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Have the MDGs fostered progress on women's SRHR? Effective policies and remaining challenges

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Introduction

The critique of the MDGs is well-known: that it is a development framework which was operationalized in silos; without a recognition that rights are critical to development and progress; and planned in a way as though development was a constant linear occurring in a vacuum. It was inevitable that many of the issues that emerged in the last decade (such as the food, fuel and financial crises), could not be dealt with quickly enough or effectively enough because the MDG framework was not flexible enough to include emerging issues and challenges.

The ICPD Programme of Action & the MDGs

Women's sexual and reproductive health and rights enjoys an uneasy relationship with the MDGs. After the victory of the women's movement in Cairo and Beijing, the implementation of the ICPD PoA has not received the adequate political commitment and financial support by governments across the board. In 1999, much investment of energies went into the Hague the ICPD+5 review which resulted in the Key Actions for the Further Implementation of the Programme of Action of the ICPD. However, both the PoA and the ICPD+5 key actions were side-lined by the Millennium Development Goals (MDGs). Additionally, the Global Gag Rule which was in force for eight years of the Bush administration hampered US development funding for abortion and contraception services in developing countries.[1]

* The views expressed in this paper are those of the author and do not necessarily represent those of the United Nations.

[1] Barot, S. (2009). Reclaiming the lead: Restoring U.S. Leadership in Global Sexual and Reproductive Health Policy. *Guttmacher Policy Review*, 12(1), 12-17.Retrieved from http://www.guttmacher.org/pubs/gpr/12/1/gpr120112.html.

Nevertheless the MDGs framework was considered important enough for NGOs working on SRHR to petition for their own target under goal 5 which initially only covered maternal mortality. Target 5B was only added 5 years later and indicators were finalised and agreed upon only 7 years into the MDGs.

Under the MDGs, MDG5 aimed to cover both maternal health and reproductive health.
Under Target 5A which aimed to reduce by three quarters, between 1990-2015 the maternal mortality ratio, we had the following indicators which monitored:

1) Maternal mortality ratios
2) Proportion of births attended by skilled health personnel

Under Target 5B which aimed to achieve by 2015, universal access to reproductive health, we had the following indicators which monitored:

1) Antenatal care coverage
2) Contraceptive prevalence rates
3) Adolescent birth rate
4) Unmet need for family planning

However, for the women's and feminist movement, SRHR is not only about health service provision and reduction of mortality and morbidity. The premise has always been that bodily autonomy and bodily integrity of women and girls are critical to establishing equal citizenship. Sexual and reproductive health and rights interventions are a range of both health and gender interventions which are aimed at enabling sexual autonomy and reproductive autonomy of women and girls. Hence, girls' access to equal education and women's access to equal employment which is covered in goal 3 on Gender Equality can also be considered as symbiotic to the achievements of goal 5. Goal 6 on HIV/AIDs covers between Targets 6A and 6B the following indicators:

1) HIV prevalence among population aged 15-24 years
2) Condom use at last high-risk sex
3) Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
4) Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
5) Proportion of population with advanced HIV infection with access to antiretroviral drugs

If we compare this to the definitions and range set out in the ICPD PoA which defines the components of reproductive health to include: family planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood; referral for family-planning services; further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV and AIDS which should always be available, as required; and active discouragement of harmful practices, such as female genital mutilation.

The PoA also recommends that the full range of reproductive health services should be an

integral component at the primary health care level: the level of health care system which is accessible to most of the population, especially women. However, this is not to limit the full range of services *only* to the primary health care.

- The ICPD PoA extensively covers contraception and family planning:removal of demographic targets (Paragraph 7.12);
- universal access to a full range of safe and reliable family-planning methods (Paragraphs 7.16 and 7.23);
- safer, affordable, convenient and accessible information and services (Paragraphs 7.19 and 7.23);
- free and informed choice, quality of care and service, privacy and confidentiality (Paragraph 7.23).

Additionally, the ICPD Programme of Action was also framed as an agenda of achieving and ensuring equality, equity and well-being, especially for the vulnerable and marginalised groups such as women and the reporting on the MDGs framework masked these inequities and inequalities between countries and within countries.

Hence although the late inclusion of MDG5B allowed some funding to go to the agenda, and allowed a platform for discussion on these critical issues between NGOs, governments, donors and the UN system, we were unable to use the development framework to create the necessary discourse and political paradigm shift for women and girls.

However for the purposes of this paper, we will examine closely some key MDG 5 indicators and what are some of the gaps. It needs to be acknowledged that the viewpoints expressed here are derived from the work that ARROW has done on the Status of SRHR in the Asia-Pacific region for the ICPD+15 and ICPD+20 [2,3] wherein the most recent work surveyed 21 countries in the Asia-Pacific region.

Key MDG5B Indicators

i. Contraceptive Prevalence Rates

According to World Health Organization (WHO), the "contraceptive prevalence rate is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time."[4] However, it is also important to note that data on contraception in this region, with the exception of Cambodia and the Philippines, surveys only married women.

China (84.0%), Thailand (77.5%) and Vietnam (59.8%) rank highest in the use of modern contraceptive methods[5] and it should be noted here that modern methods comprise the bulk

[2] Thanenthiran, S., & Racherla, S. (2009). *Reclaiming & Redefining Rights. ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

[3] Thanenthiran, S., Racherla, S., Jahanath, S (2012). *Reclaiming & Redefining Rights. ICPD+20: The Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

[4] *Contraceptive Prevalence Rate (Percentage)*. (2008). Retrieved August 5 2009, from http://www.who.int/whosis/indicators/compendium/2008/3pcf/en/index.html -

[5] United Nations, Department of Economic and Social Affairs (UNDESA), Population Division. (2011). *World Contraceptive Use 2011*. New York, NY:UNDESA Retrieved from http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm

of contraceptive use in these countries. However, in China the method mix is largely concentrated on female sterilisation and IUDs; and in Vietnam, a large proportion of contraceptive users use either IUDs or traditional methods. In both of these cases, policies and provider bias influence women's choices in contraception. However in almost all countries, a predominance of one or sometimes two methods prevailed. This is largely due to provider bias (inference drawn from the respective DHS). Traditional methods for contraception prevail in Malaysia (34.0%), the Philippines (32.9%), and Cambodia (32%) and it needs be explored if this was due to provider bias, influence of religion on either the clients or the providers, or just a pure lack of access to any other method.

Hence although access to contraception has been part of the MDG agenda, ***women's access to a range of contraceptive methods based on individual choice continues to elude them.***

The second key point we can derive from the CPR data is that in countries that strongly implement population control policies such as China and India, permanent methods and long-term methods such as sterilisation and IUDs are favoured. China has the highest CPR of 84.6% and the most popular methods used were IUD (48% of all methods) and female sterilisation (33.9% of all methods). India, on the other hand, has the highest rate of female sterilisation in the region, 66.3% of all methods, i.e. two-thirds of all contraceptive users are sterilised women. This is probably in line with the strict population policies that both of these countries have.

In addition, Thailand has the third highest rate of female sterilisation, 29.7% of all methods. Nepal also has a large proportion of sterilisation – female sterilisation comprising 30.6% of all methods.

It is interesting to contrast these numbers of female sterilisation with those for male methods of contraception. Male contraception methods comprise mainly of condom usage and male sterilisation. The importance of male contraception rates indicate shared responsibility for contraception, shared reproductive burden and one form of equality within relationships.

In all countries, male contraception is at comparatively low rates, and is nowhere near the desired ideal of having both men and women share equal responsibility over sexual and reproductive health decisions as couples. The corresponding numbers in China and India for male sterilisation is at 5.3% and 1.8%. In Thailand, male sterilisation is low despite government attempts to promote male contraception by providing vasectomies free of charge at government hospitals.[6] Male sterilisation accounts for 0.1% - 2.8% (as proportion of all contraceptive users) across most of the countries with only Bhutan and Nepal demonstrating 19.2% and 15.7%.

When ranking contraceptives according to their ability to protect against infection and prevent pregnancy, condoms routinely out rank other methods as condoms are the safer choice and the only method which provides dual protection,[7] yet condom usage remains low. In Cambodia, despite increasing HIV prevalence in new infections among husband-wife/intimate partners (husband-to-wife-transmission is the main route of HIV transmission, causing two-fifths of new infections), the use of male condom stands at 7.3% among all

[6] United Nations (UN). (2004). Article 12: Health. *Thailand Committee on the Elimination of Discrimination against Women (CEDAW)* (p. 76). Geneva, Switzerland: UN.

[7] Ravindran, T. K. S., & Berer, M. (1994). Contraceptive Safety and Effectiveness: Re-evaluating Women's Needs and Professional Criteria. *Reproductive Health Matters (RHM)*, *2*(3), 6-11.

contraceptive methods.[8] In Cambodia, condom use between husband and wife is culturally viewed as implying mistrust and makes it difficult for the propagation and popularisation of the method, although it is much needed.

In the Philippines, one-fifth of women reported that their husbands preferred more children, so very few of them use condoms, or take the responsibility of contraception. Men also tend to prefer having more children, unlike the vast majority of married women (81%) who either wanted to space their next birth or to limit childbearing altogether."[9]

Hence it is legitimate to conclude that ***women continue to bear the burden of contraception and continue to be the focus of contraceptive and family planning programmes and policies.*** And in countries which have strict population policies, the contraceptive services which are most readily made available are permanent methods for women, and this is accompanied usually by incentive or disincentive schemes.

ii. Unmet Need for Contraception

Unmet need for contraception is defined as "the number of women with unmet need for family planning. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child."[10] Unmet need is expressed as a percentage of women of reproductive age who are married or in a union or sexually active but are not using any method of contraception.

The concept of unmet need is important as it shifts the focus from the limits on family size set by the government to rightly focus "on the 'need' for contraception based on whether and when a woman wants a child."[11] However, there are certain limitations as to how the data for unmet need for contraception is being sampled and calculated in the national surveys. One limitation is the fact that the sample population for this indicator in most countries in the region, with the exception of Cambodia and the Philippines, is married, heterosexual women and not single, unmarried women, which does not accurately represent a holistic picture of unmet need in a country. Another limitation arises from an assumption that all current users of contraceptive methods are having their needs 'met' when there are examples of women using a particular contraceptive method due to provider bias or government policy and not because of their free choice as earlier discussed. Lastly, the current analysis around contraception is primarily focused on pregnancy prevention and is not heavily inclusive of

[8] National Institute of Public Health, National Institute of Statistics, & Macro ORC. (2006).*Cambodia Demographic and Health Survey 2005*. Cambodia: National Institute of Public Health, National Institute of Statistics, & Macro ORC.
[9] National Statistics Office [The Philippines], & ORC Macro. (2008). Article 12: Equality in Access to Health. *Philippines Demographic and Health Survey 2008*. The Philippines: National Statistics Office, & ORC Macro.
[10] United Nations, Department of Economic and Social Affairs (UNDESA), Population Division. (2011). *World Contraceptive Use 2011*. New York, NY:UNDESA Retrieved from http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm
[11] Thanenthiran, S., & Racherla, S. (2009). *Reclaiming & Redefining Rights. ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

the need for reproductive healthcare in general, which also incorporates contraception to prevent STIs.[12]

Despite these limitations, it still produces an important analysis for contraceptive as part of the comprehensive reproductive health package service – its provision, quality and accessibility.

The differential trends in unmet need of women in these countries, according to their wealth, area of residence, age and education, provide an in-depth view of the effects of the inequality in socio-economic status of these women. Unmet need is higher among women living in rural areas compared to those in the urban areas as evident in Pakistan,[13] India,[14] and Lao PDR.[15] Unmet need is also highest among the youngest age group of women (15-19 years) in Vietnam[16] and the Philippines.[17] Unmet need for spacing purposes is higher among younger women in Pakistan[18]and India,[19] while unmet need for limiting births is higher among older women in Pakistan.[20] Not only unmet need but all SRH indicators when disaggregated by education and wealth quintiles show that ***access to sexual and reproductive health are issues not only of gender equality but also of socio-economic inequity***.

A key point is that emergency contraception has not yet been included within the numbers for contraceptive prevalence rates and unmet need. Data only exists within the category of ever-use of emergency contraception, and this might lie around the controversies around EC.[21] EC, if endorsed as an essential part of a reproductive health service package, can tremendously reduce unmet need for contraception (as having infrequent sex is one of the reasons that women are not currently using a method), can reduce unintended/unwanted pregnancies as well as give women more control over their fertility.

iii. Adolescent Pregnancies

Adolescent birth rate is the annual number of births to women aged 15-19 years per 1,000 women in that age group that represents the risk of childbearing and the related complications among adolescent women between 15-19 years of age.

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[12] Thanenthiran, S., & Racherla, S. (2009). *Reclaiming & Redefining Rights. ICPD+15: The Status of Sexual and Reproductive Health and Rights in Asia*. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

[13] National Institute of Population Studies, & Macro International Inc. (2007). Fertility Preferences. *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies.

[14] National Institute of Population Studies, & Macro International Inc. (2007). Fertility Preferences. In *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies.

[15] Committee for Planning and Investment (CPI), National Statistics Centre (NSI), & United Nations Population Fund (UNFPA). (2007*). Laos Reproductive Health Survey 2005*. Vientiane, Laos PDR: CPI..

[16] Committee for Population, Family and Children [Vietnam], & ORC Macro. (2003). Fertility Preference. *Vietnam Demographic and Health Survey 2002* (p. 71). Vietnam: Committee for Population..

[17] National Statistics Office (NSO) [Philippines], & ORC Macro. (2009). Fertility. *Philippines Demographic and Health Survey 2008* (p. 41). Philippine: National Statistics Office.

[18] National Institute of Population Studies, & Macro International Inc. (2007). Fertility Preferences. In *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies.

[19] International Institute for Population Sciences (IIPS), & Macro International. (2007). Summary of Findings. In *National Family Health Survey (NFHS-3), 2005–06: India: Volume* (p.xxix). Mumbai, India: IIPS.

[20] National Institute of Population Studies, & Macro International Inc. (2007). Fertility Preferences. In *Pakistan Demographic and Health Survey 2006-07* (p. 81). Islamabad, Pakistan: National Institute of Population Studies.

[21] Miller, A. (2012, March 27). Why EC=BC: Emergency Contraception of Birth Control. *RH Reality Check.* Retrieved from http://www.rhrealitycheck.org/article/2012/03/27/why-ecbc

In the Asia and the Pacific region, about 176 million adolescent girls (aged 15-19) are vulnerable to early pregnancies. While the adolescent birth rates, between 1990 and 2008, declined in South Asia and the Pacific, these sub-regions continue to have high adolescent birth rates in the region. Bangladesh (133.4), Lao PDR (110), Afghanistan (90.8), Nepal (81.0) and PNG (70.0) report high adolescent birth rates.[22] These are amongst the highest in the world.

Early childbearing entails an increased risk of maternal deaths or physical impairment. Almost 10% of the girls become pregnant by age 16 in South and South-East Asia.[23]

Table 1. Adolescent birth rates across the region

Country	Adolescent birth rate per 1000 girls aged 15-19
EAST ASIA	
China	6.2
SOUTH ASIA	
Afghanistan	90.8 (2008)
Bangladesh	133.4
Bhutan	59.0
India	38.5
Maldives	15
Nepal	81.0
Pakistan	16.1
Sri Lanka	24.3
SOUTHEAST ASIA	
Burma	17.4
Cambodia	48.0
Indonesia	52.3
Lao PDR	110
Malaysia	14.0
Philippines	53
Thailand	46.7
Vietnam	35.0
PACIFIC	
Fiji	31.1
Kiribati	39
Papua New Guinea	70.0
Samoa	28.6

Source: Table from Reclaiming and Redefining Rights – ICPD+20: Status of Sexual and Reproductive Health and Rights in Asia Pacific, ARROW.

Data from South Asia is particularly startling. In Bangladesh, one-third of adolescents aged 15-19 have begun childbearing, 27% of these teenagers in Bangladesh have given birth, and

[22] Data was taken from Millennium Development Goals Indicator: The Official United Nations site for the MDG Indicators. Retrieved from http://mdgs.un.org/unsd/mdg/Default.aspx

[23] World Health Organization (WHO). (2009). *Adolescent Pregnancy*. Retrieved September 25, 2009, from http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/print.html

another 6% are pregnant with their first child.[24] Early childbearing among teenagers in Bangladesh is more prominent in rural areas, compared with urban areas.[25]

In Nepal, 17% of adolescent women age 15-19 are already mothers or pregnant with their first child,[26] while in Afghanistan, 12% of women between 15-19 years of age have started childbearing, with 8% having had a live birth, and 4% pregnant with her first child.[27]

The 2010 Afghanistan Adult Mortality Survey notes that early childbearing is higher among women in rural areas,[28] and the government has introduced a National Child and Adolescent Health Strategy (2009-2013).[29]

However we have to ask key questions, is reduction in adolescent pregnancy require programmatic interventions which are merely family-planning and reproductive health oriented? Girls' access to free, quality education which includes not only free and nutritious meals but also aspects of getting safely to and from schools would be an essential part of the intervention. However these are not linked together in a meaningful way.

Additionally we must also ask were we thinking we were going to see an end to adolescent pregnancies without tackling early marriage and child marriage and asking for the implementation and legislation on enforcing the legal age of maariage? Therefore it is essential to compare and contrast data on adolescent pregnancies with that of early marriage and child marriage which are important issues in our region, which are slowly transitioning out of their earlier cultural and historical contexts. As well as in some contexts which are experiencing a revivalism of religious extremism. The legal moves in a number of Muslim countries to lower the legal age of marriage signifies this. In order to ensure the health and well-being of women and girls, and access to equal opportunities in life for women and girls, it is important to ensure that the end of early and child marriage is a non-negotiable.

Additionally it is also essential when we look at interventions that reduce adolescent pregnancies that we also look at government commitment towards and implementation of programmes on comprehensive sexuality education.

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[24] National Institute of Population Research and Training (NIPORT), Mitra and Associates, & Macro International. (2009). *Bangladesh Demographic and Health Survey 2007.* Dhaka, Bangladesh : NIPORT Retrieved from http://www.measuredhs.com/pubs/pdf/FR207/FR207%5BApril-10-2009%5D.pdf

[25] National Institute of Population Research and Training (NIPORT), Mitra and Associates, & Macro International. (2009). *Bangladesh Demographic and Health Survey 2007.* Dhaka, Bangladesh : NIPORT Retrieved from http://www.measuredhs.com/pubs/pdf/FR207/FR207%5BApril-10-2009%5D.pdf

[26] Ministry of Health and Population (MOHP) [Nepal], New ERA, & ICF International Inc. (2012). *Nepal Demographic Health Survey 2011*. Kathmandu, Nepal: MOHP. Retrieved from http://www.measuredhs.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf

[27] Afghan Public Health Insititute. (2010) Afghanistan Mortality Survey. Kabul, Afghanistan: Afghan Public Health Institute, Ministry of Public Health pp49

[28] Afghan Public Health Insititute. (2010) Afghanistan Mortality Survey. Kabul, Afghanistan: Afghan Public Health Institute, Ministry of Public Health pp 50

[29] Afghan Public Health Insititute. (2010) Afghanistan Mortality Survey. Kabul, Afghanistan: Afghan Public Health Institute, Ministry of Public Health pp 89

iii.a. Non-consensual marriages: early and child marriages and forced marriages

Table 2. Legal age and median age at marriage

COUNTRY	WOMEN	MEN	REMARKS	MEDIAN AGE AT MARRIAGE FOR WOMEN (AGE GROUP 25-49)
Afghanistan	16	18		17.7
Bangladesh (2004)	18	21		15
Bhutan	18	18		
Burma	20	20		
Cambodia	18	20	If an under aged girl becomes pregnant, with the consent of parents/guardian, marriage can be requested	20.1
China	20	22		
Fiji	21	21	Requires parental consent	
India	18	21		17.4
Indonesia	16	19		19.8
Kiribati	21	21		20
Lao PDR	18	18	In special and necessary cases, age less than eighteen years but no less than fifteen years of age.	
Malaysia	18	18	16 for women and 18 for men under Muslim law, Individuals aged 18-21: written parental consent.	
Maldives	18	18	No minimum legal age for marriage. An individual can enter into marriage once puberty has been reached, however, government policy strictly discourages marriages under the age of 16	19.0
Nepal (2003)	20	20	18-requires parental consent	17
Pakistan (2007)	16	18		19.1
Papua New Guinea	16	18	Under customary law, the emphasis is on physical maturity rather than on the chronological age, a girl of 14 years of age who has the	

			attributes of a physically 'fit' person may enter into a valid customary marriage	
Philippines	18	18	Individuals aged 18-21: written parental consent and must undergo marriage counselling; 21-25: parental "advice."	22
Samoa	19	21	Requires parental consent	-
Sri Lanka	18	18	Does not apply to Muslim population	22.4
Thailand	17	17		
Vietnam	18	20		21.1 (2002)

Source: ARROW, Table from Reclaiming & Redefining Rights – ICPD+20: Status of SRHR in Asia-Pacific. Median age at first marriage source: Measure DHS. (2009). *Demographic and Health Surveys* [30]

The table above shows the legal age of marriage in all 21 countries. In 11 of the 21 countries – Bhutan, Burma, Fiji, Kiribati, Laos PDR, Malaysia, Maldives, Nepal, Philippines, Thailand and Sri Lanka – the legal age of marriage is the same for both men and women. In other countries, the legal age of marriage of women tends to be lower than that of men.

Where legal age of marriage is below the age of 18, it is to be recollected that according to the definition of 'child' in Article 1 of the Convention on the Rights of the Child,[31] such marriages as allowed by the law can be termed as child marriages. It is disturbing that five countries in the region, Afghanistan, Indonesia, Pakistan, Papua New Guinea and Thailand have a legal age of marriage under 18. In Pakistan, the legal age of marriage, according to the Child Marriage Restraint Act, 1929, is 16 for girls, and 18 for boys. This law is inadequately enforced. The religious lobby is of the view that a girl's puberty is indicative of her maturity, a perspective that carries weight in many instances; *jirgas* force little girls to be exchanged as 'compensation' between warring groups or tribes.[32] The Human Rights Commission of Pakistan in its 2006 annual report also noted a rise in the number of child marriages while the Global Gender Gap Report said that "21% of girls aged 15-19 were married, divorced or widowed."[33]

Different regulations may exist for different communities within one country: in Malaysia, and Indonesia under Muslim law, for example, the age of marriage is 16 for women and 18 for men. There have been cases in recent years, however, of underage marriages in Malaysia. For example in 2010, a 14 year old girl married her 23 year old teacher after being given permission by the Islamic Sharia court.[34,35] In 2012 alone the Sharia courts approved 1022

[30] Measure DHS. (2009). *Demographic and Health Surveys* Retrieved February, 2012 from http://www.measuredhs.com.
[31] The Convention on the Rights of the Child was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25
[32] Ali, M. (2008). Getting Away With Murder. *Dawn.* Retrieved August 10, 2009 from http://www.dawn.com/wps/wcm/connect/dawn-content-library/dawn/news/pakistan/getting-away-with-murder--qs
[33] Social Institutions and Gender Index (SIGI). (2008). *Pakistan.* Retrieved September 29, 2009, from http://genderindex.org/country/pakistan
[34] mysinchew.com. (2010, December 15). 14-year-old-bride - Tay Tian Yan. *The Malaysian Insider.* Retrieved from http://www.themalaysianinsider.com/breakingviews/article/14-year-old-bride-tay-tian-yan/

marriage applications concerning Muslim minors (i.e. below 16 years of age) in a middle-income country.[36] There are also special dispensation for girls from Muslim communities in countries such as Sri Lanka. This is an interesting situation to note, because in essence, such dispensation creates two classes of women and girls citizens in these countries, one class which is subject to civil law and entitled to rights under civil laws and another class which is subject to Sharia law and entitled to rights under Sharia laws. These systems are pre-determined at birth, and women and girls cannot opt for the legal system which affords them greater rights, especially with regards to Family Law.

Despite the existence of a legal minimum age, girls may be getting married very early. This is evident in the country DHS data on median age at first marriage. In Bangladesh, India and Nepal, the median age at first marriage for women aged 25-49 is lower than the legal age of marriage.

It is recognised that early marriage and child marriage is a violation of many aspects of rights including of sexual rights. Countries in the region are rated amongst those having the highest number of early and child marriages, with the highest concentration in South Asia. However, a recent study in the Journal of the American Medical Association noted that the prevalence of child marriage in South Asia has declined over the past twenty years. This decline has reduced the number of girls under 14 getting married; the situation, however, remains the same for adolescent girls above 15.[37] The study noted that "the practice fell by 35% in India, 45% in Bangladesh, 57% in Nepal and 61% in Pakistan"[38] for girls under 14 years of age.
In Afghanistan, 54% of girls are victims of early marriage,[39] and in Bangladesh, there is a disturbing statistic of one in three adolescents already having begun child-bearing.[40] Among the Pacific islands, in Kiribati, although the minimum age of marriage for a woman is 18 years of age, data shows that among women aged 20 to 49 years, 5% were married by the age of 15, while another 26% were married by the age of 18.[41]

Alternative sources of information indicate that marriages at a young age are not always consensual. In Cambodia, under special circumstances, for example, when a girl becomes pregnant, marriage can be requested with the consent of parents or guardians. In the context of Cambodian society and its culture of censuring children born outside marriage, it is very

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[35] Agence France-Presse (AFP). (2010, December 2011). Malaysia's 14-year-old bride defends marriage. *AFP*. Retrieved from http://www.google.com/hostednews/afp/article/ALeqM5jCV8t4A9UJ-f-EfIZNHSiLvgo68Q?docId=CNG.43f69b8e9aa2bdf4b87b46d21e9df578.541

[36] The Star. (2013, October 6). Child Marriages on the Rise. The Star. Retrieved from http://www.thestar.com.my/News/Nation/2013/10/06/Child-marriages-on-the-rise-1022-applications-approved-in-2012-compared-to-900-in-2011.aspx

[37] International Business Times. (2012, May 16). South Asia: Child Marriage Still Prevalent Among Adolescents in South Asia: Report. *Peace Women.* Retrieved from http://www.peacewomen.org/news_article.php?id=4958&type=news

[38] International Business Times. (2012, May 16). South Asia: Child Marriage Still Prevalent Among Adolescents in South Asia: Report. *Peace Women.* Retrieved from http://www.peacewomen.org/news_article.php?id=4958&type=news

[39] United Nations Population Fund (UNFPA). (2005). *Child Marriage Fact Sheet.* Retrieved from http://web.unfpa.org/swp/2005/presskit/factsheets/facts_child_marriage.htm.

[40] National Institute of Population Research and Training (NIPORT), Mitra & Associates, & ORC Macro. (2005). Fertility. In *Bangladesh Demographic and Health Survey* (p. 61). Dhaka, Bangladesh and Calverton, Maryland ,USA: NIPORT, Mitra & Associates, & ORC Macro.

[41] Kiribati National Statistics Office (KNSO) & Secretariat of the Pacific Community (SPC). (2010). *Kiribati Demographic and Health Survey 2009* (p. 92). Noumea, New Zealand: SPC. Retrieved from http://www.spc.int/sdp/index.php?option=com_docman&task=cat_view&gid=67&Itemid=4

likely that young pregnant girls will be forced to get married.[42] There is also customary law in some Pacific countries such as Papua New Guinea, Solomon Islands and Vanuatu, allowing girls to be married at 12 or 13.[43] In Papua New Guinea, families traditionally sell girls into forced marriages to settle their debts, leaving them vulnerable to forced domestic service, and tribal leaders trade the exploitative labor and service of girls and women for guns and political advantage. Young girls sold into marriage are often forced into domestic servitude for the husband's extended family.[44] Also in Papua New Guinea, while the legal age of marriage for women is 16, the emphasis is on physical maturity rather than on the chronological age, under customary law. This means that if a younger girl whose physical attributes are similar to those of a 16 year old, she would be eligible for marriage.

In Thailand, if a man "mistakenly has sexual relations with a girl over age 13 but under age 15, with the consent of the girl or her parents, the Criminal Law allows the Court to permit the couple to marry without the man being prosecuted."[45]

As of now, most of the laws around the legal age of marriage are constructed within a hetero-normative framework. It would be interesting to look at Nepal in the coming years to see if similar age structures would apply to consent for same-sex marriages.[46] Raising women's legal age of marriage will enable women to spend time in education and labour, both of which have positive correlations on their SRH and their empowerment.[47]

iii.b. Sex Education and Sexuality Education within the National Education Curriculum

The ICPD PoA acknowledges that young people and adolescents have sexual and reproductive health (SRH) needs that must be addressed. It urges the governments to address adolescent SRH issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, as well as HIV and AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.[48]

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[42] Cambodian NGO Committee on CEDAW 2001; Cambodian Committee of Women (CAMBOW). (2006). *Joint Coalition Shadow Report for the CEDAW Committee, Report on Elimination of all forms of Discrimination against Women In Cambodia.* (p.79) Cambodia; Cambodian NGO Committee on CEDAW 2001;

[43] Agence France-Presse (AFP). (2011, October 30). New Commonwealth focus on tackling forced marriage. *Vanguard.* Retrieved http://www.vanguardngr.com/2011/10/new-commonwealth-focus-on-tackling-forced-marriage/

[44] United States Department of State. (2011). *2011 Trafficking in Persons Report - Papua New Guinea.* Retrieved from http://www.unhcr.org/refworld/topic,45a5fb512,45a608be2,4e12ee5437,0,,,PNG.html

[45] United Nations (UN). (2006). Thailand Committee on the Elimination of Discrimination against Women (CEDAW) (p. 7). Geneva, Switzerland.

[46] The Supreme Court of Nepal has recognised LGBTIs as natural persons. The Court issued directive orders to Nepal government to ensure rights to life according to their own identities and introduce laws providing equal rights to LGBTIs and amend all the discriminatory laws against Lesbian, Gay, Bisexuals, Transgender and Intersexes (LGBTIs). Further to this, the Supreme Court (2008), ordered the government to formulate same-sex marriage act.
Library of Congress. (2008). *Nepal: Supreme Court Orders Drafting of Same-Sex Partnership/Marriage Law*. Retrieved, August 10, 2009, from http://www.loc.gov/lawweb/servlet/lloc_news?disp3_896_text

[47] Jejeebhoy, S. J. (2000). *Women's Education, Autonomy and Reproductive Behaviour: Experience from Developing Countries*. USA: Oxford University Press.

[48] Para. 7.44 of the ICPD PoA. Furthermore, in paragraph 7.46, governments are urged to protect and promote the rights of adolescents to reproductive health education, information and care..." and in Paragraph 7.47, in collaboration with NGOs, to "meet the special needs of adolescents and to establish appropriate programmes to respond to those needs."

Sex education is defined as the basic education about reproductive processes, puberty and sexual behaviour. Sex education may include other information, for example, about contraception, protection from sexually transmitted infections and parenthood.[49] Sexuality education is defined as education about all matters relating to sexuality and its expression. Sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about SRH services. It may also include training in communication and decision-making skills.[50]

Progress in providing sex education, in the 21 countries, is uneven. In fact, there are vast differences in the interpretation of what constitutes sex/ sexuality education among and within countries. Some governments have already begun to address incorporating sex education into the education curriculum. In addition to this, the scope and coverage of sex education curriculums differ significantly within the countries. The current emphasis seems to be on biology rather than health and rights. In the 21 countries, NGOs have been working on creating awareness about the demand for sex/sexuality education and this contributes to creating an atmosphere of acceptance of sex/sexuality education in the countries.

Five out of the 21 countries (Afghanistan, Bangladesh, Indonesia, Nepal and Thailand) have national population and reproductive health strategies or plans that made direct reference to the education sector, and there are also other population and reproductive health strategies and/or plans that include activities that are related to education. For example, Indonesia has a National Strategy for Adolescent Health (2004) which includes sex education, focusing on the "improvement of skills of health personnel in adolescent counselling, life skills education, prevention and detection as well as HIV/AIDS management," but the activities are not being implemented by the education sector and there is no direct link with education. [51]

It is also worth noting that in these five countries, while the focus is on working with the Ministry of Education in order to include the relevant contents into the education curriculum, this is often done with other ministries such as the health or social affairs, and only a few of these plans/strategies have defined at which level of education (primary, secondary) the integration should take place and whether this intervention covers the education environment (formal, non-formal).[52]

Indonesia, Malaysia, Pakistan, Bangladesh, Bhutan and Samoa have not started providing sex education in schools as part of the school curriculum. Indonesia has a policy to extend information and reproductive health education to adolescents, to be implemented by the National Family Planning Coordinating Board and the Department of Education. Controversies persist on whether SRH education and services need to be extended to adolescents in the country and this has implications on the implementation of the policy. Training modules for parents and adolescents were also developed, however their integration

[49] International Planned Parenthood (IPPF). (2009). *Glossary.*
[50] International Planned Parenthood (IPPF). (2009). *Glossary*.
[51] United Nations Educational, Scientific and Cultural Organization (UNESCO). (2012). *Sexuality Education in Asia and the Pacific: Review of Policies and Strategies to Implement and Scale Up.* Bangkok, Thailand: UNESCO. Retrieved from http://unesdoc.unesco.org/images/0021/002150/215091e.pdf
[52] United Nations Educational, Scientific and Cultural Organization (UNESCO). (2012). *Sexuality Education in Asia and the Pacific: Review of Policies and Strategies to Implement and Scale Up.* Bangkok, Thailand: UNESCO. Retrieved from http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

into the school curriculum is limited.[53] Similarly, in Malaysia and Pakistan, sex education has not been integrated into the school curriculum, although the demand for sex education among adolescents has been documented by NGOs.

In Bangladesh, sex education is not taught by teachers in schools although some basic reproductive health topics are included in the school curriculum. In the Philippines, adolescent reproductive health (ARH) education is mostly community- based. Some are school-based, and a few are implemented in the workplace. Information and education interventions include lectures, workshops, discussions, trainings, and media-based activities. Most of these programmes are focused on ARH, sexuality and fertility issues, in which counselling is provided.[54] In 1997, the Population Commission of the Philippines, with the assistance of the national and local governments and NGOs, launched "Hearts and Minds," a nationwide information, education and communication (IEC) campaign that teaches young Filipinos about sexual health, responsible adulthood, and parenthood.[55]

In Vietnam, Afghanistan, India and Nepal, there are attempts to introduce sex education but there are limitations. In Vietnam, from 1995-96 onwards, the Ministry of Education and Training decided to integrate education on HIV/AIDS prevention into the official curriculum of secondary schools throughout the whole country. This move consisted of incorporating lessons on reproductive health and HIV/AIDS.[56] From 2002 to the present, after the issuance of the decision 40/2000/QH10 regarding school reformation, and with the support of UNFPA, the Population and RH curriculum in upper-secondary schools has been developed and is in the process of being piloted. It has been integrated into the school text books for Biology, Civics Education, Geography, Language and into extracurricular activities for Grades 10 to 12 in some provinces. In the final evaluation, UNFPA noted that most of the information on adolescent RH mainly focuses on pathological aspects of RH and contains poorly clarified/confusing/wrong concepts and statements; information which is sometimes insufficient or even incorrect; the use of outdated statistics; and poorly written Vietnamese. Yet, the integration of adolescent RH in upper-secondary schools has shown increased knowledge among students. Rapid assessment confirmed that more than 60% of students in all schools are aware of basic adolescent RH issues such as STDs/HIV/AIDS, condoms, oral contraceptive pills and emergency contraception.

In Afghanistan, the National Reproductive Health Strategy (2003-2005) specifically foresees a pilot on family life education and life skills in schools which will be "tested sensitively in the first phase in the appropriate age group of secondary students."[57]

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[53] Situmorang, A. (2003). *Adolescent Reproductive Health in Indonesia*. Jakarta, Indonesia: United States Agency for International Development (USAID) & The Sustaining Technical Achievements in Reproductive Health (STARH) Program. Retrieved from http://pdf.usaid.gov/pdf_docs/PNACW743.pdf

[54] World Health Organization. (2005). *Sexual and Reproductive Health of Adolescents and Youth in the Philippines. A review of Literature and Projects. 1995-2003*. Manila, Philippines: WHO. Retrieved from http://www.wpro.who.int/publications/docs/ASRHphilippines.pdf

[55] Centre for Reproductive Rights (CRR), & Asian- Pacific Resource and Research Centre for Women (ARROW). (2005). *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia*. New York, USA: CRR.

[56] Save the Children Fund, US (SC US) & MOET. (2005). *A qualitative study on the education reproductive health and HIV/AIDS prevention within school system in Vietnam*. Hanoi, Vietnam: SC US.

[57] United Nations Educational, Scientific and Cultural Organization (UNESCO). (2012). *Sexuality Education in Asia and the Pacific: Review of Policies and Strategies to Implement and Scale Up.* Bangkok, Thailand: UNESCO. Retrieved from http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

As for India, the sex education curriculum is called the Adolescence Education Programme (AEP). The curriculum was developed by the National AIDS Control Programme, and was rejected by several state governments including Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Kerala and Karnataka, with the chief ministers writing to the Ministry of Human Resources Development accusing it of corrupting the morals of the young. The module was revised but, in turn, was rejected by 33 NGOs from across the country, including youth groups, sexual rights groups, women's groups and groups working with child sexual abuse. In a joint statement, they declared: "The thrust of the... curriculum is abstinence. It is silent even about the biological aspects of reproduction. The lesson on conception, whilst addressing internal biological mechanisms, omits any description of intercourse. Sexual intercourse is shrouded in the euphemism 'intimate physical relationships.' Without the knowledge of what does cause conception, the curriculum will fail in one of its own objectives - that of addressing teenage pregnancy."[58]

In Nepal, the National Adolescent Health and Development Strategy (2000) considers adolescents a key target group for information and services. Nevertheless, the extent to which sex education is being provided in schools has received little attention. At higher secondary level, students are supposed to be taught basic sex education using a chapter in a textbook called *Health, Population and Environment.* Little is known about how or how well this material is covered. A study in 2002 found that adolescents in these schools did not appear to be getting the information they needed. Most of the teachers did not want to deal with sensitive topics and feared censure by their colleagues and society. Some lacked the skills to give such instruction. Many students also felt uncomfortable with the topics. The challenge is to strengthen sex education, make it more appropriate for the students and ensure that teachers are more comfortable and able to give instruction on the topic.[59]

In Thailand, there has been progress on sex education, with the boundaries being pushed forward with each revision of the curriculum. Thailand has already introduced sexuality education. The first national policy on sexuality education in schools was announced in 1938, but sex education was not taught in schools until 1978. In the past, it was called "Life and Family Studies," and its content consisted of issues related to the reproductive system and personal hygiene. The education curriculum has been revised several times, involving efforts from both government and non-government sectors, and sex education has been accepted as a problem solving tool for adolescent SRH issues. This has been a consequence of educational reform following the National Education Act B.E. 2542, increasing awareness of problems related to adolescents' sexual practices, and the emergence of women's sexuality, and queer movements. The most remarkable new approach in sexuality education curricula in Thailand has been the Teenpath Project developed by PATH, Thailand. PATH has also succeeded in institutionalising sexuality education curricula in schools since 2003.[60]

Sexuality education seems to be an area where intellectual theory and perspectives have far surpassed the ability of governments in the region to deliver for young people especially girls. Both sex education and sexuality education are contentious issues for voters, especially

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[58] Sehgal, R. (2008, September). Sexuality Education, Minus the Sex. *InfoChange NEws & Features.* Retrieved August 18, 2009, from http://infochangeindiaorg/200809107334/Health/Features/Sexuality-education-minus-the-sex.html

[59] Pokharel, S., Kulczycki, A., &; Shakya, S. (2006) School-Based Sex Education in Western Nepal: Uncomfortable for Both Teachers and Students. *Reproductive Health Matters*, *14* (28), 156-161.

[60] South-East Asian Consortium (SEACON). (2009). *Thailand ICPD Final Report* (Unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

in the countries where conservative/religious fundamentalist parties hold considerable power in parliament. In the countries where sex education has been initiated, challenges with regards the comprehensiveness of the curriculum still remain. The increased acceptance in the countries for sex education is attributed to combating the HIV epidemic rather than providing sex education to adolescents. Recent developments have also contributed to re-conceptualising sex education as sexuality education, mostly in NGO-led programmes in Thailand and Vietnam, to include dimensions such as sexual expression, negotiation and communication.

Hence despite the political focus on reducing adolescent pregnancies, there has been less emphasis on interventions such as eliminating early marriage and providing sex education which challenge socio-cultural norms but are essential to fulfilling the objective of reducing adolescent pregnancies. It is clear from the lack of provision of education, information, and services to young people who are in dire need of these, that governments in the region are hesitant to recognise the role of sexuality beyond its function in reproduction.

Comprehensive sexuality education should be considered as an essential, core subject in national curriculums as it addresses not only subjects of safe sex and pregnancy prevention, but also of negotiating relationships, reducing violence, creating more equal partnerships, and a worldview based on mutual respect, non-discrimination and equality.

Other necessary interventions

I have used how the focus on current, specific indicators in MDG5, without looking at other possible indicators which could help in a more qualitative rights-based analysis have impoverished strategies and approaches that would have had a greater impact. Likewise in the reduction of MMR, emphasis was only on the skilled attendants at birth intervention, whereas a continuum of quality care approach would ensured access to other critical interventions such as at least 4 antenatal care visits and post-partum care for the first 48 hours. This narrow emphasis also did not enable investments in health system strengthening, including the strengthening of a referral service, which became the call of many after a number of years into the MDGs. Hence driving programmatic and policy interventions around one, and only one indicator is not something that will be able to provide for the needs of citizens especially the poor, the most vulnerable and the most marginalised. This is probably true for a number of other interventions for example, keeping girls in school after puberty may require providing access to safe and clean toilets as well as the distribution of free, good quality, culturally appropriate sanitary materials during menstruation, accompanied by community education and awareness on the fact that girls are still able to continue with and move about freely in society after the onset of menstruation.

An erasure of the most marginalised? Of the most vital issues?

In the Asia-Pacific region which has seen high and also highly unequal economic development, the MDGs seem to have erased the most marginalized groups which struggle with issues of identity and citizenship. Migrants, indigenous people, ethnic minorities, refugees, those affected by conflict and disaster as well as those living in the borders of countries have had their issues and their agendas engulfed within the framework and before any discussion on post-2015 can take place, we working in the development community must first and foremost answer the perennial question: development for whom and development for what ends?

A critical issue which has been left out of the MDGs has been the issue of violence against women and girls. Critical indicators which must be considered for the issue of VAW include:

- access to emergency contraception, post exposure prophylaxis, a range of abortion methods for survivors of VAW
- the recognition of marital rape in current laws
- recognition of corrective rape for LGBT as a serious and heinous crime
- proper implementation of anti-sexual harassment policies

Additionally, VAW on the internet is on the rise and largely unaddressed. Current internet laws have not addressed harassment, bullying and sexual coercion of women and girls through messages, photos and videos through social media. Especially vulnerable are adolescents and young girls.

Another critical challenge, left out of the MDGs, for women's sexual and reproductive health is the ability of governments and health systems to address reproductive cancers. More women die from breast and cervical cancer than maternal deaths. In 2008 alone, WHO's Globocan estimated that there were 458000 deaths from breast cancer and 275000 deaths from cervical cancer. 70% of these deaths occurred in low and middle income countries and the Asia Pacific region alone bears 51.6% of world burden of cervical cancer.

Access to prevention, screening and treatment and care will be essential for women, girls and their families. Already existing lower cost technologies such as visual inspection with acetic acid (VIA) and cryotherapy need to be made more accessible and governments need to make investments in preventive as well as treatment and care interventions.

Amongst the most vital issues to be left out has been the issue of sexual rights. Bodily integrity and bodily autonomy are two key concepts which help concretise equal citizenship and enable the achievement of substantive equality, especially for women and girls. Sexual rights are fundamental to bodily autonomy and bodily integrity. The concept of sexual rights is also closely intertwined and interlinked with that of reproductive rights so much so that, in some aspects, it is difficult to separate both. In order to achieve desirable sexual and reproductive health outcomes, within a human rights and gender equality paradigm, it is crucial to empower men and women with rights which enable them to be equals[61] in the public and in the most private spheres of life. It is also important to empower women to exercise their decision making with regards to sexuality and reproduction.[62] It is also

[61] As said in Paragraph 7.34: "Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour." This is reiterated under the section's objectives in Paragraph 7.36: "permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals."

Paragraph 7.35 also recognises that: "In a number of countries, harmful practices meant to control women's sexuality have led to great suffering." Paragraph 7.38 encourages governments to "base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour."

[62] Paragraph 4.1 states that: "The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public…. In addition, improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction."

imperative to establish these rights for women, in contexts where these rights may not currently exist, in order to enable women's decision-making capacities.[63]

Additionally the ICPD also acknowledges sexual rights when it states that in order to have a safe and satisfying sex life, men and women have "the capability to reproduce and the freedom to decide, if, when and how often to do so..." in Paragraph 7.2. The interpretation of what constitutes a 'safe and satisfying sex life' and the conditions that provide for this, include key aspects of sexual rights such as the choice of sexual partners.

The Beijing Platform for Action para 96 further concretises this: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent, and shared responsibility for sexual behavior and its consequences."

Key aspects of sexual rights include human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, including access to SRH care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life.

These concepts cover critical issues in the area of gender equality and sexual and reproductive health which member states have already accepted and are working on as well as some issues on which there is no consensus agreement yet. For example, issues of early and forced marriage concern sexual rights of girls around choice of partner, decision to be sexually active or not, and having consensual sexual relations and consensual marriage.

Issues of eradicating harmful practices, sexual violence and human trafficking concern sexual rights around bodily integrity.

Issues of non-discrimination based on sexual orientation and gender identity concern sexual rights in relation to sexuality.
Sexual rights have been affirmed in the outcome documents of the ICPD Beyond 2014 processes in both the Bali Declaration and the Montevideo consensus and we hope governments can move towards a recognition of the term.

Emerging challenges

In the current context, we are now not only living with the gaps created by the MDGs but at the same time, the world continues to struggle with issues of democratic governance, for greater transparency and accountability, north-south divides and financial governance – all of which in their own right – are part of the feminist movement's struggles – however, may not

[63] Paragraph 4.4 (c) under Actions proposes: "Eliminating all practices that discriminate against women; assisting women to establish and realise their rights, including those that relate to reproductive and sexual health."

result in the high prioritization of substantive gender equality as the key demand.

The commodification of health and the weakening of health systems have eroded the ability of people to access essential health services, including vital sexual and reproductive health services. In many societies, there has also been a return to traditional, cultural values in the onslaught of globalisation, rapid modernisation and capitalism. The impact has been felt greatest with regards to women's rights and sexual and reproductive rights. There is a lack of progress on the issues that could be regarded as the litmus test for women's rights.

These paradigms also contribute to a silo-ed approach to development which in turn promotes thinking that rights are relative and negotiable, especially women's rights; or that these rights are secondary rights; and in negotiations – leaders from these backgrounds continue to use women's rights issues as the bargaining chip. Although context is important, the principles on which the dialogues of rights take place are relatively unchanging. The questions around power – who holds powers, who does not; which groups are vulnerable and to what situations, whose rights need to be championed are not new, but need to be re-iterated with greater clarity and persuasion.

Achieving gender equality is not only about enabling girls and women to go to schools and universities, to go to work, and to go to Parliament; it is about dismantling existing inequitable power structures. We cannot conclude that power has shifted in any meaningful way in our region to provide full equality to women: equal opportunity, equal access, equal power and equal citizenship.

Finally, it is necessary to ask the difficult, critical, and the big questions. Do the current, existing systems work for women? Can these be made to work for women? Is the need to innovate within systems? Or is the need to replace these systems?