Third Stakeholder Consultation of the Seventh Asian and Pacific Population Conference

Universal Access to Sexual and Reproductive Health and Rights (SRHR) in Asia and the Pacific: equality, quality, and accountability

Thursday, 17 August 2023 (11:00-14:45 UTC+7), Virtual

SUMMARY REPORT

I. Background

1. Pursuant to ESCAP resolution 74 (XXIII) of 17 April 1967 and Commission on Population and Development decision 2022/101, ESCAP, in collaboration with UNFPA in Asia and the Pacific, will organize the Seventh Asian and Pacific Population Conference (APPC) from 15 to 17 November 2023 at the United Nations Conference Centre in Bangkok, Thailand. The intergovernmental meeting will coincide with the 10-year anniversary of the adoption of the 2013 Asian and Pacific Ministerial Declaration on Population and Development.

2. As part of this process the CSO Steering Committee (SC), with support from ESCAP and UNFPA is organizing stakeholder consultations on the priority issues of the Seventh APPC and the Asia and Pacific Ministerial Declaration (APMD). Gender considerations are mainstreamed.

3. Main findings and recommendations of the consultations will be summarized in an information paper to be submitted to the Seventh APPC. The objective of these consultations is to bring a bottom-up participatory approach of the review of the APPC, APMD and the Programme of Action of the International Conference on Population and Development at the regional level and identify challenges and opportunities of population and development that transcend national boundaries from stakeholder perspectives.

4. This third of the four consultations was held on 17 August 2023. The topic for the consultation was Universal Access to Sexual and Reproductive Health and Rights (SRHR) in Asia and the Pacific: equality, quality and accountability.

5. There were four sub-themes for the consultation which were discussed during breakout sessions.

   a. Sexual and reproductive rights & justice
   b. Access and inclusion of SRHR in UHC
   c. Sexual and reproductive health services, information, and education for all
   d. Policies, governance, financing for SRHR

II. Objectives, organization and attendance

6. The purpose of the stakeholder consultation was to facilitate and expand collaboration and participation in the regional review and appraisal process, and to elicit stakeholder experiences and views around the review objectives, namely:
• Take stock of the overall progress of implementation of the priority issues of the APMD and the ICPD PoA in Asia and the Pacific to date.
• Identify key challenges, opportunities, gaps, and prevalent and emerging issues.
• Identify established and emerging good practices and lessons learnt.
• Formulate recommendations.

7. The consultation consisted of an opening followed by two rounds of four simultaneous working groups and a closing plenary (please see the agenda for more details).

8. All working groups addressed the following guiding questions, with a focus on the implementation of APMD priority actions:

• Who are excluded and how do we ensure inclusion and meaningful participation of communities, in particular those facing multiple and intersecting forms of discrimination, to ensure principles of equality for achieving SRHR?
• What are the biggest gaps, and emerging issues in SRHR for the region?
• What are the opportunities/best practices to address SRHR in the region?
• How can we learn from/ advance SRHR as we recover from COVID?
• Recommendations for the way forward

9. Working Group 1: Sexual and reproductive rights & justice

This sub-theme focused on sexual and reproductive rights and achieving justice in Asia and the Pacific. Violations of sexual and reproductive rights are often due to deeply ingrained beliefs and harmful societal values pertaining to sexuality and sexual orientation, gender identity, gender expression and sex characteristics, disproportionately impacting women, young people and gender diverse persons across the region. Achieving sexual and reproductive rights and bodily autonomy entails respect for expression of sexuality and sexual orientation, gender identity, gender expression and sex characteristics, and decriminalization of adult consensual behaviours, and sex work. A rights-based approach places a focus on eliminating sexual and gender-based violence (SGBV) and harmful practices such as early and child forced marriage and female genital mutilation, and involuntary or forced sterilization. Harmful and negative gender stereotypes also impact the issue of infertility, and who is understood to be ‘desirable’ in terms of forming a family and who is counted as having fertility problems. A rights-based approach involves uncovering and addressing multiple and intersecting forms of discrimination based on age, sex, sexual orientation, gender identity, gender expression and sex characteristics, location, economic class, gender, ethnicity, religion, minority status, and disability amongst other aspects. By incorporating principles of equality, the discussions in this sub theme harnessed recommendations for the achievement of sexual and reproductive justice in the region.

10. Working Group 2: Access and inclusion of SRHR in UHC.

Strong health systems are needed to ensure equitable and universal access to quality healthcare, with a focus on SRHR. Marginalized groups in particular face intersecting forms of discrimination and structural barriers to accessing UHC and the fulfilment of their SRHR. At the same time, SRHR selfcare, which includes self-management, self-testing, and self-awareness places decision-making directly into the hands of people and integrating it into UHC can reduce the current burden placed on healthcare systems, improving health outcomes and at the same time helping government achieve their commitments to UHC.
This sub-theme discussed recommendations for achieving self-care for SRHR in Asia and the Pacific and thus access to quality healthcare.

11. Working Groups 3: Sexual and reproductive health services, information, and education for all

This sub-theme focused on the achievement of access to quality health services, information, and education for all. Quality SRHR services are defined within the framework of available, affordable, accessible, acceptable, and quality, and taking a life-course approach. An essential and comprehensive package of SRH services includes contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS and sexually transmitted infections (STIs); comprehensive sexuality education; safe abortion care; prevention, detection and counselling for gender-based violence; prevention, detection and treatment of infertility and cervical cancer; and counselling and care for sexual health and well-being, access to hormone therapy. Comprehensive sexuality education (CSE) aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives. While most countries in the region have some form of sexuality education, it is often not comprehensive, and it is unevenly implemented. This sub-theme discussed recommendations for access to quality health services information and education, including emerging opportunities such as digital health interventions and assisted reproductive technologies.

12. Working Groups 4: Policies, governance, financing for SRHR

This sub-theme uncovered the role of policies, governance and financing in ensuring accountability for the achievement of SRHR for all. The political environment impacts whether countries advocate for, ignore, or do not provide access to SRHR, including national policies and legislation with a global impact. All forms of reproductive coercion violate human rights. Examples of harmful laws include those that restrict women’s and adolescents’ access to health services by requiring third-party authorisation, laws that require service providers to report personal information (breaching patient confidentiality), and laws that criminalize same-sex relationships or access to safe abortion services. It is important to strategize opportunities to work and partner with health sector trade unions. Finally, there is a need to address high out of pocket expenditures which unfairly impact marginalized communities, and commit budget allocation to ensure the availability, affordability, accessibility, acceptability, and quality SRHR for all. Health sector reforms upholding the right to health should inform policies, governance, and health financing. This sub-theme discussed the way forward with recommendations to strengthen policy, governance and financing related to SRHR.

13. The consultation was a closed meeting and was not recorded. In order to have open and frank discussions, Chatham House Rules were followed, which meant that participants were free to use the information received but did not reveal the identity or the affiliation of the speaker(s), or of any other participant.

14. This report aims to be a non-exhaustive summary of the key points raised in the consultation.

15. This stakeholder consultation was co-designed and implemented by the CSO Steering Committee (SC) with support from ESCAP and UNFPA.

16. A total of 96 stakeholders, from 62 CSOs, representing 22 countries in Asia and the Pacific, attended the consultation. Participants came from a broad range of sectors including academia,
civil society, intergovernmental organizations, local authorities, communities, and the private sector. There was balanced gender and regional representation among participants.

III. Opening

17. Ms. Alexandra Johns, Asia Pacific Alliance, Thailand, Seventh APPC CSO SC member, welcomed all participants and recalled previous global agreements around sexual and reproductive health and rights. She emphasized the importance of stakeholder engagement in the preparatory process for the Seventh APPC.

18. Ms. Sivananthi Thanenthiran, ARROW, Malaysia gave the keynote speech. She focused on the International Conference on Population and Development and traced important milestones in the past 29 years such as sustainable development goals and the impact of climate change. She identified five key parameters: equity, violence, care-work, legal frameworks and technology.

19. Ensuring equity between different groups was key and these challenges were often cause by poor investment in health systems, groups such as older persons being left out of surveys, a lack of inclusivity for all groups and fragile contexts such as crisis’s which deepens inequality. Inequity consequently increases inaccessibility of the basic needs of women and the deprivation of SRHR.

20. Ms. Thanenthiran noted the interlinkages between violence and SRHR. Forms of violence contribute to a higher likelihood of miscarriage, premature labour or delivery, among others. Violence also reinforces power dynamics and hierarchy such as male domination. Additionally, care work also perpetuated power dynamics as well. Women and girls in Asia in the Pacific work the longest hours in the world, mostly through unpaid reproductive labour and care work. The lack of opportunity and choice reinforces the economic subjugation of women in the micro-level economy.

21. Legal frameworks reinforce dominant biases in society. The criminalisation and stigmatization of sexuality see young people being unable to access the sexual and reproductive health services they may need. Even in countries that legalized abortion, women, particularly those from low-income households and who belonged to marginalized groups faced difficulties in access. They often faced issues related to term limits, legislative and provider-induced delays. COVID-19 has accelerated the shift to digital health, although it increased access, there were issues related to increase authoritarian surveillance along with biases.

22. Ms. Ketia Toakarawa, Pacific Disability Forum, Fiji, spoke about her experience as a young, disabled woman from the Pacific. She recalled the 2030 Sustainable Goals’ ambition in leaving no one behind, however factors such as accessibility and stigma disproportionately impact women and girls with disabilities. Access to SRHR and other significant services pertaining to the enhancement of the quality of life of disabled women continue to be a barrier, especially to those with higher needs. There is a lack of technology, which could be used to assist people with disability, but there is a lack of understanding and awareness on the needs of women and disabilities. She stressed on the importance of improving assistive technology in order to improve accessibility and achieve the sustainable development goals.

23. Mr. Srinivas Tata, Director, Social Development Division, ESCAP, thanked the previous speakers. He stressed the importance of the sexual reproductive health and reproductive rights within the Programme of Action of the International Conference on Population and Development. The Seventh Asian and Pacific Population Conference will ensure that the sentiments and contexts of the Asia-Pacific region are discussed and relayed on the global scale.
24. Ms. Sabine Henning, Chief, Sustainable Demographic Transition Section, Social Development Division, ESCAP reiterated the importance of universal access to sexual reproductive health and reproductive rights for the Seventh Asian and Pacific Population Conference.

IV. Working Groups

A. Subtheme 1: Sexual and reproductive rights & justice

   Round 1: 20 Participants
   Round 2: 19 Participants

   i) Key Challenges

25. Young people faced obstacles in accessing SRH information, services, and medication. They were often discouraged from or looked upon when discussing sexuality and reproductive health.

26. Young people and women often faced stigmatizing and discriminatory attitudes, practices and norms from service providers and gatekeepers.

27. In some countries, half of new HIV infections in the region were among young persons between the ages of 15 – 19.

28. The region saw a lack of funding on policies, programmes and plans targeted at young people and women in all their diversity.

29. Sex workers had a heightened risk for HIV and sexually transmitted infections. The criminalization of sex work across the region increased their risk of sexual violence.

30. Gender inequality and gendered power imbalances created barriers for women and women living with HIV.

31. Migrant women, older persons, persons with disabilities, unmarried adolescents, Dalits, and ethnic minorities were identified as groups that often faced discrimination and were excluded from fulfilling their SRHR. The already-fragile state of rights of certain marginalized groups was often further reduced.

32. SRHR was not prioritized by funders or governments, despite its relevance.

33. There were insufficient initiatives on SRHR among people living with HIV, specifically tailored towards young people in the region. Participants speculated that this may have been caused by budgetary constraints.

34. Women living with HIV and their children, often faced high levels of discrimination and exclusion.

35. Grassroots programmes were often barred and constrained due to social norms around gender, caste, and ethnic groups.

36. Effective menstrual hygiene management was a challenge due to many factors, including the availability of affordable sanitary napkins.

37. The prevalence of unsafe abortions and intimate partner violence was high in many countries.

38. The rise in authoritarianism and religious fundamentalism pushed back progress on SRHR in some countries.
39. CSOs and human rights defenders felt often targeted due to a shrinking civic space and utilization of laws that restricted the work of CSOs.

40. People living in geographically remote areas, homeless and neglected children lacked caretakers and support in assisting them in fulfilling their sexual and reproductive health and rights.

41. The COVID-19 pandemic highlighted the inaccessibility of health services in many countries. During the pandemic young people faced difficulties in accessing products such as condoms.

ii) Good Practices

42. Stakeholders supported youth-led movements and work around SRHR.

43. Young people working on SRHR were convened to unify different demands.

44. Digital platforms were used to run innovative campaigns which promoted telehealth and uplifted urgent issues.

B. Subtheme 2: Access and Inclusion of SRHR in UHC

Round 1: 16 Participants

Round 2: 19 Participants

i) Key Challenges

45. There was large unmet need of access to essential health services along with a deficit of healthcare workers.

46. There was a lack of high quality, affordable and accessible health and SRH services across the region. Which lead to many people falling into extreme poverty due to health expenses.

47. Examples were shared of young men and unmarried women who were excluded from and discriminated against while trying to access health services. Healthcare providers were not trained or sensitive to their needs and repeatedly asked them about their marital status.

48. Rural women faced barriers in accessing primary healthcare; there was a lack of suitable healthcare facilities within a reasonable distance. Additionally, the services available in rural areas were sometimes of poor quality and inadequate in responding to women’s needs such as a room to protect their privacy.

49. In the region, SRHR language and vocabulary was extremely outdated and stigmatized.

50. Groups such as sex workers, LGBTQ+ community, young persons and people involved in drug-use faced difficulty in accessing information and services at healthcare facilities. Many individuals in these communities had a high risk of sexually transmitted infections.

51. Migrant women and partners of returning migrants had a high risk of HIV due to their male partners.

52. Social stigmas and cultural practices led to women being uncomfortable to openly share health concerns with service providers.
53. Participants noted a range of challenges for women during their pregnancy such as poor diet, substandard hygiene, and a lack of vaccinations.

54. Parliamentarians had very little awareness and information on SRHR.

55. Information around nutrition and personal hygiene did not take place in conversations on SRHR.

56. Many women were unaware of free and readily available services, such as basic medication and contraceptives, that they could have accessed.

57. Married individuals found it difficult to access SRHR information, especially around domestic violence.

   ii) **Good Practices**

58. CSOs in the region advocated for and used a broad range of self-care interventions during the pandemic to provide ensure people’s SRHR were fulfilled.

59. The region had seen good practices on providing access to improved health services, such as programmes that facilitated home deliveries through the support of local health attendants, emergency phone lines that provided health advice and services, improved facilities inside ambulances and midwives trained in assisting pregnant women with disabilities.

60. Participants cited the successful implementation of volunteer peer models which provided adolescent friendly psychological services.

C. **Subtheme issue 3: Sexual and reproductive health services, information, and education for all**

   Round 1: 19 Participants

   Round 2: 19 Participants

   i) **Key Challenges:**

61. Examples were shared on how SRHR services were not available, affordable, accessible, acceptable, or of high-quality in the region.

62. Marginalized groups were often unable to access SRHR services. LGBTQ+ individuals and young people often faced stigma and discrimination. Persons with disabilities and those living in rural areas faced difficulty due to a lack of infrastructure and digital access.

63. Marginalized groups were impacted by healthcare discrimination, and they were often unaware of their sexual and reproductive health and rights.

64. Comprehensive sexuality education remained inaccessible or absent in many countries.

65. Cultural taboos, harmful cultural practices and religious norms often prevented access to SRHR information and services.

66. The COVID-19 pandemic exacerbated gender inequality, gender-based violence and unwanted pregnancy. It also illustrated the inadequacy of emergency response and preparedness in many countries.
67. Gender-based violence was largely undiscussed, instances of adolescent girls that are sexually abused within relationships and marriages was often unreported.

68. There was a lack of data on the impact of the pandemic on marginalized communities.

69. The region had low levels of digital literacy especially among rural women due to the inaccessibility of digital services.

70. In some countries in the region, school dropout rates for children remained high which affected their prospects for employment.

71. Young people faced obstacles in accessing sexual and reproductive health, and rights information, services, and medication. Young people were often discouraged or incriminated when discussing sexuality and reproductive health. Additionally, sometimes, they faced stigmatizing and discriminatory attitudes, practices and norms from service providers and gatekeepers, including teachers.

ii) Good Practices:

72. Governments harnessed telehealth and digital platforms to share information and services around SRHR. These initiatives also expanded access to SRHR as e-learning was used to education people on important issues.

73. Implementation of evidence-based comprehensive sexuality education was inclusive and promoted gender equality.

74. Creation of safe spaces for young people to participate in the decision-making, programme-design, and advocacy of SRHR services was important.

D. Subtheme issue 4: Policies, governance, financing for SRHR

Round 1 - 21 participants

Round 2 - 20 participants

i) Key Challenges:

75. Sex workers often faced criminalization and stigma; they were excluded from discussions around SRHR, even by other CSOs.

76. Older women experienced taboos and their sexual and reproductive health needs were often ignored, or hospitals had limited resources to cater to them.

77. Communities of those without a fixed address such as nomadic communities, migrants, overseas workers, and persons experiencing homelessness were often overlooked. Female domestic migrant workers were often subjected to sexual abuse by their employers, many cases went unreported and unprosecuted.

78. There was reduced government funding for national social services such as health and education in favour of increased spending on militarization and other austerity measures.

79. Laws and policies sometimes excluded certain groups from accessing public healthcare.

80. The mobilization of young people who advocated for SRHR was often ignored and these advocates struggled to acquire funding and investment.
81. There was a lack of initiatives to counsel those from low-income communities or key populations living with HIV.

82. Persons with disabilities including blind and deaf individuals had limited opportunities for participation in discussions and decision-making around SRHR.

83. Women living with HIV and their children were excluded from accessing basic services and faced discrimination.

   **ii) Good practices**

84. Some countries had expanded the coverage of abortion and decriminalized sexual activities among adolescents.

85. Many CSOs worked with sex workers to support them in advocating for their needs with governments and policy-

86. SRHR care was made affordable by governments providing subsidies and using telemedicine to increase health equity.

87. Efforts were made to address social stigma through parliamentary commissions and the creation of ‘National Abortion Services Day’ in some countries.

V. Final Recommendations

A. Subtheme 1: Sexual and Reproductive Rights and Justice

88. Repeal restrictive and discriminatory laws and address systemic barriers that exclude groups.

89. Provide safe shelters, which include SRHR provisions.

90. Increase HIV prevention, testing, and treatment.

91. Governments must protect and increase the number of democratic spaces for civic engagement.

92. Ensure that SRHR agendas were incorporated into other interventions such as conflict and climate change, and at all levels.

93. Establish more collective spaces to work together with the states, sensitisation of the government representatives over the issues of SRH rights and justice.

94. SRH and HIV service providers and key governments officials must be trained and sensitized in addressing groups such as unmarried adolescent and young people. This must be done through increased information-sharing between CSOs and governments.

95. Encourage youth groups to take leaderships towards HIV response.

96. Provide high-quality comprehensive sexuality education to young people.

97. Ensure a comprehensive approach to healthcare which prioritized marginalized communities and invested in innovation for service delivery.

98. Governments should commit to and implement at least three percent of their GDP as their health budget. Prioritising primary health care services included essential SRHR services.
99. Utilize an intersectional approach to sexual and reproductive health services and information delivery which includes disability-inclusive comprehensive sexuality education for older persons.

100. Promote the collaboration of regional national, and local CSOs and International NGOs to target key marginalized populations.

101. Governments must adopt the use of traditional mass-media alongside digital media to execute digital interventions.

102. Interlink and integrate discussions around SRHR with other issues such as peacebuilding and climate change.

B. Subtheme 2: Access and inclusion of SRHR in UHC

103. Ensure the access and inclusion of quality SRHR for everyone, everywhere and always.

104. Expand UHC packages to include comprehensive SRHR interventions, that are health promotive, preventative, low cost and cost effective. It must serve as an integral part of reformed health systems, primary health care services and preparedness strategies.

105. Implement self-care interventions and invest in a greater number of self-care facilities. Self-Care must include self-awareness, self-testing, and self-management.

106. Create safe spaces for women and other groups to have conversations on SRHR, free of judgement.

107. Place a greater emphasis on young people. Including the establishment of youth networks, the creation of programs that train providers to deliver youth-friendly information and services, implementation of counselling centres for young people, and the amplification youth-led campaigns.

108. Respect, protect, and fulfil human rights, inclusiveness, non-discrimination, the right to the highest attainable standard of physical and mental health for all regardless of gender, race, sexual orientation or gender identity, HIV status, marital status, or any other ground.

109. Ensure that the principles of inclusiveness, non-discrimination, non-violence, social justice, and solidarity are at the centre of any policy and/or action plan on universal health coverage.

110. Introduce packages that include abortion services for all people, especially young girls.

111. Include transgender identities within the SRHR discussions and interventions.

112. Increase access to sexual and reproductive health services which could also be addressed by increased opening hours of clinics and hospitals including weekends and evenings.

113. Place a greater focus on groups such as nonbinary individuals who are often left out of legal systems, health services and SRHR discussions.

114. Discuss global health, gender equality and poverty as one framework.

115. Utilize a person-centred care approach in all SRHR services.

116. Create more accessible information and educational documents on comprehensive sexuality education and SRHR that are translated into ethnic languages.
117. Emphasize gender quality, redress gender power dynamics, and ensure women’s and girl’s rights as foundational principles for UHC.

**C. Subtheme issue 3: Sexual and reproductive health services, information, and education for all**

118. Create youth-friendly, non-judgmental spaces for young people to access SRHR information and services.

119. Ensure a rights-based and inclusive approach for all staff members in the implementation of comprehensive sexuality education. Increase public financing to enhance teaching and non-teaching staff’s understanding of comprehensive sexuality education.

120. Encourage multistakeholder collaboration in all facets of SRHR including cross-sectoral sharing of resources and best practices.

121. Foster engagement between local leaders, young people, CSOs and governments in the planning of SRHR services.

122. Utilize digital platforms and telemedicine to provide SRHR information, consultations, and appointment reminders.

123. Provide adequate allocation of budget towards healthcare and SRHR services.

124. Ensure service providers’ training includes both clinical and SRHR topics from a rights-based perspective.

125. Educate young people on SRHR, consent, gender-based violence and mental health.

126. Support efforts by marginalized communities to uplift their challenges and publicly advocate for their sexual and reproductive health and rights.

127. Implement evidence-based comprehensive sexuality education in schools and communities.

128. Develop feedback mechanisms to improve SRHR services.

129. Ensure that men serve as ‘champions’ for SRHR in rural and semi-urban contexts.

**D. Subtheme issue 4: Policies, governance, financing for SRHR**

130. Ensure that there is increased information-sharing between civil society organizations and governments.

131. Create local policies in each province to protect marginalized groups with regards to their SRHR.

132. Ensure a greater representation of marginalized groups in the SRHR discourse and policymaking, especially when addressing the accessibility of healthcare services.

133. Advocate for a bottom-up approach in which a greater emphasis is placed on local level governments, to increase long-term sustainability of health mechanisms.

134. Prioritize a comprehensive approach to healthcare of marginalized communities and invest in innovation for service delivery.
135. Ensure healthcare committees have an increased representation of women and other marginalized groups. Advocate for these committee to draw upon international conventions such as CEDAW to ensure that a rights-based approach is utilized.

136. Introduce laws and policies to decriminalize sex work across the region.

137. Allocate adequate budget towards healthcare, SRHR and provider training, at local and national levels.

138. Ensure governments are accountable to meet the sustainable development goals, CSOs should monitor this progress.

139. SRHR narratives must be expanded beyond the current narratives to include all groups and issues.

D. Keynote

140. Ensure that member states provide social protection and benefits to care workers.

141. Redistribute care work through paternity leave, paternal care leave, and elevate the compensation for female dominated care jobs.

142. Include adolescents and older persons in all sexual and reproductive health surveys.

143. Make sexual and reproductive health care affordable with a focus on subsidies through public healthcare interventions.

144. Decriminalize laws regulating abortion, adolescent sexuality, premarital sexuality, same-sex sexual relationships, gender identity, discrimination based on pregnancy and HIV status.

145. Utilize the digital health equity framework to overcome challenges of data protection and low literacy in the region.

E. Plenary

146. The rapporteurs of the four working groups Ms. Riju Dhakal, Mr. Bilal Ahmed, Ms. Lady Lisondra, and Ms. Caecelia Roth provided a summary of their respective subtheme discussions.

147. During the Q&A, participants noted the importance of recognizing the array of policies and commitments that currently exist, finding linkages between multiple frameworks was viewed as an opportunity to push multiple issues.

VI. Closing

148. Ms. Madu Dissanayake Regional Programme Specialist a.i., UNFPA APRO, closed the consultation. She recognized that SRHR issues are intersectional. She highlighted, the feminization of poverty, the gendered dimension to ageing and the importance of civil society engagement. She thanked the moderators, speakers and all other stakeholders for participating in the consultation, including in the group discussions, as well as ESCAP and UNFPA colleagues.

149. The consultation was the third in series of four consultations with stakeholders. The fourth consultation on ‘Regional Cooperation, Accountability and Modalities for Implementation of Actions on Population and Sustainable Development in Asia and the Pacific.’ would be held on 12 September August 2023.
150. The concept note, agenda, presentations and report for all four consultations would be uploaded onto the ESCAP website. https://www.unescap.org/events/2023/seventh-asian-and-pacific-population-conference
# ANNEX

## PROGRAMME

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<thead>
<tr>
<th>Time</th>
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<tr>
<td>10:30-11:00</td>
<td>Participants join virtual meeting</td>
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<tr>
<td>11:00-11:35</td>
<td><strong>Welcome and opening</strong></td>
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<td>35 minutes</td>
<td><strong>Moderator:</strong> Alexandra Johns, Asia Pacific Alliance for Sexual and Reproductive Health and Rights</td>
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<td></td>
<td>• Keynote speech: Sivananthi Thanenthiran, Executive Director, ARROW (15 minutes)</td>
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<td>• Youth reflections: Pacific Disability Forum, Thailand (5 minutes)</td>
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<td></td>
<td>• Welcome: Srinivas Tata, Director, Social Development Division, UN ESCAP and Sabine Henning, Chief, Sustainable Demographic Transition Section, Social Development Division, UN ESCAP (10 mins)</td>
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*Participants allocated to working groups - Introduction to working group topics and speakers. Participants pre-allocated working groups by UN ESCAP*

| 11:35-12:20| **Working groups – Round 1**                                           |
| 45 minutes | **Working group 1**                                                    |
|            | **Topic:** Sexual and Reproductive Rights & Justice.                   |
|            |   • Moderator: Marevic Parcon, Women’s Global Network for Reproductive Rights |
|            |   • Resource person: Ikka Noviyanti, YouthLEAD                         |
|            |   • Rapporteur: Riju Dhakal, ARROW                                     |

This sub-theme will focus on sexual and reproductive rights and achieving justice in Asia and the Pacific. Violations of sexual and reproductive rights are often due to deeply ingrained beliefs and harmful societal values pertaining to sexuality and SOGIESC, disproportionately impacting women, young people and gender diverse persons across the region. Achieving sexual and reproductive rights and bodily autonomy entails respect for expression of sexuality and SOGIESC, and decriminalization of adult consensual behaviors, and sex work. A rights-based approach places a focus on eliminating sexual and gender-based violence (SGBV) and harmful practices such as early and child forced marriage and female genital mutilation, and involuntary or forced sterilization. Harmful and negative gender stereotypes also impact the issue of infertility, and who is understood to be ‘desirable’ in terms of forming a family and who is counted as having fertility problems.

1 The same clusters of objectives will be discussed in round 1 and 2 of the consultation.
A rights-based approach involves uncovering and addressing multiple and intersecting forms of discrimination based on age, sex, SOGIESC, location, economic class, gender, ethnicity, religion, minority status, and disability amongst other aspects. By incorporating principles of equality, the discussions in this sub theme will harness recommendations for the achievement of sexual and reproductive justice in the region, and will address the following questions:

- Who are excluded and how do we ensure inclusion and meaningful participation of communities, in particular those facing multiple and intersecting forms of discrimination, to ensure principles of equality for achieving sexual and reproductive rights and justice?
- What are the biggest gaps, and emerging issues in sexual and reproductive rights and justice for the region?
- What are the opportunities/best practices to address sexual and reproductive rights and justice, and advance equality?
- How can we learn from/ advance sexual and reproductive rights and justice as we recover from COVID? What are the social and healthcare reforms we want to take forward?
- Recommendations for the way forward

Working group 2

Topic: Access and inclusion of SRHR in UHC

- Moderator: Rey Asis, Asia Pacific Mission for Migrants
- Resource person: Harjyot Khosa, IPPF SARO
- Rapporteur: Bilal Ahmed, SPEAK Trust

Strong health systems are needed to ensure equitable and universal access to quality healthcare, with a focus on SRHR. Marginalized groups in particular face intersecting forms of discrimination and structural barriers to accessing UHC and the fulfillment of their SRHR. At the same time, SRHR selfcare, which includes self-management, self-testing, and self-awareness, places decision-making directly into the hands of people and integrating it into UHC can reduce the current burden placed on healthcare systems, improving health outcomes and at the same time helping government achieve their commitments to UHC.

This sub-theme will discuss recommendations for achieving self-care for SRHR in Asia and the Pacific and thus access to quality healthcare, and will address the following questions:

- Who are excluded and how do we ensure inclusion of communities’ equitable and universal access to quality healthcare, in particular SRHR, for those facing multiple and intersecting forms of discrimination?
- What are the biggest gaps, and emerging issues in SRHR self-care for the region?

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3 Agenda 2030, the Political Declaration on UHC, and International Conference on Population and Development (ICPD) Programme of Action
● What are the opportunities/best practices to address access to UHC and SRHR self-care, and advance the voice and agency of marginalized groups?
● How can we learn from/advance self-care and access to SRHR in UHC as we recover from COVID?
● Recommendations for the way forward

Working group 3

Topic: Sexual and reproductive health services, information and education for all

- Moderator: Nurmajdina Abdullah, IPPF ESEAOR
- Resource person: Bipani Shrestha, YUWA Nepal
- Rapporteur: Lady Lisondra, IPPF ESEAOR

This sub theme will focus on the achievement of access to quality health services, information and education for all. Quality SRHR services are defined within the framework of available, affordable, accessible, acceptable and quality, and taking a lifecourse approach. An essential and comprehensive package of SRH services includes contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS and STIs; comprehensive sexuality education; safe abortion care; prevention, detection and counseling for gender-based violence; prevention, detection and treatment of infertility and cervical cancer; and counseling and care for sexual health and well-being⁴, access to hormone therapy, and support to use assisted reproductive technology.

Comprehensive sexuality education (CSE) aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives ⁵. While most countries in the region have some form of sexuality education, it is often not comprehensive, and it is unevenly implemented.

This sub theme will discuss recommendations for access to quality health services information and education, including emerging opportunities such as digital health interventions and assisted reproductive technologies, and will address the following questions:

- Who are excluded and how do we ensure inclusion and access of communities, in particular those facing multiple and intersecting forms of discrimination, to quality SRH services, information and education that is available, affordable, accessible, and acceptable?
- What are the biggest gaps, and emerging issues in SRH services, information and education, including comprehensive sexuality education (CSE) for the region?

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● What are the opportunities/best practices to address quality SRH services, information, education, (including CSE) and advance the voice and agency of marginalized groups?
● How can we learn from/advance as we recover from COVID?
● Recommendations for the way forward

Working group 4

Topic: Policies, Governance, Financing for SRHR

● Moderator: Musarrat Perveen, CARAM Asia
● Resource person: Faustina Pereira and Prabina Bajracharya, Center for Reproductive Rights
● Rapporteur: Caecilia Roth, FP NSW

This sub theme will uncover the role of policies, governance and financing in ensuring accountability for the achievement of SRHR for all. The political environment impacts whether countries advocate for, ignore, or do not provide access to SRHR, including national policies and legislation with a global impact. All forms of reproductive coercion violates human rights. Examples of harmful laws include those that restrict women’s and adolescents’ access to health services by requiring third-party authorisation, laws that require service providers to report personal information (breaching patient confidentiality), and laws that criminalize same-sex relationships or access to safe abortion services. It is important to strategize opportunities to work and partner with health sector trade unions. Finally, there is a need to address high out of pocket expenditures which unfairly impact marginalized communities, and commit budget allocation to ensure the availability, affordability, accessibility, acceptability and quality SRHR for all. Health sector reforms upholding the right to health should inform policies, governance and health financing.

This subtheme will discuss the way forward with recommendations to strengthen policy, governance and financing related to SRHR, and will address the following questions:

● Who are excluded and how do we ensure the inclusion and needs of communities, in particular those facing multiple and intersecting forms of discrimination, and ensure accountability for SRHR policies, governance and finance?
● What are the biggest gaps, and emerging trends regarding SRHR policies and governance in the region?
● What are the opportunities/best practices to ensure accountability, and advance the voice and agency of marginalized groups?
● How can we learn from/advance SRHR policies, governance and financing as we recover from COVID?
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<tr>
<th>Time</th>
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<tr>
<td>12:23-13:00</td>
<td>Working groups – Round 2</td>
<td>35 minutes</td>
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<td>Working groups as above</td>
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<td>13:00-13:20</td>
<td>Break</td>
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<td>13:20-13:50</td>
<td>Plenary: Highlights, challenges and recommendations</td>
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<td>Moderator: Alexandra Johns, Asia Pacific Alliance for Sexual and Reproductive Health and Rights</td>
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<td>Rapporteur Working Group 1: Riju Dhakal, ARROW</td>
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<td>Rapporteur Working Group 2: Bilal Ahmed, SPEAK Trust, Pakistan</td>
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<td>Rapporteur Working Group 3: Lady Lisondra, IPPF ESEAOR, Malaysia</td>
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<td>Rapporteur Working Group 4: Caecilia Roth, FP NSW</td>
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<td>13:50-14:00</td>
<td>Closing and next steps</td>
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<td>Closing and next steps: Madu Dissanayake, Regional Programme Specialist a.i., UNFPA APRO</td>
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PROVISIONAL LIST OF PARTICIPANTS

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Asia LBQ Network
Asia Pacific Mission for Migrants, Hong Kong, SAR
Asia South Pacific Association for Basic and Adult Education
Bandhu Social Welfare Society
Bangladesh Women's Health Coalition (BWHC)
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Reproductive and Family Health Association of Fiji
Restless Development
RUWSEC and CommonHealth, India
Saksham Trust
SERAC Bangladesh
SHISHUK, Bangladesh
SPEAK Trust
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Yuwa

UNITED NATIONS AND OTHER AGENCIES

UNESCAP
UNFPA