

# ICPD+30: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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# ICPD+30

The ICPD process 30 years ago brought different stakeholders – governments, NGOs, donors in order to chart out a vision for people and development. The lead-up to the ICPD was, at the regional prep coms, where regional agendas were discussed and included. The ICPD made the shift from demographic targets to individual and couple centred rights and choices in policies & programmes.

# In these 30 years ....

**1994**

Geo-political developments call us to consider both age-old challenges, and newer threats to the fulfilment of sexual and reproductive health and rights

**2023**

**1995**

**Beijing Platform for Action**

**2000**

**MDGs; progresses made in the human rights mechanisms**

**2014**

**ICPD+20 anniversary, continuation of the ICPD PoA till goals are met; 6<sup>th</sup> APPC document**

**2015**

**SDGs framework, established also regional mechanisms for follow-up eg APFSD**

**2020**

**Covid-19 pandemic, climate change induced disasters, rollback of gains in health, poverty reduction and human rights**

# Pushing the envelope ...

“

We cannot afford further reversals. The stakes for women, girls and young people are far too high.

Dr. Natalia Kanem  
UNFPA Executive Director

These developments, frameworks, challenges have deepened, nuanced the understanding of achievement of SRHR in the region, which need to be discussed at this pivotal time of the 30<sup>th</sup> anniversary of ICPD.

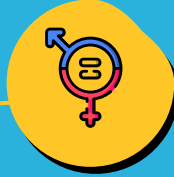
In every goal, the pandemic and climate change have taken us backwards instead of forwards, and we need to get governments and UN agencies to double down, and invest resources and energies to ensure people's rights, especially, marginalized are being fulfilled.

# Key parameters for consideration



## **EQUITY**

The AAAQ of SRHR for marginalised groups



## **VIOLENCE**

Violence and linkages with SRHR need to be considered



## **CARE WORK**

Reproductive labour & reproductive rights



## **LEGAL F'WORKS**

Limitations on access, esp to marginalised



## **TECHNOLOGY**

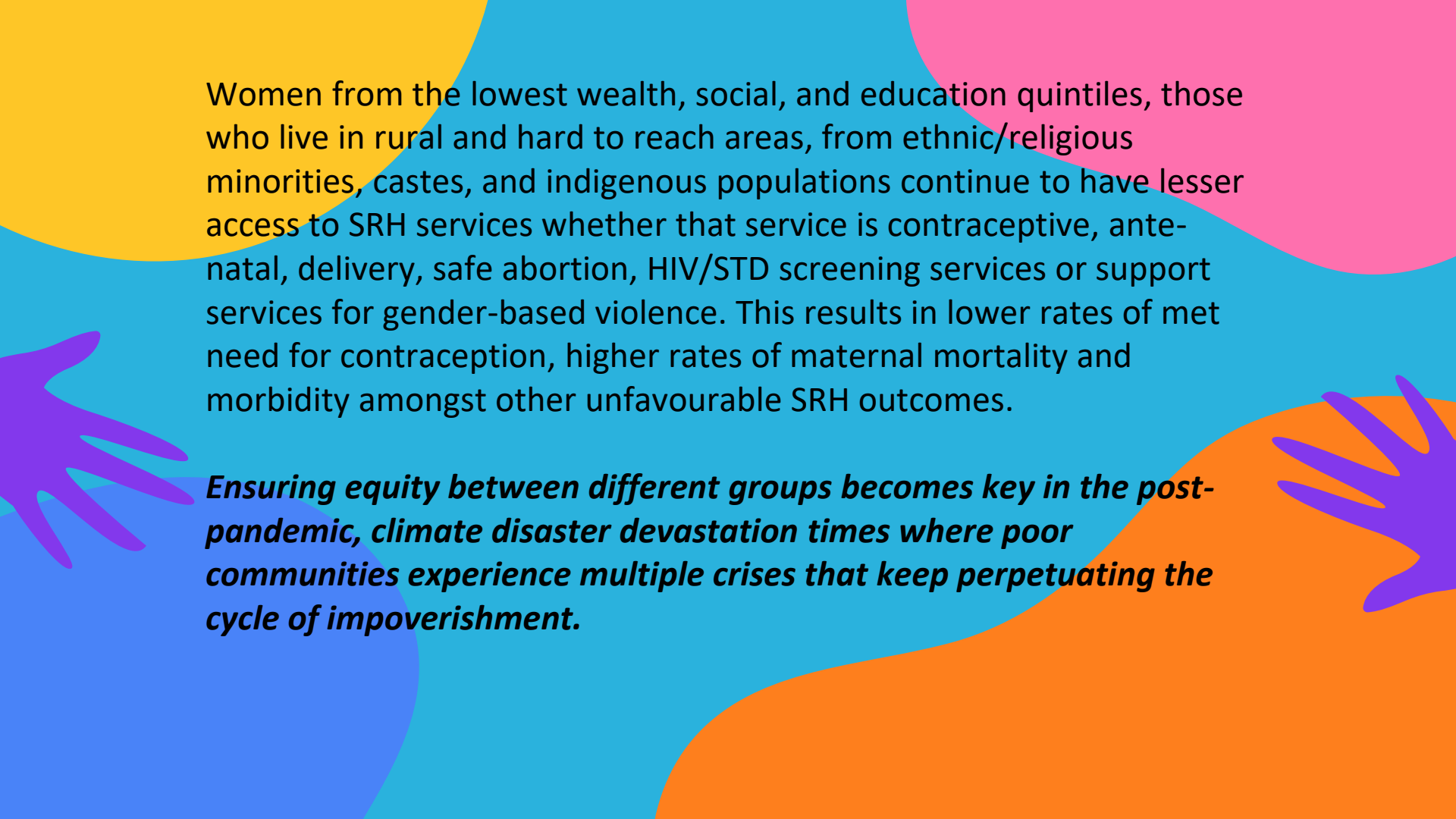
Digital health, promise, possibilities and limitations and threats

01

# EQUITY

The absence of systematic disparities in health, between groups with different levels of power based on social advantage/disadvantage



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Women from the lowest wealth, social, and education quintiles, those who live in rural and hard to reach areas, from ethnic/religious minorities, castes, and indigenous populations continue to have lesser access to SRH services whether that service is contraceptive, ante-natal, delivery, safe abortion, HIV/STD screening services or support services for gender-based violence. This results in lower rates of met need for contraception, higher rates of maternal mortality and morbidity amongst other unfavourable SRH outcomes.

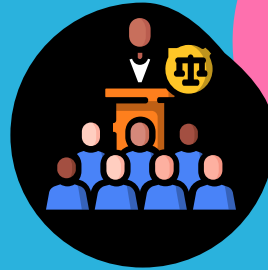
***Ensuring equity between different groups becomes key in the post-pandemic, climate disaster devastation times where poor communities experience multiple crises that keep perpetuating the cycle of impoverishment.***

# Equity challenge is caused by ....



## Systems limitations

Investment in robust, resilient health systems in era of austerity measures, reduced public spending. Quality an issue for poor, marginalized. Comprehensive services as per the ICPD ideal non-existent p. 8.25



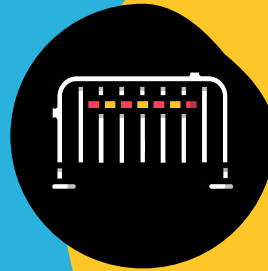
## Data limitations

Older persons and adolescents left out of ALL SRHR as surveys 15-49 as 'reproductive age'



## Lack Inclusivity

Women and girls with disabilities, face especially challenges to SRHR



## Fragile contexts

Gendered impact of crises little recognized, systemic marginalization amplified, cycles of poverty reinforce SRHR deprivations – early marriage, GBV, increased care burden

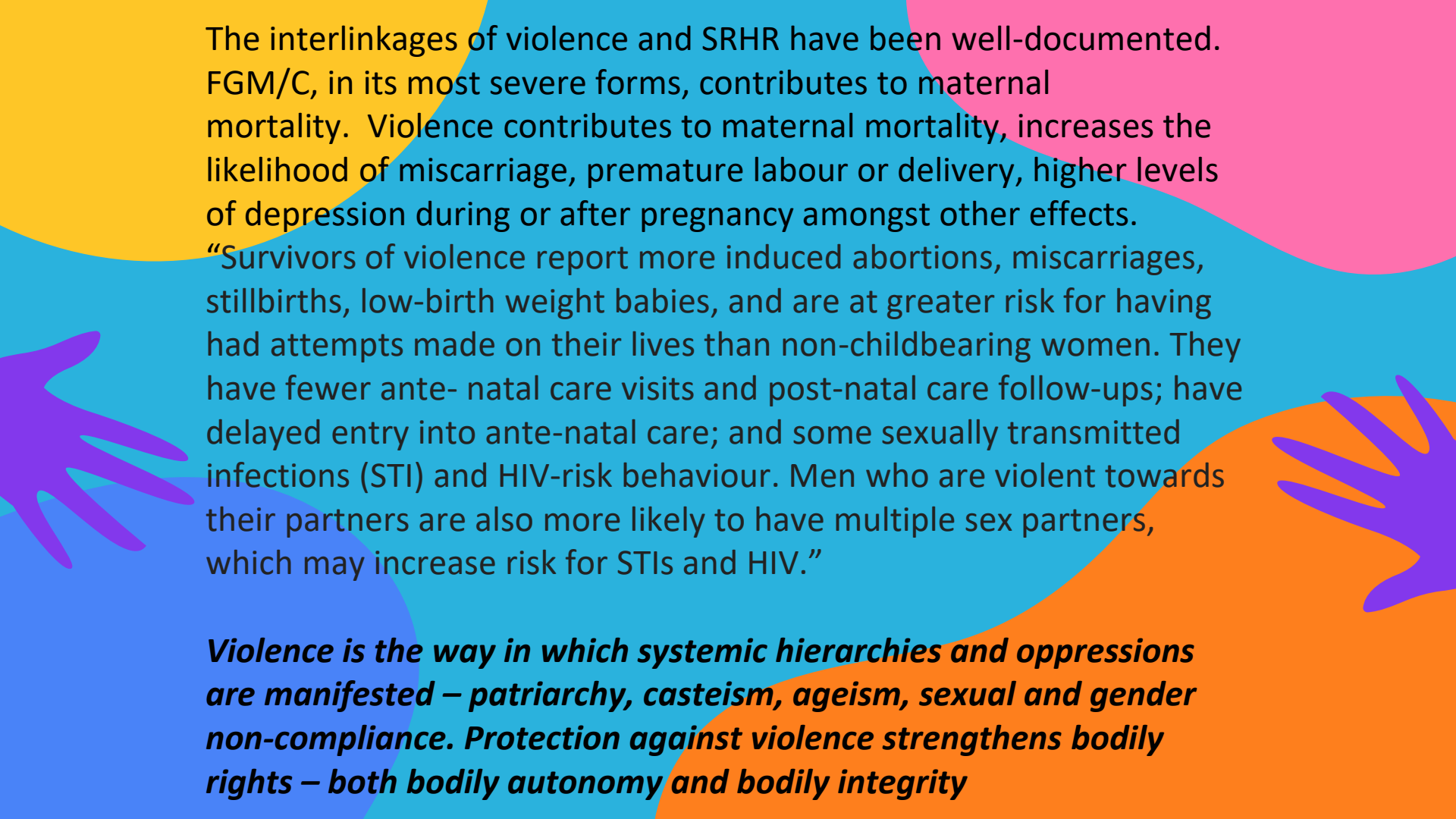


02

# VIOLENCE

The 'shadow' pandemic; intertwined with SRHR needs but also reinforces bodily autonomy and bodily integrity



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The interlinkages of violence and SRHR have been well-documented. FGM/C, in its most severe forms, contributes to maternal mortality. Violence contributes to maternal mortality, increases the likelihood of miscarriage, premature labour or delivery, higher levels of depression during or after pregnancy amongst other effects.

“Survivors of violence report more induced abortions, miscarriages, stillbirths, low-birth weight babies, and are at greater risk for having had attempts made on their lives than non-childbearing women. They have fewer ante- natal care visits and post-natal care follow-ups; have delayed entry into ante-natal care; and some sexually transmitted infections (STI) and HIV-risk behaviour. Men who are violent towards their partners are also more likely to have multiple sex partners, which may increase risk for STIs and HIV.”

***Violence is the way in which systemic hierarchies and oppressions are manifested – patriarchy, casteism, ageism, sexual and gender non-compliance. Protection against violence strengthens bodily rights – both bodily autonomy and bodily integrity***

# Persistent violence underlying causes....



## Persistent gender inequality

Laws, implementation gaps;  
newer forms of violence



## SRHR linkages

Less addressed considered, though impacts  
contraception, abortion, maternal mortality  
& HIV. Lack of comprehensive referral  
services for survivors!



## Reinforces domination/ subordination hierarchies

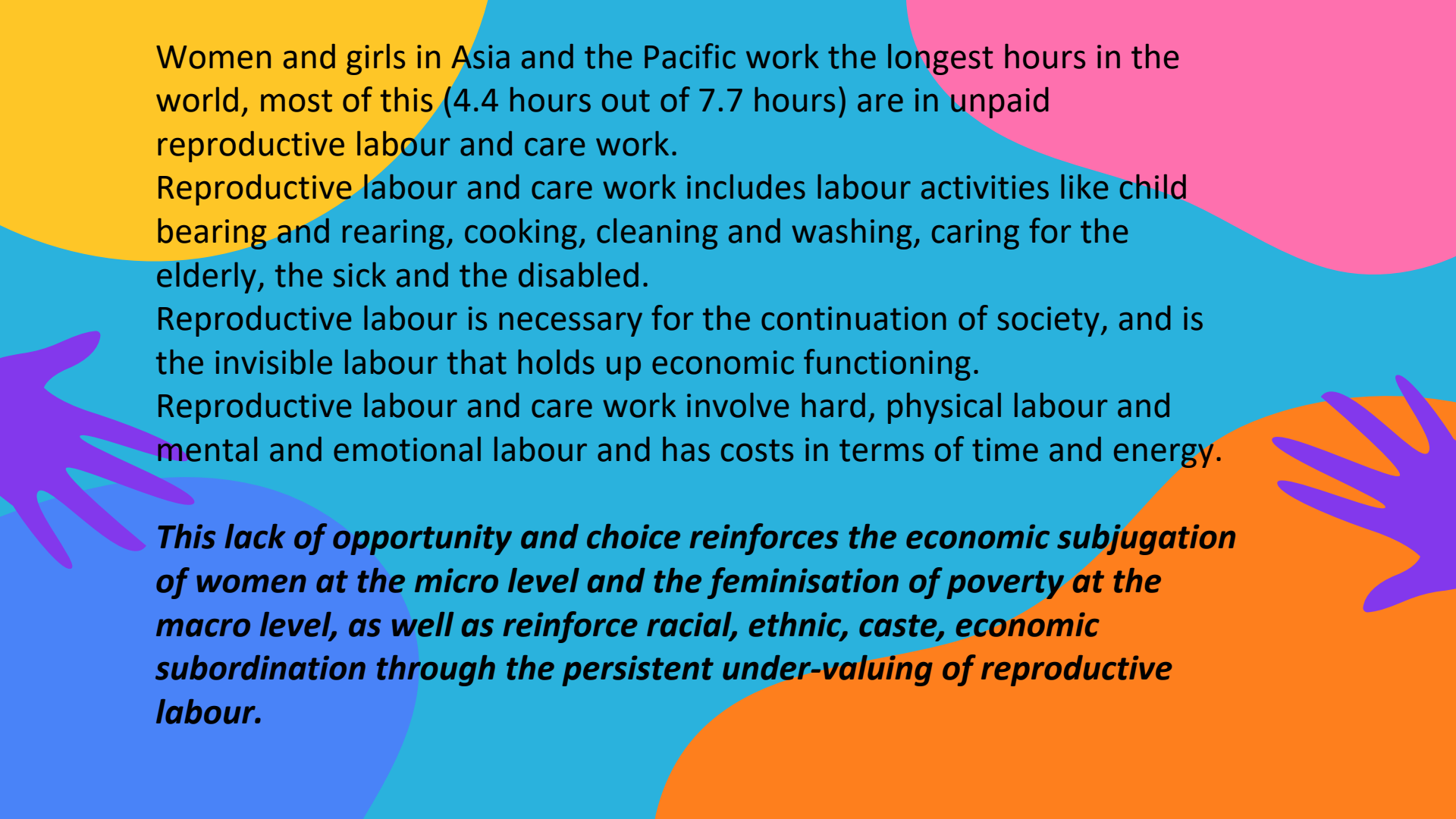
Male domination, caste domination;  
violence as a tool to punish and  
ensure compliance

03

# CARE WORK/ REPRODUCTIVE LABOUR

Reproductive labour/ care work stems from gender hierarchies and is perpetuated by the gender power imbalances in families and societies





Women and girls in Asia and the Pacific work the longest hours in the world, most of this (4.4 hours out of 7.7 hours) are in unpaid reproductive labour and care work.

Reproductive labour and care work includes labour activities like child bearing and rearing, cooking, cleaning and washing, caring for the elderly, the sick and the disabled.

Reproductive labour is necessary for the continuation of society, and is the invisible labour that holds up economic functioning.

Reproductive labour and care work involve hard, physical labour and mental and emotional labour and has costs in terms of time and energy.

***This lack of opportunity and choice reinforces the economic subjugation of women at the micro level and the feminisation of poverty at the macro level, as well as reinforce racial, ethnic, caste, economic subordination through the persistent under-valuing of reproductive labour.***

# CARE WORK APPROACHES NEEDED ...



## RECOGNISE

Compensate, raise earnings, provide social protection & benefits for care workers



## REDUCE

Public (state funded) care services for children, elderly, disabled, sick



## REDISTRIBUTE

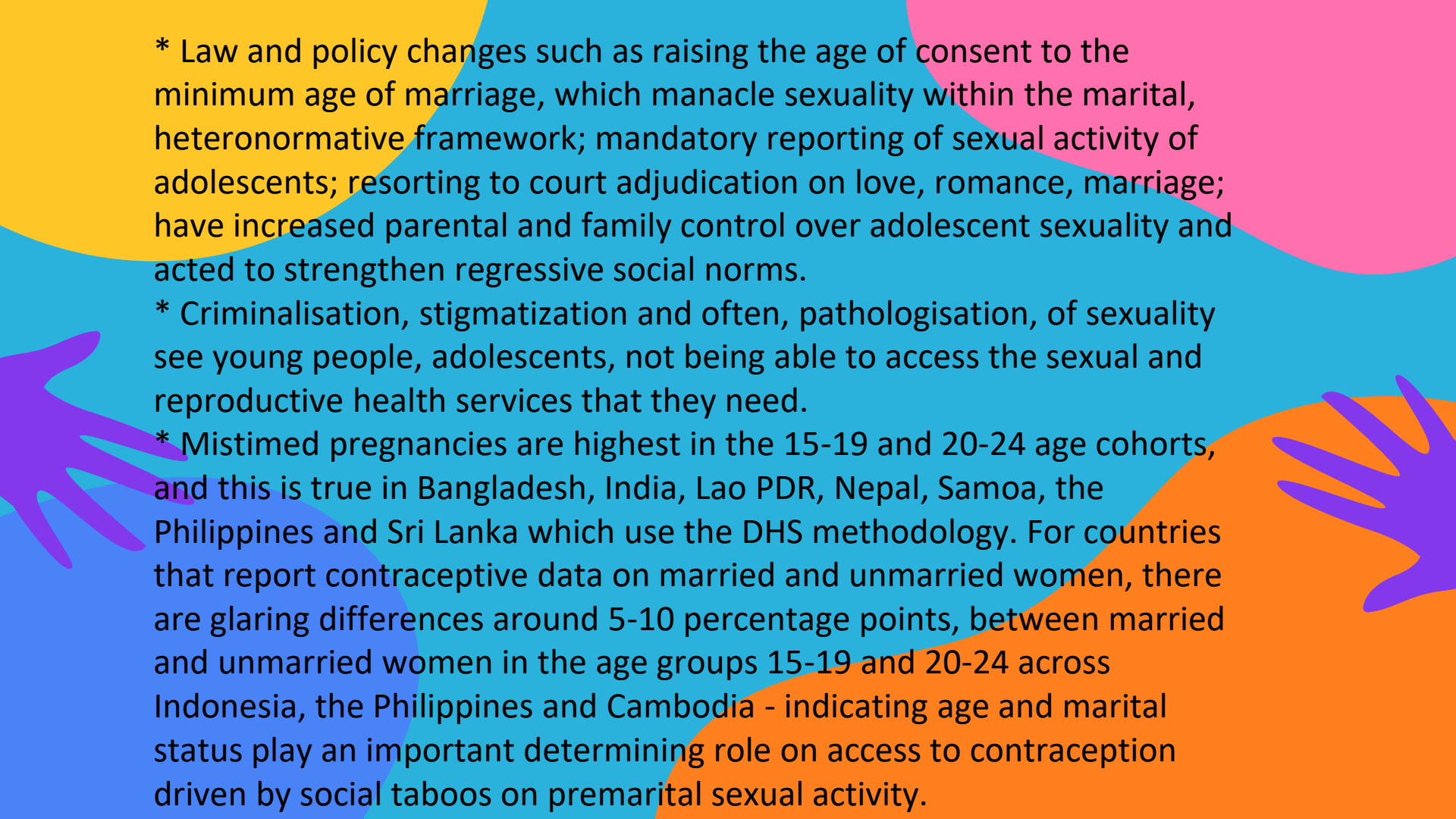
Redistribute care work through paternity leave, paternal care leave, elevate the compensation for female dominated care jobs

04

# LEGAL FRAMEWORKS

Legal frameworks reinforce dominant biases in society, colonialist, patriarchal, casteist, racist, ageist






\* Law and policy changes such as raising the age of consent to the minimum age of marriage, which manacle sexuality within the marital, heteronormative framework; mandatory reporting of sexual activity of adolescents; resorting to court adjudication on love, romance, marriage; have increased parental and family control over adolescent sexuality and acted to strengthen regressive social norms.

\* Criminalisation, stigmatization and often, pathologisation, of sexuality see young people, adolescents, not being able to access the sexual and reproductive health services that they need.

\* Mistimed pregnancies are highest in the 15-19 and 20-24 age cohorts, and this is true in Bangladesh, India, Lao PDR, Nepal, Samoa, the Philippines and Sri Lanka which use the DHS methodology. For countries that report contraceptive data on married and unmarried women, there are glaring differences around 5-10 percentage points, between married and unmarried women in the age groups 15-19 and 20-24 across Indonesia, the Philippines and Cambodia - indicating age and marital status play an important determining role on access to contraception driven by social taboos on premarital sexual activity.





\* Abortion laws and sodomy laws are commonly mentioned and inherent in these laws are assumptions on sexuality, agency, autonomy and privacy of individuals and couples which then hinder full attainment of sexual and reproductive rights.

\* Where abortion has been legalized, there continue to be issues of access especially with regards term limits. It is often poorer, marginalized women who come for termination services later due to cost, distance and transport barriers. The centrality of abortion in the reproductive justice framework needs to be reinforced. An unwanted pregnancy is a result of intersecting marginalisations and vulnerabilities and failures: economics, violence, access to health systems and services, information and education, access to suitable methods of contraception, healthcare insurance that covers contraceptives and reproductive health services, as well as autonomy.

\* Legislative or provider induced delays such as waiting periods, parental or spousal consent, court orders or psychiatric evaluations make it harder for poorer, younger, those who live in remote areas, or come from marginalised social identities such as migrant, disabled, indigenous, lower caste, trans-persons' to access the abortion services they may need.

***Decriminalisation of laws regulating abortion, adolescent sexuality, premarital sexuality, same-sex sexual relationships, gender identity, discrimination based on pregnancy and HIV status helps improve sexual and reproductive health outcomes for the most marginalized groups in our society.***

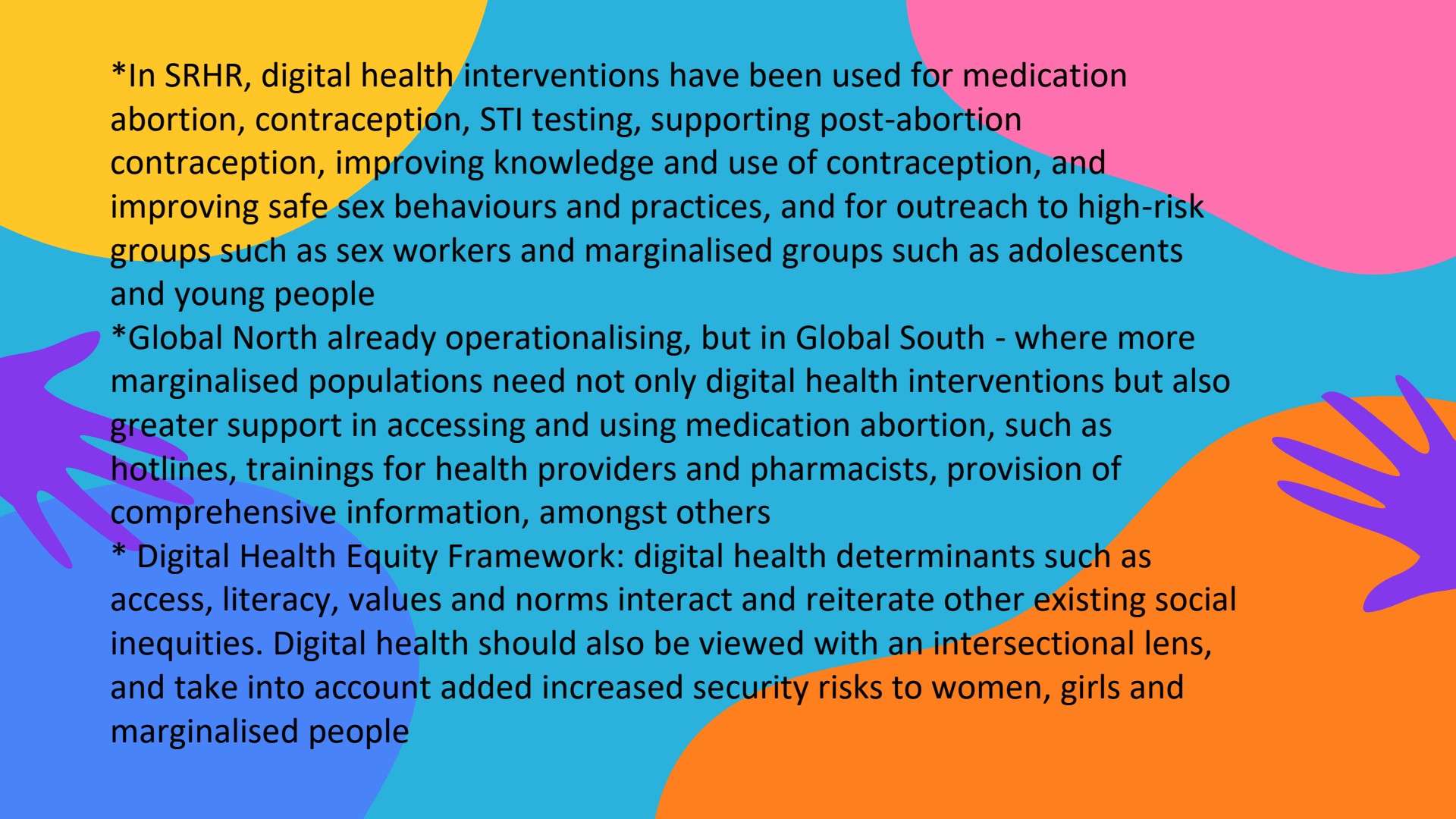


05

# TECHNOLOGY

COVID-19 accelerated the shift to digital health; 87% of countries investing in digital health for health system recovery, resilience and preparedness



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\*In SRHR, digital health interventions have been used for medication abortion, contraception, STI testing, supporting post-abortion contraception, improving knowledge and use of contraception, and improving safe sex behaviours and practices, and for outreach to high-risk groups such as sex workers and marginalised groups such as adolescents and young people

\*Global North already operationalising, but in Global South - where more marginalised populations need not only digital health interventions but also greater support in accessing and using medication abortion, such as hotlines, trainings for health providers and pharmacists, provision of comprehensive information, amongst others

\* Digital Health Equity Framework: digital health determinants such as access, literacy, values and norms interact and reiterate other existing social inequities. Digital health should also be viewed with an intersectional lens, and take into account added increased security risks to women, girls and marginalised people

# Flip side of digital health ...

Gate keepers, persons in control (parents, spouses, abusers) having access to the devices being able to track the usage of apps around violence, contraception, abortion services or to place surveillance apps

Safety, privacy and ownership of data shared with such platforms should authorities request data from the platform owners.

State & authoritarian surveillance.

Biases in design - of digital apps and platforms, skewed towards white, male, models results in biased algorithms which mis-diagnose and





**06**

# **MOVING FORWARD**

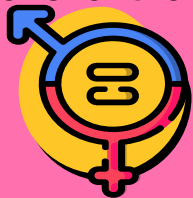
RECOMMENDATIONS FOR ICPD+30

# SOME IDEAS....



## INCLUSIVE

Laws, policies, institutions must be made more inclusive, by looking at those most marginalized groups and the reasons for that marginalisation



## INTERSECTIONAL

understanding power and social disadvantage which results in unequal outcomes



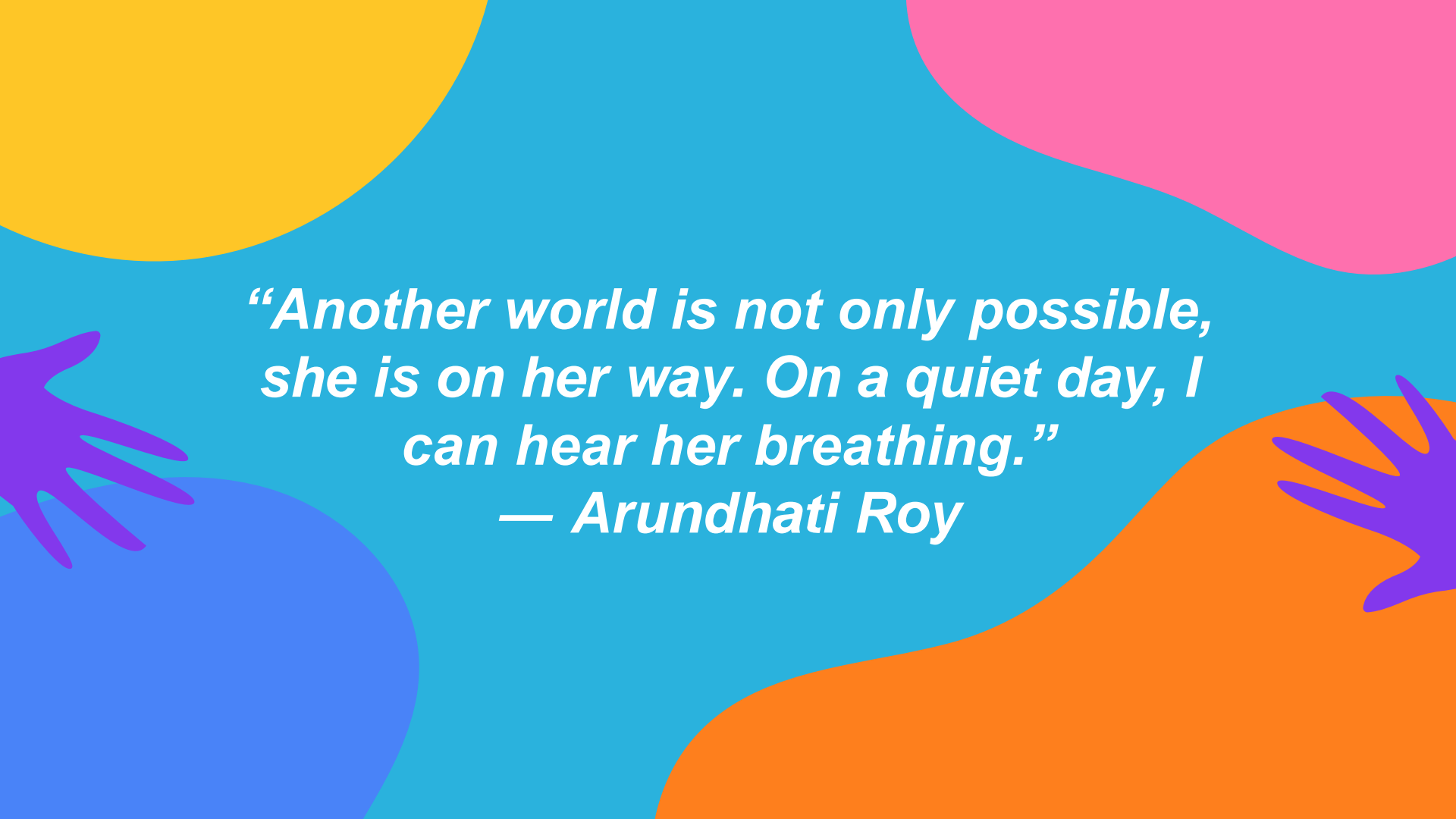
## INTERLINKED RIGHTS

Beyond reproductive justice, other rights also affect SRHR outcomes



## SYSTEMS CHANGE

Reinvestment in public systems (health, care, social protection). Systems geared to serve the marginalised

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*“Another world is not only possible,  
she is on her way. On a quiet day, I  
can hear her breathing.”  
— Arundhati Roy*



# THANK YOU

Do you have any questions?

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