.com/actualidad/pais/20180121/morales-anuncia-abrogacion-del-codigo-del-sistema-penal.
414. La Asamblea Legislativa Plurinacional [Bolivia] (2013), *Ley N. 342*, www.ilo.org/dyn/natlex/docs/ELECTRONIC/92668/108070/F-175193599/BOL92668.pdf.
415. *Sentencia Constitucional Plurinacional 0206/2014* [Bolivia] (2014), www.derechoteca.com/gacetabolivia/sentencia-constitucional-plurinacional-no-02062014-del-05-de-febrero-de-2014/.
416. Ministerio de Salud [Bolivia] (2015), *Procedimiento Técnico para la Prestación de Servicios de Salud en el Marco de la Sentencia Constitucional Plurinacional 0206/2014*, La Paz: Ministerio de Salud del Estado Plurinacional de Bolivia, https://data.miraquetemiro.org/sites/default/files/documentos/Bolivia.%20Technical%20Procedure.pdf.
417. Mira que te Miro (2017), *Bolivia: Abortion*, www.miraquetemiro.org/en/countries/BOL/38/.

weeks, in addition to abortion access on the above grounds. This article along with other progressive clauses in the Code generated extensive opposition and backlash from conservative and religious groups, political parties opposed to the government and colleges of medical professionals who mobilized to reject it; however in December 2017, Assembly members reaffirmed the full retainment of the article in the draft Penal System Code. Regrettably, the announcement of the President on January 21, 2018 to repeal the entire Penal System Code was a huge setback in terms of further expanding abortion access in Bolivia. There now remains uncertainty regarding when the national debate to decriminalize abortion will be re-opened; and whether future Penal System Code articles relating to abortion will retain as progressive language as that in the repealed law, particularly in the face of strong anti-choice opposition and political influence from conservative and religious groups.

LGBTI RIGHTS

The social monitoring initiative *Mira que te Miro* notes some promising aspects of Bolivia's legal framework, in so far as LGBTI rights. The right to live free of all forms of discrimination based on sex, sexual orientation, gender identity or expression and sexual characteristics is protected via Art. 14.1 of the Constitution,[418] and this is also upheld through Law 45 "Against all forms of Discrimination."[419] Commendably, in May 2016 the government enacted the Gender Identity Law (Law 807),[420,421] which allows transsexuals and transgender people to change their image, name and sex in their identification documents. Other promising developments included the submission in 2015 and 2016 of the draft "Agreement on Family Life" Bill (AVF, according to its Spanish acronym) to the relevant Chambers of the Plurinational Legislative Assembly, which would grant same-sex couples the right to form a family with the corresponding constitutional rights and obligations. As well, the approved Penal System Code prior to its repeal included a proposed article regarding hate crimes (and associated impunity and injustice), which particularly affects the LGBTI population, since they are often victims of crimes, violence, harassment and discrimination because of their real or perceived SOGIE.

However, there are major challenges in practice, in terms of the implementation of these progressive laws. The passing of the Gender Identity Law in May 2016 was marred by an outbreak of homophobic protests, particularly from evangelical and Catholic groups. Religious fundamentalist groups and opposition legislators then filed a petition for the government to deem the Gender Identity Law as unconstitutional; and lamentably in November 2017, the Plurinational Constitutional Court issued a Constitutional Judgment against the law. This decision was hugely regressive in regards to LGBTI rights in Bolivia, jeopardizing both that law and the rights of trans people, plus the currently tabled AVF Bill. Moreover, the total abrogation of the revision of the Penal System Code similarly jeopardizes whether (once resumed) the revised Penal System Code will retain the same progressive article concerning hate crimes.

418. Mira que te Miro (2017), *Bolivia: Sexual and Reproductive Rights*, www.miraquetemiro.org/en/countries/BOL/31/.

419. La Asamblea Legislativa Plurinacional [Bolivia] (2010), *Ley N. 045*, www.acnur.org/t3/fileadmin/Documentos/BDL/2014/9502.pdf .

420. La Asamblea Legislativa Plurinacional [Bolivia] (2016), *Ley N. 807*, https://sistemas.mre.gov.br/kitweb/datafiles/SantaCruz/pt-br/file/bolivia%20-%20ley%20807%20-%20ley%20de%20identidad%20de%20g%C3%A9nero%20-%2022%20mai%2016.pdf .

421. Human Rights Watch (2018), *Bolivia: Events of 2017*, www.hrw.org/world-report/2018/country-chapters/bolivia#e81181.

RECOMMENDATIONS

YOUTH-FRIENDLY SRH SERVICES

- Ensure and expedite the full implementation of the *National Strategic Plan for Sexual and Reproductive Health (SRH: 2016-2020)*, guaranteeing access to comprehensive SRH services for young people, including sexually diverse young people, along with adequate budget lines at municipal level for its implementation.[422]
- In future development processes of a new Penal System Code, guarantee progressive language in human rights, particularly in relation to sexual and reproductive rights.

SAFE ABORTION SERVICES

- Fully implement the current regulations regarding access to legal abortion, ensuring women and girls' ability to access abortion services at least in the cases of sexual violence and incest, protection of the health and life of the mother, and fetal malformations incompatible with life, in line with the country's current Penal System Code, Constitutional Judgment 206/2014, and the *Procedimiento Técnico del Ministerio de Salud para la interrupción legal del embarazo (ILEs)*.
- Develop and implement a comprehensive definition of the concept of health, to fully ensure women and girls' ability to access abortion for health reasons.
- Resume the revision of the Penal System Code, and ensure the retainment of Art. 157, thereby decriminalizing abortion on all grounds; and fully implement respective policies to guarantee the provision and accessibility of safe, legal, and affordable abortion services.

LGBTI RIGHTS

- Rescind the ruling against the Gender Identity Law, as part of the State's human rights obligations to transgender citizens in Bolivia.
- Ensure that once resumed, the revised Penal System Code retains the proposed article to counter hate crimes based on SOGIE.
- Ensure the passing and implementation of the AVF legislative Bill by the Plurinational Legislative Assembly.

422. Mira que te Miro (2017), *Bolivia: Sexual and Reproductive Health Services*, www.miraquetemiro.org/en/countries/BOL/36/.

Honduras

SRHR-RELATED INTERNATIONAL HUMAN RIGHTS COMMITMENTS

	ICCPR	ICESCR	CEDAW	CAT	CRC	CRPD
Year of ratification	1997	1981	1983	1996	1990	2008
Date of last review	2017	2016	2016	2016	2015	2017
Next report due date	Report is due in 2021	Report is due in 2021	Report is due in 2020	Report is due in 2020	Report is due in 2020	Report is due in 2022

SRHR SNAPSHOT

More than half of Hondurans are under the age of 25.[423]

In 2012, 42% of pregnancies in the country were unwanted or mistimed.[424]

Honduras has the second highest rate of teenage pregnancy in the region.[425]

The country is characterized by high rates of gender-based and sexual violence, as well as a 95% impunity rate for sexual violence and femicide crimes.[426,427]

60% of all new HIV infections reported in Central America occur in Honduras.[428]

Only 34% of young men and 33% of young women aged 15-24 indicated comprehensive knowledge of HIV.[429]

423. UNFPA (2016), *UNFPA Honduras*, www.unfpa.org/data/transparency-portal/unfpa-honduras .
424. Hall, Marissa G. et al (2014), "La Situación Económica: Social Determinants of Contraceptive Use in Rural Honduras," *Glob Public Health* 9(4):455-468, www.ncbi.nlm.nih.gov/pmc/articles/PMC4310570/.
425. Levine, Carlisle J. et al (2014), "AIDS, Pregnancy and the Church: Young Hondurans Take a Stand," *The Guardian*, www.theguardian.com/global-development-professionals-network/2014/jun/11/honduras-hiv-teen-pregnancy-rates.
426. "Femicide Rates Spike in 'Machista' Honduras" (2017), *Telesur*, www.telesurtv.net/english/news/-Femicide-Rates-Spike-in-Machista-Honduras--20170505-0001.html.
427. "Honduras Must Address Widespread Impunity for Crimes Against Women, Girls – UN Expert" (2014), *UN News*, https://news.un.org/en/story/2014/07/472762-honduras-must-address-widespread-impunity-crimes-against-women-girls-un-expert.
428. Levine, Carlisle J. et al (2014).
429. UNICEF (2013), *Honduras*, www.unicef.org/infobycountry/honduras_statistics.html.

In recent years, Honduras has shown great setbacks in terms of SRHR, evidenced in laws and declarations that hinder related progress. In Honduras, abortion continues to be penalized under any circumstance, in addition to this in 2009, with the coup d'état, the sale, use and distribution of Emergency Contraception (EC) is prohibited, a serious obstacle to the prevention of unwanted pregnancies, and therefore the SRH of the people. The adverse outcomes of these restrictions can be seen in how on average, 1 out of every 4 adolescent girls under the age of 18 has been pregnant,[430] and the majority of these pregnancies are the product of sexual violence.

There are national public policies that at one time signified an advance in the formal recognition of SRHR and the corresponding obligations of the government, such as the *National Strategy for Adolescent Pregnancy Prevention in Honduras (2012)*, the *National Response Strategic Plan to HIV and AIDS in Honduras 2015–2019*, and the *National Health Plan 2021*, among others. However, there have been many problems in terms of such policies' content, scope and implementation. Rather than using a comprehensive and rights-based approach, existing SRH policies tend to focus predominantly on maternal and reproductive health, promote gender stereotypes and a conservative and religious view of health and sexuality. Many standards are also outdated and processes are not emerging to approve new policies. In most cases, the documents that establish such policies do not include a budget or an implementation plan along with the appropriate resources. There has also been little government-generated data regarding SRH realities in the country, making it difficult to accurately know the challenges faced by vulnerable groups. It is thus evident that the country's current policies and efforts are not focused on the SRH of young people or other vulnerable populations such as LGBTI people. The current situation is further complicated by the November 2017 national elections,[431] which destabilized the country and resulted in limited political space for SRHR issues in this militarized context. This, combined with the predominant political and legislative influence of religious fundamentalist groups, exacerbates the current lack of political will and focus on SRHR issues, particularly in terms of CSE, abortion and LGBTI rights.

CSE

Since the 1990s, the issue of CSE has been a subject of constant struggle in Honduras, where adamant resistance from the Church against CSE has resulted in continuous revision and/or revocation of any related guidelines, with any retained content focused heavily on the issues of abstinence and morality.[432] In this vein, following the 2009 coup d'état in Honduras the existing CSE guidelines were eliminated from the National Youth Policy, and replaced with "Integral Health and Healthy Lifestyles." Since 2009, the government has refused to systematically implement the Methodological Guidelines for CSE throughout the country, and the Ministry of Education has yet to fully develop an official strategy regarding sexuality education.[433] Where sexuality education has been implemented, its curricular content is often weak on areas relating to life skills, human rights, interpersonal skills, and gender, among others, as per the criteria of the *Montevideo Consensus* and international standards.[434] The dearth of CSE coupled with young people's lack of access to SRH services is evident in the available SRH data on Honduras outlined in the above SRHR Snapshot. Moreover, in a study on CSE undertaken by the RHRN Honduras Platform, aimed at teachers and students from seventh to ninth grade of public schools in 10 departments, 70% of young people indicated they would like to have more sex education, with this need being most expressed at the age of 14. Although 73% of young people and 69% of young women in the study said they have received at least one sex education talk, they did not consider it sufficient in the amount or type of information they received.

There have been some indications that the government has been working to revise and reinstate CSE-related guidelines; in 2018, a deputy of the National Congress proposed for the second time a

430. Orellana, Dunia (2013), "Embarazos y Falta de Educación Condenan a Niñas a la Pobreza," *La Prensa*, www.laprensa.hn/mundo/americalatina/392508-96/embarazos-y-falta-de-educacion-condenan-a-ninas-a-la-pobreza.

431. Malkin, Elisabeth (2017), "Political Unrest Grips Honduras After Disputed Election," *The New York Times*, www.nytimes.com/2017/11/30/world/americas/honduras-vote-political-crisis.html.

432. See for example "Iglesia Católica Tampoco Avala las Guías Sexuales" (2018), *La Prensa*, www.laprensa.hn/honduras/1170958-410/-sexualidad-educacion-sexual-honduras-iglesia_catolica-.

433. Mira que te Miro (2017), *Honduras: Comprehensive Sexuality Education*, www.miraquetemiro.org/en/countries/HND/42/.

434. Ibid.

bill for comprehensive sexual education. However, discussions surrounding this bill and CSE guidelines have largely been undertaken without participation from civil society, while being primarily influenced by conservative religious actors, potentially entailing very conservative and/or regressive discussions in terms of CSE scope and content. It is thus imperative that such discussions be held in a transparent way and with the meaningful participation of CSOs and young people themselves, in order to ensure that once reinstated, the CSE guidelines are consistent with what a secular State should provide, and with the CSE-related international standards to which Honduras has committed.

ABORTION

Articles 126 to 128 of the Penal Code in Honduras completely criminalize abortion, with sentences ranging from 3 to 10 years of imprisonment,[435] based on the premise that life begins from the moment of conception. However, clandestine abortion is a reality that exists in Honduras. Records from the Ministry of Health indicate that every year more than 13,000 women leave the country's public hospitals with a diagnosis of abortion, with abortion being the second cause of hospital discharges for the year 2013.[436] It is noteworthy that this figure does not include the cases of women who are having clandestine abortions but do not seek medical services. There is also no data available on how many of these cases are induced abortions or miscarriages. Nearly half of the abortion discharges occur in women aged 15 to 24 years,[437] indicating how a lack of access to SRH services including safe and legal abortion is an issue that particularly affects young women and girls.

The complete criminalization of abortion in Honduras was further exacerbated in 2009, when the government issued the Ministerial Agreement 2744 which prohibits the promotion, marketing, sale and use of Emergency Contraception pills. That the EC pill is considered an abortion method by the government and the general public is a result of rampant misinformation surrounding abortion and contraceptives, combined with intense discrimination towards women and the influence of fundamentalist groups. To date, this Ministerial Agreement continues to be in effect.[438] The issues of decriminalizing EC and abortion are rarely championed by politicians, because of close ties between the Church and State, and for fear of losing political support if they oppose influential religious fundamentalist groups. This can be seen in the outcome of the 2017 debate on the criminalization of abortion, which was part of a wider debate regarding the country's Penal Code.[439] An encouraging public opinion study undertaken by the *Somos Muchas* platform in the lead up to the debate indicated that the majority of the Honduran population is actually in favour of decriminalizing abortion on the grounds of sexual violence, threats to the woman's health or life, and terminal fetal malformations.[440] However, in spite of growing public support, Honduran congress members supportive of decriminalizing abortion discretely shared that they were unable to vote in favour of decriminalizing the procedure, as it would generate conflict with churches and religious groups and in turn jeopardize their political careers. As a result, the 2017 debate resulted in a majority vote to retain Honduras' current abortion laws, entailing that abortion continues to be completely criminalized in the country, with little political will to fulfill Honduras' human rights-related commitments on abortion.

LGBTI RIGHTS

In regards to LGBTI rights, the legislative framework is not favourable in Honduras. Although under the Honduran Constitution, homosexuality and other diverse sexual identities are allowed, and though Article 321 of the current Penal Code recognizes and penalizes discrimination as a crime, there are several Articles that perpetuate discrimination against LGBTI individuals. For example, Article 112 was amended in 2005 to expressly prohibit marriage and de facto unions among persons of

435. Mira que te Miro (2017), *Honduras: Abortion*, www.miraquetemiro.org/en/countries/HND/38.

436. Centro de Derechos de Mujeres (2015), *Secreto a Voces: Una Reseña Sobre el Aborto en Honduras*, http://derechosdelamujer.org/wp-content/uploads/2016/02/Secreto-a-voces-una-resena-sobre-el-aborto-en-Honduras.pdf, p. 2.

437. Ibid, p. 2.

438. Center for Reproductive Rights (2012), *Honduras Supreme Court Upholds Absolute Ban on Emergency Contraception, Opens Door to Criminalize Women and Medical Professionals*, www.reproductiverights.org/press-room/honduras-supreme-court-upholds-absolute-ban-on-emergency-contraception-opens-door-to-crim.

439. Amnesty International (2017), *Honduras: Historic Opportunity to Decriminalize Abortion*, www.amnesty.org/en/latest/news/2017/04/honduras-oportunidad-historica-de-despenalizar-el-aborto/.

440. According to this study, the population is in agreement on decriminalization under the following causes: in cases where the pregnancy is the product of sexual violence or incest, 52% agree; when the life and/or health of the woman is in danger, 65% agree; when the fetus has null possibilities of life, 69% agree. These data consider people belonging to different political parties, people of different religions or of no religion. Somos Muchas (2017), *¿Qué Opina Honduras Sobre el Aborto?* http://derechosdelamujer.org/wp-content/uploads/2017/07/Aborto-HN-Estudio-opinion-2016.pdf.

the same sex. Moreover, SOGIE-related prejudice, stigma and discrimination are prevalent in Honduras, evident in the high rates of violence and hate crimes experienced by LGBTI activists and the LGBTI community. Available data indicate that from the period between 2009-2016 there were 223 violent deaths of LGBTI persons, most of them gays and transgender women; of all these cases, only 48 were prosecuted,[441] indicating a high rate of impunity.

However, there seems to be some political will among certain legislators and government officials for the draft "ley de Igualdad y Equidad" (Equality and Equity Law). Developed by diverse CSOs including LGBTI organizations, the draft law intends to establish measures against discrimination based on sex, gender, age, sexual orientation, gender identity, or other grounds, such as belonging to indigenous or afro-descendant groups. It is meant to offer further protections and respect for the rights of eight different groups in vulnerable situations in Honduras, one of them being those who identify as LGBTI, and arguably indicates some support from the government for LGBTI rights. However, the law has yet to be approved and its content yet to be finalized, entailing that there remains extensive work to be done to ensure that the draft bill retains progressive language, is finalized and presented to the National Congress, Ministry of Justice and of Human Rights, and in turn approved to become law. Moreover, in a context of persistent stigma, violence and discrimination towards LGBTI populations, it will be essential that the government undertake necessary steps to ensure that once approved, the law is fully implemented in conjunction with public awareness raising initiatives. This will be necessary in order to meaningfully address the rights violations experienced by LGBTI individuals, and not render the law ineffective in practice.

RECOMMENDATIONS

CSE

- Approve the bill on Comprehensive Sexual Education, presented for the second time on February 21, 2018 in the National Congress.
- Create and ensure space for young people's meaningful participation in the revision of the CSE methodological guidelines.
- Ensure the full implementation of the Methodological Guidelines for CSE at both primary and secondary levels of education, and that these guidelines and related content are in line with international standards on CSE.

ABORTION

- Continue national discussions and recognize abortion as a public health problem that must be addressed, and decriminalize abortion at least on the grounds of threats to the woman's life or health, rape or sexual violence, or fetal malformations incompatible with life, in order to reduce high rates of maternal mortality and unwanted pregnancies among adolescents.[442]
- Repeal Ministerial Agreement 2744 that prohibits the use and sale of EC, and include EC in the comprehensive care protocol for victims of sexual violence.

LGBTI RIGHTS

- In collaboration with LGBTI CSOs, ensure that the draft Law on Equality and Equity contains progressive and rights-based language regarding SOGIE, and the rights of LGBTI persons.
- Support the draft anti-discrimination law prohibiting discrimination based on sex, gender, age, sexual orientation, gender identity or any other grounds; and fully implement the law, as a step towards ensuring the rights and protection of LGBTI persons as committed to under the *Montevideo Consensus*.
- Undertake awareness raising initiatives to increase public understanding and support for the rights of all Hondurans, including those who are LGBTI, to live free from violence and discrimination.

441. Damasco, Diego Perez (2016), "Cattrachas y el Observatorio de Muertas Violentas de Personas LGBTI en Honduras," *Distintas Latitudes*, https://distintaslatitudes.net/cattrachas-observatorio-muertes-violentas-persona-lgbti-en-honduras.

442. Mira que te Miro (2017), *Honduras: Abortion*.

Caribbean

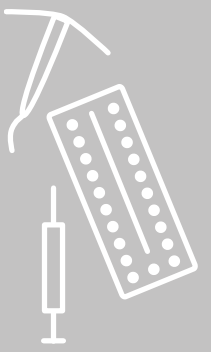
SRHR SNAPSHOT

20% of women in the Caribbean have a child by age 19.[443]

Adolescent pregnancy is linked to existing marriage legislation in several countries that allow girls from as early as 11 years to be married or engaged in common-law unions.

Average age of sexual debut is lower than the world average, with boys and girls averaging at 14 years.[444]

The unmet need for contraceptives among Caribbean adolescents is 41%,[445] partly because the age of consent to access medical services in most Caribbean countries is higher than the average age of sexual debut.



The Caribbean has the second highest HIV prevalence rate worldwide.[446]

On average in the Caribbean, one in three young people aged 15–24 have insufficient knowledge or are unaware of the ways to prevent HIV.[447]

While there are some progressive regional policy developments and commitments regarding SRHR in Latin America, these are not always apparent at the sub-regional level in the Caribbean. With the strong presence and influence of faith-based and fundamentalist organizations and actors, individual governments within the Caribbean tend to follow the collective, mostly conservative positions of CARICOM.[448]

Amplifying this sub-regional tendency are increasing economic challenges and rising unemployment, where as a result many countries (with the exception of Curacao) have undertaken cuts in social services and health systems.[449] This has contributed to an overall challenging context for advancing SRHR, where there has been less governmental policy focus on the need for SRHR-related social and legal reform, particularly in relation to CSE, abortion, and LGBTI rights.

443. CARICOM (2014), *Integrated Strategic Framework for the Reduction of Adolescent Pregnancy*.

444. Ibid.

445. Ortega, S. G. (2016), *Proyecto "Right Here, Right Now," Red de Salud de Mujeres Latinoamericanas y del Caribe*.

446. Avert (2018), *HIV and AIDS in Latin America and the Caribbean Regional Overview*, www.avert.org/professionals/hiv-around-world/latin-america/overview#footnote6_otimnex.

447. Advocates for Youth, *Youth and the Global HIV Pandemic*, www.advocatesforyouth.org/publications/publications-a-z/2054-youth-and-the-global-hiv-pandemic.

448. Ortega, S. G. (2016). *Proyecto "Right Here, Right Now." Red de Salud de Mujeres Latinoamericanas y del Caribe*.

449. UNFPA Caribbean Sub-Regional Office (2017), *Sexual & Reproductive Health Thematic Brief*, http://caribbean.unfpa.org/en/news/sexual-reproductive-health-thematic-brief.

CSE

The Caribbean is characterized by strong cultural taboos regarding formal discussions around sex and sexuality; as a result there is typically staunch resistance by educators and parents towards the inclusion of CSE in school curricula. In its place, many countries in the sub-region have a Health and Family Life Education (HFLE) curriculum; however there is no policy or monitoring mechanism to ensure that standards are maintained. This has resulted in a lack of cohesion with teachers deciding (based on their religious and social beliefs) what aspect of the syllabus to adhere to or not. Moreover, the quality and content of HFLE curricula across the sub-region is generally not in keeping with the regional and international standards to which Caribbean countries have committed, such as those under the *Montevideo Consensus*. HFLE curricula typically employs an abstinence-only approach, and does not adequately address the range of issues affecting Caribbean youth, therefore their capacities are not built to enable their ability to resolve, address and/or report SRHR violations and risks. This is evident in the high rates of adolescent pregnancy, early age of initial sex, GBV, maternal mortality, and low knowledge levels among young people of HIV and STIs in the region.

At the Twenty-Seventh Meeting of the Council for Human and Social Development (COHSOD) on July 16-17, 2015, CARICOM leaders approved an *Integrated Strategic Framework for the Reduction of Adolescent Pregnancy in the Caribbean*, which was also approved by the Organization of Eastern Caribbean States (OECS). Among the issues addressed in the Strategic Framework are adolescents' access to CSE and SRH services, including contraceptives. Progress towards the implementation of the *Strategic Framework* has been varied from territory to territory. Anguilla and St. Lucia reported the establishment of National Multi-Stakeholder Commissions to drive the implementation of the *Strategic Framework*; both territories have also been able to advance the work of the established National Multi-Stakeholder Commissions. In Anguilla, through the support of UNFPA efforts are being made to craft an SRH policy. Grenada and Dominica have also recorded significant progress with respect to the *Strategic Framework*, where in Grenada a National Consultation was convened with support from UNFPA. In Dominica meanwhile, the National Multi-Stakeholder Commission has been constituted and convened in 2016. However, cultural and legal barriers along with institutional weaknesses continue to obstruct the implementation of the Strategic Framework in all countries.[450] Notably, 30 CARICOM Ministers of Education and health signed a Ministerial Declaration on the integration of CSE in the school curriculum in 2008; however increased opposition from conservative forces, political volatility and lack of political will, as well as a lack of CSE training strategies for teachers and educators adversely affects its implementation.

ABORTION

The legislative status of safe abortion services varies across the sub-region. Abortion laws in Cuba, Guyana, and Puerto Rico are very flexible, where women have a right to request abortion services. In Barbados, Belize, St. Lucia, and St. Vincent the laws are less flexible, where women must satisfy one of four justifications to obtain the service (typically in cases of threats to the health or life of the mother, rape or incest). Despite a strict abortion law in Suriname, women have access to safe abortion services in private clinics. In the Dominican Republic, Haiti, and Jamaica abortion is completely criminalized under all circumstances.

Notably, there were some high-level political affirmations of support for legalizing abortion in the Caribbean. Ms. Billie Miller, former deputy prime minister of Barbados who spearheaded the movement for abortion law reform in the 1980s, publicly shared in an interview the positive outcome of her progressive stance in relation to abortion law reform in Barbados,[451] which in turn was shared via RHRN with Health Ministers throughout the Caribbean. The Minister of Health in St. Lucia similarly proclaimed publicly her support for abortion as a human right.[452] However, ensuring access to safe and legal abortion continues to be a challenge. This can be seen both in the strong opposition from religious and conservative groups to abortion law reform, as in the case of the Dominican Republic;[453] and

450. Ibid.

451. Miller, Billie (2017), "Why do Politicians Still Force Women Through Unwanted Pregnancies?" *The Guardian*, www.theguardian.com/global-development/2017/sep/28/why-do-politicians-still-force-women-through-unwanted-pregnancies-dame-billie-miller-barbados.

452. Sukhnandan, Samuel (2016), "Health Minister Speaks on Abortion," *St. Lucia News Online*, www.stlucianewsonline.com/health-minister-mary-isaac-speaks-on-abortion/.

453. Center for Reproductive Rights (2017), *Dominican Republic Senate Halts Decriminalization of Abortion*, www.reproductiverights.org/press-room/dominican-republic-senate-halts-decriminalization-of-abortion.

in how even though there are varying degrees of access and law reform across the sub-region, this has not been accompanied by the implementation of effective protocols for abortion access free of stigma and discrimination. Research undertaken by the Caribbean RHRN Platform in 2017 illustrated that aside from restrictive legislation, ongoing barriers to safe abortion services include cultural barriers like shame and stigma, fear of enforcement, lack of knowledge, lack of policies to make services available, unfriendliness of available personnel, and monetary cost of safe abortions, often pushing many women to resort to unsafe options. Interestingly, this research also indicated that though public discourse surrounding abortion is still dominated by patriarchal and religious morals, it is becoming more accepted that abortion is a common practice and that government policies should be separated from religious beliefs. Opinions obtained through the research similarly indicated that the majority of the population in all surveyed countries approves of decriminalizing abortion in at least some circumstances.

LGBTI RIGHTS

LGBTI rights have a high disapproval rating in the Caribbean. A look at the legislative framework within the sub-region reveals that some countries do not explicitly or fully recognize the economic, social, civil, and political rights of LGBTI people. This is primarily a result of the fact that many civil and other rights are linked to the definition of marriage and common-law unions, where same-sex marriage and intimacy is often criminalized. There are also a number of laws and/or legislative provisions that implicitly discriminate against people based on their SOGIE; for example, persons who identify as LGBTI are not explicitly included in many national policies which impacts their lives, such as in situations of domestic violence between same-sex partners and the securing of housing. Moreover, in the Caribbean, medical professionals are not trained to treat or serve members of the LGBTI community, particularly transgender persons.

Positively, there have been some public declarations of support from high level officials, indicating the beginning of increased political support for LGBTI rights in the sub-region. The Prime Minister Eugene Rhuggenaath of Curacao made a public statement at Curacao's Pride Week, promoting acceptance of diversity and respect for human rights, and the ability of all peoples to be "embraced and loved, free to practice their faith, free to express their opinions but also free to love, free to be."[454] There also have been some progressive legislative developments, where the Supreme Court in Belize struck down the country's anti-sodomy law,[455] and the High Court in Trinidad and Tobago ruled that the nation's buggery laws were unconstitutional.[456,457] However, high rates of stigma continue to persist in the region, where LGBTI individuals continue to experience discrimination and violence at the hands of both their families, communities, and wider society, such as in Jamaica,[458] Trinidad and Tobago,[459] Guyana,[460] and small island states in the eastern Caribbean.[461]

454. "Speech Prime Minister: 'Welcome to the Curacao Pride 2017'" (2017), *Curacao Chronicle*, http://curacaochronicle.com/local/speech-prime-minister-welcome-to-the-curacao-pride-2017/.

455. Zeldin, Wendy (2016).

456. Brown, Desmond (2018).

457. Doodnath, Alina (2018), "Victory at the High Court Against Buggery Laws," *Loop*, www.looptt.com/content/victory-high-court-against-buggery-laws#disqus_thread.

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459. Parsanlal, Nneka (2017), "Man Charged for Transgender Woman's Murder," *TV6TNT*, www.tv6tnt.com/news/local/man-charged-for-transgender-woman-s-murder/article_75a07b4e-ec22-11e7-a4b3-236409ac623c.html.

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RECOMMENDATIONS

CSE

- Fully implement the *Integrated Strategic Framework for the Reduction of Adolescent Pregnancy* across the sub-region, ensuring young people and adolescents' access to CSE and comprehensive SRH services.
- Ensure that the quality and content of CSE delivered across the sub-region is consistent with regional and international standards to which Caribbean countries have committed.

ABORTION

- Ensure that CARICOM adopts a more progressive position on abortion, based on the visibility of best practices of countries that decriminalized abortion in the Caribbean.
- Develop and implement effective protocols to address existing hurdles to safe and legal abortion services, and improve access to abortion services free of stigma and discrimination.

LGBTI RIGHTS

- Improve the recognition and protection of the civil, political, cultural, and socio-economic rights of LGBTI persons in the Caribbean, by undertaking actions to foster CARICOM's inclusion of Measure 36 (SOGIE-related rights) of the *Montevideo Consensus* among its priorities.
- Enact comprehensive anti-discrimination legislation to prohibit all forms of discrimination, including SOGIE-based discrimination. This legislation should prohibit discrimination at the hands of State and non-state actors in all areas of life, including but not limited to housing, employment, education and provisions of services. Additionally, this legislation should establish a body to receive and investigate complaints and conduct hearings where necessary.
- Support constitutional challenges to discriminatory laws impacting the LGBTI community within the region, particularly in countries with colonial-era laws similar to Belize, Trinidad and Tobago.
- Undertake human rights public education campaigns in the Caribbean to engender a culture of respect for the rights of all persons, including LGBTI persons; specifically targeting families, employers, community members and State actors, in order to reduce discrimination and violence as well as the number of displaced LGBTI persons.

Conclusion

RIGHT HERE
RIGHT NOW

Through the above report, we can see that some notable steps are being taken at national, regional, and global levels regarding governments' youth SRHR-related commitments. These efforts, however, need to be amplified and accelerated, sufficiently resourced, and undertaken with the full participation of CSOs and young people themselves, in order to:

- Expedite the formulation and full implementation of progressive SRHR-related policies and commitments across country, regional, and global levels;
- Comprehensively account for the barriers young people currently face in relation to their SRHR;
- Resist and remain steadfast in the face of any attempts to rollback or undermine young people's rights, including their SRHR.

In the lead-up to the 25th anniversary of the ICPD, we need renewed momentum, political will and leadership to navigate the often-adverse political climate facing SRHR. We also need a comprehensive approach that acknowledges, accepts, and celebrates young people's sexuality, and in turn is willing to fully address the "difficult" issues of CSE, youth-friendly SRH services, safe abortion, and LGBTI rights. This approach will be pivotal to making any real progress towards the ICPD agenda, and ensuring that these ambitious commitments are transformed from laudable aspirations to everyday reality. It is also critical that the ICPD+25 regional and global reviews be inclusive at every step of the process, with meaningful spaces for civil society, youth-led organizations and young people in all their diversity to participate and contribute to the outcomes of the reviews. Young people are not just key actors in achieving sustainable development, but also rights holders in and of themselves, and must have a seat the decision-making table. In this sense, we at RHRN stand ready to work with our allies and partners to champion and center young people's voices in these processes, in order to fully realize the health, rights, and wellbeing of adolescents and young people, and their ability to exercise informed and meaningful decision-making power throughout and over all aspects of their lives.

ANNEX 1: ACRONYMS

ACHPR	African Commission on Human and Peoples' Rights
ARROW	Asian-Pacific Resource and Research Centre for Women
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AVF Bill	Agreement on Family Life Bill
CARICOM	Caribbean Community
CAT	Convention Against Torture
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSE	comprehensive sexuality education
CSO	civil society organization
ECA	Economic Commission for Africa
EAC	East African Community
EC	emergency contraception
ECLAC	Economic Commission for Latin America and the Caribbean
ESA	Eastern and Southern Africa
ESCAP	Economic and Social Commission for Asia and the Pacific
GBV	gender-based violence
GFF	Global Financing Facility
HFLE	Health and Family Life Education
HIV	human immunodeficiency virus
HRC	Human Rights Committee
HRD	human rights defender
IACHR	Inter-American Commission on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICPD PoA	International Conference on Population and Development Programme of Action
IHRC	Inter-American Court of Human Rights
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IPPF	International Planned Parenthood Federation
IPPF AR	IPPF Africa Region
ITGSE	International Technical Guidelines on Sexuality Education
KP	Khyber Pakhtunkhwa
LACWHN	Latin American and Caribbean Women's Health Network
LGBTI	lesbian, gay, bisexual, transgender and intersex
LSBE	Life Skills Based Education

MESECVI	Committee of Experts of the Follow-Up Mechanism to the Belém do Pará Convention
MoE	Ministry of Education
MoH	Minister of Health
MoNE	Ministry of Education and Culture
MoRA	Minister of Religious Affairs
MPoA	Maputo Plan of Action
MSM	men who have sex with men
MYP	meaningful youth participation
NAHS	National Adolescent Health Strategy
NCED	National Center for Education Development
NCTB	National Curriculum and Textbook and Board
NEAPACOH	Network of African Parliamentary Committees of Health
NGO	non-governmental organization
OECS	Organization of Eastern Caribbean States
OHCHR	Office of the United Nations High Commissioner for Human Rights
PANCAP	Pan Caribbean Alliance against HIV/AIDS
RHRN	Right Here Right Now
RMNCAH	reproductive, maternal, newborn, child and adolescent health
S&Gs	standards and guidelines
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SOGIE	sexual orientation, gender identity and expression
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SRI	Sexual Rights Initiative
SRMNEA	Santé de la Reproduction, de la Mère, du Nouveau-né, de l'Enfant et de l'Adolescent
STI	sexually transmitted infection
ToP	Termination of Pregnancy
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
VYA	very young adolescent
WHO	World Health Organization

ANNEX 2: BIBLIOGRAPHY

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