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**Young People: Sexuality, Families, Rights and Well-Being**

**Progress, Gaps, Perspectives and Recommendations from the Global South**

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This paper addresses the current, critical, much-contested issues of sexuality, families, rights and well-being of young people. The paper first examines the theme within the lens of government commitment to sexuality, families, rights and well-being of young people; and marks the progress/ lack of progress towards these across specific regions in the world and posits the need for broader and bolder frameworks in order to realize improved health and rights outcomes.

**I. International Agreements related to Young People: Sexuality, Families, Rights and Well-Being**

Various international conventions and declarations, as well as consensus documents, can be utilised for addressing sexuality and sexual and reproductive health and rights issues for young people. This section will briefly discuss each of these, both in terms of their progressive aspects and their limitations.

**The 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).**[[1]](#endnote-1) CEDAW was the first international human rights treaty that alluded to sexuality, with its affirmation of the right to reproductive choice, the right to choice of partner and to marry. It also called for a minimum age of marriage.

**The 1989 Convention on the Rights of the Child (CRC).**CRCprovidesthe strongest legally enforceable document for certain aspects of adolescent and youth sexuality issues.[[2]](#endnote-2)CRC recognises children and adolescents’ capacity and competence to make decisions about their lives and the need to respect these decisions; it also recognises their right to privacy. Further, the CRC legally binds governments to remove legal, regulatory and social barriers to adolescents accessing essential reproductive health information and care; and ensure that health care providers are trained to assess the capability of adolescents to make reasonable, independent, and confidential decisions regarding their reproductive health.[[3]](#endnote-3)

CRC requires governments to “respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.” Some contend that the concept of the “evolving capacities of the child” limits parental involvement as the adolescent become capable of making independent decisions. We argue, as do others, that young people capable of being sexually active without parental control are equally capable of receiving SRH counseling and care without parental control.[[4]](#endnote-4)

**The 1993 Vienna Declaration and Programme of Action.** The consensus document from the World Conference on Human Rights in Vienna affirmed the rights of the girl-child as human rights. It specifically called on governments to “repeal existing laws and regulations and remove customs and practices which discriminate against and cause harm to the girl child” and to take effective measures against child prostitution, child pornography, as well as other forms of sexual abuse.

**The 1994 International Conference on Population and Development Programme of Action (ICPD PoA).** While the term ‘sexual rights’ does not explicitly appear in the consensus document, ‘reproductive rights’ was incorporated for the first time in a UN document, along with sexual health and some elements of sexuality. Cairo was also ground-breaking in recognising the linkages between gender and sexuality, as well as noting that individuals should be “able to have a satisfying and safe sex life.” The PoA also notes, “…the purpose of [sexual health] . . . is the *enhancement of life and personal relations*, and not merely counseling and care related to reproduction and sexually transmitted diseases.”(authors’ emphasis)

The ICPD PoA[[5]](#endnote-5) also affirmed the rights of adolescents and young people, expanding on the CRC, and devoting a full section to this group. Meaningful youth participation in programming was a key aspect of the ICPD PoA. Moreover, for the first time, adolescents’ sexuality was explicitly mentioned, with the PoA underlining adolescents’ special vulnerabilities to reproductive ill-health “because of their lack of information and access to relevant services in most countries.” Further, it called on governments and other stakeholders to meet“the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.”

As a consensus document, the language of the final ICPD document was a compromise and far from ideal from the perspective of sexual rights.

The ICPD PoA acknowledged that “various forms of the family exist in different social, cultural, legal and political systems.” This opened the space for a widened concept of family, to potentially include same-sex couples and families, heterosexual non-marital unions, extended families, multi-generational families, a family with a single parent, one-person households, families composed of grandparents and grandchildren, and other adults who act as parents, amongst others.

At the five-year review of the ICPD PoA, governments again agreed to reaffirm adolescent’s sexual and reproductive rights. A section was devoted to adolescents, and there was more youth involvement in the ICPD process. The outcome document, Key Actions for Implementation of the Programme of Action,[[6]](#endnote-6) recognised adolescents’ vulnerability to sexual and reproductive health risks, and called on governments to “ensure the protection and promotion of the rights of adolescents, including married adolescent girls, to reproductive health education, information and care.” It also called for governments to develop youth-specific HIV education and treatment projects, in partnership with youth, and for sex education at all levels of schooling.

**1995 Fourth World Conference on Women (FWCW, also Beijing).**Beijing affirmed the definition of reproductive health and rights agreed at Cairo, and pushed governments to contemplate law reform of criminalisation of abortion. Moreover, the Beijing Declaration extended the definition of reproductive rights to cover sexuality with respect to health and freedom from violence: "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." (paragraph 96).

**1995 World Programme of Action for Youth (WPAY) to the Year 2000 and Beyond.** This international strategy provides a policy framework and guidelines for national action and international support to improve the situation of young people. It focuses on actions to strengthen capacities at the national level in the area of youth and to increase opportunities for young people’s full, effective and constructive participation in society. WPAY initially outlined 10 priority areas to be addressed, but five additional issues were added at the ten-year review of its implementation. WPAY affirms ICPD and BPfA about family planning, family life and sexual and reproductive health.

**The 2000 Millennium Development Goals (MDGs).**The MDGs,which set priorities for international development through 2015, included a significant focus on improving maternal health (MDG5) and combating HIV/AIDS (MDG6). Achieving universal access to reproductive health was included as a target under MDG5, with a specific indicator for adolescent birth rates.[[7]](#endnote-7)

**45th Session of the Commission on Population and Development (CPD) 2012.** During the 45th CPD session, a landmark resolution on sexual and reproductive health rights for adolescents and youth[[8]](#endnote-8) was adopted, as a result of the leadership of governments and concerted efforts from NGOs, particularly youth groups.

Through this historic resolution, governments have recognised for the first time the right of adolescents and youth, regardless of age and marital status, to “have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health.” The resolution also called on “governments, with the full involvement of young people and with the support of the international community, to give full attention to meeting the reproductive health-service, information and education needs of young people, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality.” Other key aspects of the resolution include protection and promotion of young people’s right to control their sexuality free from violence, discrimination and coercion; inclusion of access to safe abortion; as well as the importance of full involvement of young people and youth participation.

Gaps remain, the most glaring of which is the non-inclusion of sexual orientation, despite world-wide attention on this issue, in the resolution. As with CRC and ICPD, the proviso on parental rights, duties and responsibilities remain, but it is circumscribed by noting that this should be consistent with adolescents’ evolving capacities and their right to confidentiality and privacy.

**2012 Rio+20 The Future We Want.** Right after the success of the 45th Session of CPD, the outcome document of Rio+20 reaffirmed the ICPD PoA and Beijing PfA. Moreover, the document reaffirmed governments’ “commitment to gender equality and to protect the rights of women, men and youth to have control over and decide freely and responsibly on matters related to their sexuality, including access to sexual and reproductive health, free from coercion, discrimination and violence.” However, it was disappointing that there was no reference on reproductive rights in the text, reflecting a step back from previous agreements.

This setback highlights the fragility of gains, the importance of connecting SRHR with other development issues, and of working with other social movements so that SRHR is not lost. This is even more crucial with the review of the ICPD and Beijing at 20, of the MDGs at 15, as well as the development of the post-2015 agenda.

**II. A Look at Progress 18 Years after ICPD**

This section looks at the progress, gaps and barriers towards the realisation of young people’s SRHR, including how young people themselves have worked on these issues, highlighting specific successes.

Adolescents and youth constitute a significant proportion of the global population today, with an estimated 1.6 billion young people aged 10-24, 721 million adolescents aged 12-17, and 850 million youth aged 18-24 living in this planet.[[9]](#endnote-9)

An examination of adolescents and young people globally shows a varied picture—with different levels of physical and psycho-social development; in-school and out-of-school; sexually active and sexually inactive; married and unmarried; pregnant and already begun child-bearing; HIV-, and HIV +, and with or without the knowledge of HIV status; of different sexual orientation; living in poverty; migrant; and of different ethnic and indigenous backgrounds and others.

Regional, sub-regional and national data can mask differences and inequities among and within countries, populations and communities. Adolescents and young girls face varying vulnerabilities depending on intersecting identities and factors. These vulnerabilities include poor education and early drop-out from school, early marriage, early child bearing, vulnerability to STIs and HIV, sexual exploitation and harassment, lack of access to sexual and reproductive health services, and lack of access to basic water and sanitation. These are aggravated among adolescent girls from marginalised groups, such as girls from poor households, and from rural and hard-to-reach dwelling, amongst others.[[10]](#endnote-10)

**A. Young People’s Sexual and Reproductive Rights and Health Status**

In this section, we examine key indicators pertaining to young people’s sexual and reproductive health and rights in line with the promises made to adolescents and young people at the International Conference on Population and Development. These include:

1. Young people’s access to comprehensive sexuality education
2. Adolescent pregnancies and child marriages;
3. The right to access youth-friendly sexual and reproductive health information and services: access to contraception, safe abortion, STI/HIV prevention, treatment and care.

The key premise in this section is that outcomes within these key development indicators which are often considered linked to only health are actually intrinsically linked with sexuality and sexual and reproductive rights of young people. The evidence presented has been collated in a collaborative manner with young activists from across the Global South.[[11]](#endnote-11)

**Sexuality Education**

Comprehensive sexuality education (CSE) entails curricula and programmes that include, but is not limited to discussions of the physical and biological aspects of sexuality; it views sexuality holistically and within the context of emotional and social development. CSE goes beyond the provision of information; it also provides young people with essential life skills that help them develop positive attitudes and values. It frames sexuality in an affirmative perspective, and is adjusted to accommodate different age groups and stages of development.[[12]](#endnote-12) A gender-sensitive, rights-based approach to CSE has been consistently shown to increase the use of contraception, decrease the onset of sexual activity and the number of sexual partners, drop the frequency of sexual activity, and prevent unwanted pregnancies.[[13]](#endnote-13),[[14]](#endnote-14)

Despite the critical importance of sexuality education, access to CSE is staggered and uneven across all countries and regions. Adolescents and young people face significant barriers in realising their full potential with regards to sexual and reproductive health due to lack of CSE in formal and informal institutions.

In the MENA region, lack of CSE is a common characteristic among countries. Evidence shows that school curricula include limited information on reproductive health. Except for Tunisia, which has reproductive health education covered within science, there is no school-based sex or sexuality education programme in the countries covered under the MENA region Global South ICPD+20 monitoring study.[[15]](#endnote-15) In addition, teachers usually overlook this information during classes either out of embarrassment or unpreparedness.[[16]](#endnote-16)

Sex is a taboo topic among many communities in sub-Saharan Africa. Most of the sex education is school-based, provided by non-state actors and is limited. Many take a biological perspective, and religious groups and parent associations define the parameters and content for age appropriateness.[[17]](#endnote-17)

In Latin America and the Caribbean, many of the countries the region have programmes or curricula that have compulsory sex education. However, conservatism and the involvement of the Catholic Church in some cases make implementation difficult.[[18]](#endnote-18)

Sexuality education is a contentious issue in Eastern Europe region as well. While today’s adolescents and young people face increasing pressure regarding sex and sexuality with conflicting messages and norms, sexuality remains taboo and official institutions tend to expect families to take care of sexuality education. Inadequate sexuality education programmes and the inability of parents to provide necessary information leave the burden of filling this gap on scarce voluntary groups/initiatives whose capacity and outreach is limited. Existing sexuality education programmes present a one-sided, biased view of sexuality which harbour myths, misconceptions, fears, discrimination, gender stereotypes and a harmful lack of information which can lead to HIV, sexually transmitted infections, unwanted teen pregnancies as well as misinformed perceptions of gender and sexuality.[[19]](#endnote-19)

In Eastern Europe, Armenia and Ukraine are among the countries that have a strongly incorporated sexuality education component in their school curriculum. However, these programmes are mostly influenced by the HIV prevention agenda. The sexuality component in Poland and Croatia is strongly influenced by the Catholic Church, which condemns contraception and sex outside marriage, while Bulgaria and the Russian Federation have failed to implement the already developed educational programmes into the school curriculum. [[20]](#endnote-20)

A review commissioned by UNESCO in 28 countries in Asia- Pacific region noted that 20 countries have national HIV laws and/or policies, of which 13 explicitly mention education. However, only Cambodia, Indonesia, Nepal, Papua New Guinea, People’s Republic of China and Vietnam have detailed discussion on sexuality education in national HIV laws and policies. National population and reproductive health laws and policies, and national youth policies, exist in 79% and 75% of all countries, respectively, and these laws and policies mention the role of education (formal and non-formal), establishing clear priorities and identifying target groups. Cambodia, China, Indonesia, Lao PDR, Papua New Guinea and Viet Nam have education sector policies on health or HIV. The study finds significant gaps in the region in the area of legal and policy frameworks pertaining to sexuality education, with clear gaps in the education sector, which is supposed to take more active role to incorporate sexuality education within the curricula.[[21]](#endnote-21)

Evidence shows that abstinence-only programs do not lead to positive health and rights-based outcomes for youth. Evidence also demonstrates that comprehensive sexuality education, including that which is integrated into the school curricula, cover sex and sexuality from a sex-positive perspective, integrate life skills such as negotiating condom use; power dynamics; and understanding one’s body have received positive feedback and result in positive outcomes. Addressing sexuality issues in a holistic, comprehensive manner challenges some of the prevailing myths, perceptions and ideas around sex and sexuality; promotes safe sexual behaviour; and subsequently, reduces risky sexual behaviour amongst young people. Evidence-based comprehensive sexuality education is a core component of working to advance young peoples’ sexual and reproductive health and rights; and has had a strong impact on the achievement of the ICPD PoA goals.

**Adolescent Pregnancies**

Globally, one in five girls give birth before they turn 18 years of age.[[22]](#endnote-22) In many countries, pregnancy and childbirth remain the leading cause of death for young women and girls. The ICPD Programme of Action calls for a substantial reduction in adolescent pregnancies, and to address the sexual and reproductive health issues of adolescents in a manner consistent with the evolving capacities of adolescents.[[23]](#endnote-23) While there has been some progress since the ICPD, it is uneven and far from sufficient.

A significant proportion of adolescent pregnancies result from non-consensual sex, and most take place in the context of child marriage, a harmful practice which violates not only the human rights of adolescent girls who are forced into marriage, but also many international commitments and national laws.

**Table 1: Regional Adolescent Fertility Rates 2011**

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| --- | --- |
| **Region** | **Adolescent Fertility Rate** |
| Arab States | 44.4 |
| East Asia and the Pacific | 19.8 |
| Europe and Central Asia | 28.0 |
| Latin America and the Caribbean | 73.7 |
| South Asia | 77.4 |
| Sub-Saharan Africa | 119.7 |

Source: Human Development Report 2011

In 2010, the global adolescent fertility rates stood at 53 births per 1,000 women. An examination of the above table shows that sub-Saharan Africa region has a very high rate of adolescent fertility(119.7), almost double the global adolescent fertility rate, followed by South Asia at a rate of 77.4, and Latin America following closely at 73.7.

About 16 million adolescent girls aged 15-19 give birth each year, roughly 11% of all birth worldwide, with 95% of the births occurring in developing countries.[[24]](#endnote-24) Half of these births occur in just 7 countries: Bangladesh, Brazil, Democratic Republic of Congo, Ethiopia, Nigeria, India and the United States.

This said, national averages skew the significant regional and local variations within many countries, with adolescents in rural and poor communities typically having a higher adolescent fertility rate.

Young adolescents face a higher risk of complications, with adolescents under 16 facing four to five times the risk of maternal death as women over age 20.[[25]](#endnote-25) In Africa, high levels of maternal mortality and the prevalence of HIV and AIDS are largely responsible for higher mortality among young women. In South Asia, early childbearing and insufficient access to health services are the main causes for the relatively high mortality among adolescent and young women.[[26]](#endnote-26)

**Figure 1: Births to Adolescents within or Before Marriage, by Region**



Adolescent pregnancies remain a persistent problem, especially in the countries of the Global South with low and medium human development, having on impact on the health, economic and social well-being of adolescents and young women. This violates the sexual and reproductive rights of adolescents and young women and the numbers involved help demonstrate the magnitude of this violation.

**Contraceptive Use among Adolescents and Young People**

The right to the highest attainable standard of sexual and reproductive health, the right to decide the number and spacing of one’s children, the right to information and the right to quality sexual and reproductive health services enshrined at ICPD PoA stipulate that adolescents and young people have access to contraceptive information and services in a enabling environment.

While data on the sexual and reproductive behavior of adolescents and young people limited and fraught with underreporting, global estimates by the Guttmacher Institute show that 52 million never-married women, mostly adolescents and young women aged 15-24 in the developing world, are sexually active and in need of contraceptives in 2012. Guttmacher notes a steady long-term trend toward increased levels of sexual activity among this group, due to reasons such as the declining age of menarche, the rising age at marriage and changing societal values.[[27]](#endnote-27)

This trend emphasises the growing need to ensure all adolescents and young women have access to sexual and reproductive health services, including contraception suitable to their needs, as envisaged in the ICPD PoA.[[28]](#endnote-28)

Never-married women, mostly adolescents and young women, have a great disadvantage in obtaining contraceptives, largely due to stigma attached to being sexually active before marriage in many societies. Among women in need of contraceptives, use of modern methods is 31 percentage points lower among never-married women than among married women in Asia; this difference is 10 percentage points in Latin America and the Caribbean. However, the situation is reversed in Sub-Saharan Africa, where the proportion of never-married, mostly adolescents and young women in need using modern contraceptives is 19 percentage points higher than among their married counterparts. Contraceptive use among sexually active unmarried women is higher than that of married women in sub-Sahara Africa.[[29]](#endnote-29)

Young people also face many barriers accessing modern contraception in the Eastern European region. In countries of the European Union, such as Bulgaria, Hungary, Poland and Romania, access to modern contraception remains an issue. The most blatant example is Poland where the use of conscientious objection by doctors and pharmacists obstructs access to modern contraceptives, including emergency contraception.[[30]](#endnote-30)

However, even married adolescents face difficulties in contraceptive access compared to married adults. In regions where contraceptives are available, married adolescents are less likely to use contraception in comparison to adults. In Latin America, Europe and Asia only 42-68% of adolescents who are married or in partnerships use contraceptives. In Africa the rate ranges from 3-49%.[[31]](#endnote-31) An unexpected finding, particularly in sub-Saharan countries, is that the contraceptive use remains low among youngest adolescents and extremely low within marriage. Data for South Asian countries is not collected for unmarried women, and hence the trend cannot be assessed.[[32]](#endnote-32)

In countries with higher contraceptive prevalence rates such as Bangladesh and Columbia, married teens do use contraception; however, when these rates are compared with all married women respectively, the contraceptive rates are significantly below those of adult married women. In India—a context where the primary form of contraception is sterilisation—adolescent and young married women prefer to use pills and condoms, and hence have poor access to contraception and a higher unmet need. [[33]](#endnote-33) This points to a need for access to a broader range of contraceptive choices by young people.

Adolescent and young girls have many problems with regards to access to contraception, such as knowledge about contraception and its usage, resulting in incorrect, inconsistent usage and higher failure rates. In addition, adolescent girls face many problems and barriers in controlling their fertility. For example, cultural norms primarily value girls for their reproductive capabilities and many communities encourage both child marriage and rapid conception.[[34]](#endnote-34) In addition, lack of knowledge of puberty, menstruation and understanding of contraception is another significant hurdle.

As earlier discussed, sexuality outside of marriage is stigmatised, especially in cultural and traditional contexts which place a premium on girls’ and women’s ‘purity,’ virginity and chastity. This paradigm results in frameworks and policies and programmes which create barriers to access to contraception and safe abortion services for unmarried adolescents and young women. One example of this are “abstinence-only” education programmes, which often do not cover issues of sexual and gender-based violence(SGBV), do not provide adequate information on contraception, do not address sexual orientation and gender identity (or only do so negatively), and do not cover sexual pleasure or other topics concerning sexuality, sexual identity, or sexual and reproductive health.

**Unsafe Abortion among Adolescents and Young Women**

Adolescent girls aged 10-19 account for at least 2.2-4 million unsafe abortions in developing countries.[[35]](#endnote-35) Young women under the age of 25 account for almost half of all abortion deaths[[36]](#endnote-36) and this group is seriously affected by the consequences of unsafe abortion.

Adolescent girls and young women account for a significant proportion of unsafe abortions, with most of them living in developing countries where the grounds on which abortion is permitted are not very liberal. Even where liberal, access to safe abortion services especially for adolescents and young girls remains a challenge. Evidence points to the fact that adolescents and young girls are more susceptible to delay seeking an abortion, and resort to unsafe abortion providers due to fear, lack of knowledge and financial resources. As a result this group is more like to suffer from abortion-related complications, including immediate and long-term disability and death.[[37]](#endnote-37)

In Africa, adolescent girls account for a quarter of all unsafe abortion and almost 60% of unsafe abortions are among young women aged less than 25 years.[[38]](#endnote-38) About 10,000 adolescent girls in Nigeria die due to unsafe abortions each year.[[39]](#endnote-39)

Generally, the MENA region is considered to be one of the most restrictive countries when it comes to abortion laws, except for Turkey and Tunisia. Legal restrictions on abortion make it difficult to seek abortion safely. The latest estimates from WHO indicate that there are more than 3 million unsafe abortions performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[[40]](#endnote-40)

Abortion policies in Latin America have long been controversial issues and remain heavily influenced by religious and cultural constructs of sexual rights. The status of abortion policies in the region has resulted in prominent international human rights cases and lawsuits against governments whose legislation restrict even life-saving abortion procedures. Health workers have also been documented for refusing to provide even the most basic of comprehensive reproductive health services, deferring to conscientious objection or hiding behind the ability to ambiguously interpret some laws. A case was recorded in Peru, by the Centre for Reproductive Rights, where a 17-year-old woman was forced to carry to term her pregnancy with an anencephalic fetus and made to breastfeed for the four days that the fetus survived. Overall, the region has very restrictive laws on abortion, particularly in the South and Central American sub-regions.[[41]](#endnote-41)

In Asia, 30% of unsafe abortions are among women under 25 years of age.[[42]](#endnote-42)In the Pacific, there is little information and few official records on induced abortion; however, key informant interviews and micro-studies reveal that young women self-induce abortion and go to hospitals for treatment of complications, or travel to other countries for services.[[43]](#endnote-43)In the Asia-Pacific region, with the exception of Vietnam, all other countries limit the access to and availability of abortion to young women, even where abortion is generally permitted or available upon request.

Although liberal abortion laws remain in place in almost all countries of Eastern Europe and these recognise a woman’s right to abortion without restrictions up to 12 weeks of pregnancy, adolescents face even more barriers accessing abortion and among these is the law that obliges young girls to receive parental consent for the procedure prior to performing it. The striking exception is Poland, which has one of the most restrictive abortion regulations in Europe, and even within the legal framework, access is difficult. As a result, many women are forced to rely on underground abortion services. Moreover, in 2012, initiatives to restrict access to abortion appeared in Azerbaijan, Bulgaria, Hungary, Poland, Russian Federation and Ukraine.[[44]](#endnote-44)

Studies and statistics have consistently shown that young women turn to unsafe abortion when they are denied access to safe abortion services and care. Young, unmarried girls who are pregnant are often forced to marry, are cast out of their homes and communities for ‘bringing shame’ upon them, are barred from educational institutions, and are forced to carry their pregnancy to term against their will. Many young girls resort to unsafe abortions, leading to many health complications and in the worst-case scenario, death.

It is thus imperative to challenge the stigma and taboo in which abortion is mired, especially in reference to young women. Recognising and supporting young women’s autonomies, their bodily integrity, and ensuring their safety is a priority and cannot be bartered away on any lines, least of all on lines of religion, culture, and poor political will. SRHR programmes cannot ignore this reality, and must look at the many intersectionalities within their own work and upholding bodily integrity as a core human right.

**Sexually Transmitted Infections (STIs) including HIV and AIDS**

STIs result from unprotected sex, and sometimes sex resulting from coerced, force, violence and transactional sex, especially among marginalised adolescent and young girls.

STIs are more prevalent among African and Caribbean adolescents than in other regions of the world, partly because sexual debut comes as early as 10-11 years in some African and Caribbean countries. Comprehensive and correct knowledge about HIV among both young men and young women has increased slightly since 2008 globally, but at only 34%, as compared to the UNGASS target of 95%.[[45]](#endnote-45)

Globally, young women aged 15-24 are more vulnerable to HIV, with infection rates twice as high as in young men, and accounting for 22% of all new HIV infections. Particularly, in sub-Saharan Africa, young women aged 15–24 years are as much as eight times more likely than men to be living with HIV. In the Caribbean, young women are approximately two and a half times more likely to be infected with HIV than young men. In Asia, HIV prevalence is twice as high amongst young women as amongst young men in this region.

The increased vulnerability of female adolescents, young women and women to HIV is due both to the biological vulnerabilities but also their gender vulnerabilities due to societal attitudes towards female sexuality and women’s sexual and reproductive rights.

**Overall conclusions on Young People’s SRHR**

Overall, the above data points to many issues, firstly the lack of recognition that adolescents and young girls have sexual rights, and the right to sexual and reproductive health information and services. Most laws and policies are restrictive, imposing controls in terms of parental consent for unmarried youth, husband consent for married young women, and other restrictions. Countries that have instituted sexuality education mostly look at this from the HIV and health entry points, or from religious frameworks, rather than human rights-based affirmative sexuality approach. Access to range of contraception services continues to be stigmatised for unmarried teens, disrespecting the ethical principles of bodily integrity and personhood. The situation of married teenagers is precarious, as they are expected to reproduce as early as possible after marriage though their young bodies are not ready for pregnancy. Access to safe abortion is again a difficult terrain, given restrictive abortion laws and policies and barriers to access safe abortion. Evidence undoubtedly shows young women are more vulnerable to HIV and AIDS across most of the globe.

This sorry state of affairs for adolescent and young people’s sexuality and rights calls for a radical and a paradigm shift in the approach to address adolescent and young people SRHR issues. There is a growing need to mainstream affirmative sexuality as the basis for law, policy and programme implementation for this group.

**B. Young People’s Initiatives in Relation to Sexuality and SRHR and Their Impact**

Secretary General Ban-Ki Moon, at the 2012 Commission on Population and Development, recalled ICPD Programme of Action language on the necessity of young peoples’ involvement and active participation in all activities that impact their daily lives when he said, “By working for and with young people, we will create a new future.”[[46]](#endnote-46)

Young people’s leadership and active engagement in pushing forward the themes, goals, and actions outlined in the ICPD Programme of Action and related development agendas has made significant contributions and must be acknowledged, reflected on and celebrated.

At the international and regional policy levels, young people have consistently held leaders accountable to their promises of ‘meaningful youth engagement.’ As early as 1999, during the ICPD+5 review processes, a cadre of young people emphasised the importance of focusing on young peoples’ sexuality, sexual health, access to information, and importantly, young peoples’ autonomy and decision-making. This led to the outcome document emphasising the commitments made to young people.[[47]](#endnote-47),[[48]](#endnote-48)

The continued mobilisation of youth activists at multiple fora, and the regular monitoring of international commitments by youth has seen a marked change in how young people are viewed at the international arena. This year’s CPD can be viewed as a highlight. The theme was ‘Adolescents and Youth,’ with a significant presence of youth activists[[49]](#endnote-49),[[50]](#endnote-50),[[51]](#endnote-51) engaging in the process. The resulting resolution[[52]](#endnote-52) was a reflection, not just of the many years of persistence and hard work, but of the importance of youth leadership and of cross-generational partnerships. The forthcoming Global Youth Forum in December 2012 in Bali will be another high point - a recognition that youth issues as well as young people’s participation are critical in the ICPD beyond 2014 process and in the corollary MDG and post-2015 development agenda processes.

Prior to and running parallel to (and oftentimes independent of) the international, policy level discussions is the ground-breaking work at grassroots, community and national levels. Young people have taken on the challenges and obstacles that prevent them from exercising or accessing their full sexual and reproductive rights in a number of ways. In countries where abortion access is restricted or where strict parental/spousal consent laws prevent young women from accessing safe services—such as in Asia, Africa, and Latin America & the Caribbean—young people have set up telephone hotlines to ensure accurate, judgment-free information is accessible and available.[[53]](#endnote-53) The fact that young pregnant women are often expelled from schools or forced to abandon their education has been addressed by initiatives and activities that call on the relevant authorities to move away from such practices. Shelters and ‘learning homes’ have been set up to assist them in continuing their education.[[54]](#endnote-54)

Peer-educators and peer education sexuality and support programmes play important and essential roles in communities, filling gaps in knowledge, creating necessary safe spaces and making the services more youth-friendly.[[55]](#endnote-55) It has long been acknowledged that young people are more likely to actively access knowledge from their peers than from other spaces. Local and national advocacy with leaders and governments has had an impact as well. Youth-led organisations and groups have liaised with governments to ensure that curricula—including those of comprehensive sexuality education[[56]](#endnote-56)—are relevant, up-to-date and evidence-based, challenging long-standing protectionist attitudes.

Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) youth have also engaged actively,[[57]](#endnote-57) but have faced staunch resistance from religious, cultural and other factors. There have been some recent positive changes though at the policy and public discourse level. For example, Ban-Ki Moon spoke out in December last year against the homophobic bullying of young people, calling it a “grave violation of human rights.”[[58]](#endnote-58)Discussing young peoples’ sexuality and pleasure is still a taboo topic, but small inroads have been made.[[59]](#endnote-59) There have been attempts to discuss sex and sexuality in a positive manner,[[60]](#endnote-60) removed from a discourse of public health or prevention, with new resources and small-scale interventions slowly emerging. This is seen in concerted attempts by youth groups and activists to engage around comprehensive sexuality education discussions, policies, and programmes.[[61]](#endnote-61),[[62]](#endnote-62),[[63]](#endnote-63),[[64]](#endnote-64),[[65]](#endnote-65)In countries where homosexuality is criminalised, young people have partnered with a number of allies to advocate for law reform and shifts in policy that also account for and affirm young peoples’ sexualities instead of perpetuating protectionist attitudes.[[66]](#endnote-66),[[67]](#endnote-67),[[68]](#endnote-68)

One of the strongest responses from young people has been to HIV and AIDS, which has often been an ‘easy’ entry point to discuss issues relating to sex and sexuality. There has been a sustained and concerted effort to engage in dissemination of accurate information and combating the stigma and discrimination, linking into concrete calls for comprehensive sexuality education and quality services.[[69]](#endnote-69) Young people living with HIV have actively engaged in communities and spaces to ensure full inclusion, access to medicines and treatment, as well as access to information on living with HIV.[[70]](#endnote-70)

There are also burgeoning efforts from youth spaces to challenge the ever-looming threat of fundamentalisms that continue to infringe on young peoples’ lives.[[71]](#endnote-71),[[72]](#endnote-72)

The road is long and stretches before us with many obstacles to overcome. Yet, the continued enthusiasm of young people to demonstrate their political participation, leadership, and realise their vision is a gratifying thought for that ‘new future.’

**III. Key Takeaways: The clear and present need for broader and bolder frameworks**

Looking back over the past two decades, there are some lessons to learn in regard to what works on programming on young people’s sexuality and SRHR, as well as what does not.

One of the core reflections has been on the importance of looking at sexual and reproductive health and rights through an affirmative framework on sexuality. This broader framework considers the non-biological or non-physical expressions and aspects of sexuality, such as desires and fantasies, as well as the gender and power relations that govern gender and sexual expressions. This is not to suggest that the body is unimportant, but to point out that there is more to sexuality than sex[[73]](#endnote-73) and reproduction alone. This understanding of sexuality and sexual rights as distinct from reproductive rights also speaks to the recognition of young peoples’ sexualities and its diverse expressions, underscores the need to approach sexuality positively, as a part of life that has the potential to offer excitement, pleasure, comfort, intimacy and all the joys that sexuality can offer.[[74]](#endnote-74),[[75]](#endnote-75)

**A. Sexuality: Contested yet Crucial to Development**

Issues related to sexuality remain fraught in controversy at the international level, as well as in national and local policymaking and programming and in public discourses. Sexuality of young people (see Definitions) in particular remains deeply contested.

At the heart of these contestations is a push by some governments, schools and religions to control sex, along with a perception that the only acceptable sex is heterosexual, married and procreative.

And yet, positive sexuality is central to development, both personal and global. And is closely inter-related to human well-being. A broadly accepted working definition of sexuality by the World Health Organization[[76]](#endnote-76) reveals how integral it is to our being and how much the decisions we make are about sexuality:

Sexuality is a central aspect of being human throughout life, which encompasses sex, gender identity and role, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[[77]](#endnote-77)

The realisation of rights related to sexuality, as well as reproduction, makes a big difference to young people’s well-being, health, social acceptance, and even life and death. It bears significantly on “how people [including young people] live and die, on their physical security, bodily integrity, health, education, mobility, social and economic status and other factors that relate to poverty.”[[78]](#endnote-78)

Indeed, the consequences of contestations and incursions on sexuality are often borne the hardest by young people. Factors such as gender, poverty, marital status, geographical location, race, citizenship, ethnicity, caste, educational status, ability, gender expression and identity, sexual orientation, religion, amongst others, would cause even greater challenges.

The development field has been addressing sexuality related issues using several approaches which includes:

1. The protectionist and violations/violence prevention approach, which focuses on eliminating and fighting sexual violence and addressing violations.
2. The discrimination and violations on the basis of sexual orientation and gender identity which have been recognised by the Human Rights Council and the UN Secretary General.
3. The public health perspective, with its emphasis on sexually transmitted infections (STIs, including HIV and AIDS) and reproductive ill health (including unwanted pregnancies, unsafe abortion and maternal mortality and morbidity).

All of these approaches are important entry points for working on sexuality issues, especially in contexts where sexuality is controversial. They also address the very real, recurring problems of battering, abuse, sexual harassment, rape, gender discriminatory and harmful traditional practices (such as female genital mutilation and, early marriages), unwanted pregnancies, unsafe abortions, HIV, STIs, maternal deaths, obstetric fistula, reproductive cancers and so on that impact on young people’s achievement of their sexual and reproductive rights, particularly those from the Global South.

To address the above limitations, there is growing call and support for rights-affirming and more positive approaches to sexuality in recent years. Chandiramani explains:

An approach that affirms sexuality as being integral and of value to people’s lives also makes demands for human rights; just as women’s rights and reproductive rights are human rights, so must sexual rights be claimed as human rights. This is reflected in the evolving articulation of sexual rights that includes rights to be free from discrimination, coercion and violence; and rights based on positive ethical principles, such as those of bodily integrity (my body is mine), personhood (the right to make one’s own choices), equality (between and amongst men, women and transgender people) and respect for diversity (in the context of culture, provided the first three principles are not violated).”[[79]](#endnote-79)

An affirmative sexuality framework is a critical part of the protection, promotion and fulfillment of rights, and thus of reaching development goals, whether that of the International Conference on Population and Development Programme of Action, the Millennium Development Goals, or the Sustainable Development Goals that are currently being developed.

These need not be abstract but some aspects are easily translatable into key actions on sexual rights such as:

1. The enforcement of a legal age of marriage;
2. Reducing and ending child marriages and forced marriages;
3. Reducing and ending female circumcision and female genital mutilation/ cutting;
4. Reducing and ending sexual violence including marital rape and sexual harassment;
5. The end of discrimination against those of diverse sexual orientation and identity.

**B. Families: Crucial yet Contested**

In much of the data and evidence gathered above, there needs to be a more nuanced understanding of the concept of ‘families.’ On the one hand, the language of the ‘different forms of family’ have been around since ICPD.

However, still, the ‘family’ as a unit has been traditionally viewed and approached from a heteronormative, class-informed lens that has consistently ignored the many iterations and formations of family units across the world. ‘Families’ as a concept has evolved, and this must be reflected in global forums, and on down to the community level.

‘Families’ and the construction of family identity by young people is a complex space that is inherently linked to their identities and the spaces they occupy. Young migrant workers, for example, build non-linear families that they rely on for support and care. Young LGBTQIs form non-heterosexual families that may or may not be legally or culturally recognized or acknowleged.[[80]](#endnote-80) Even within heterosexual spaces, common law marriages or live-in relationships are challenging the concept of family that has traditionally been linked to ‘marriage’ or ‘biology’.

Additionally, there needs to be further interrogation of the concept of the heteronormative family as the ‘ideal.’ Many of the data and evidence pointing towards child marriage, forced marriage, female circumcision and female genital mutilation, early child-bearing and resulting mortalities and morbidities are all perpetuated within this supposedly ‘safe’ space of the ‘ideal’ family. For real and meaningful change to take place policies and programmes must not only recognise and affirm these myriad forms of families to be effective but also ensure that the traditional, heteronormative family does not become the blind-spot when addressing young people’s sexuality and sexual and reproductive health and rights.

**C. Rights: Affirmative, Protective, Preventive Rights include Reproductive and Sexual Rights**

Sexual and reproductive rights go hand-in-hand with sexual and reproductive health services, activities and events. It is essential to recognize that the elements of sexuality, rights and health cannot continue to be compartmentalized especially with regards to making policies and implementing programmes on sexual and reproductive health.

There is a need to reinforce reproductive rights as committed to by governments in 1994 in Cairo i.e. the rights of individuals and couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so with all corresponding policy and programme frameworks with universal access to contraception and family-planning and a choice of methods including emergency contraception as well as access to safe abortion services.

A need to broaden acceptance of sexual rights and its key components such as respect for bodily integrity, choice of partner, consensual sexual relations, consensual marriage, access to comprehensive sexuality education is essential to making future progress with development indicators as shown above.

The ‘rights’ of young people, especially to be independent, participate and make decisions, are also seen very much to be something that threatens the security and/or authority of families and governments, rather than something to be affirmed and realised and enjoyed. Affirming and underscoring young peoples’ rights—especially their SRHR—and how it is intricately linked to concepts of citizenship and the body is central to a discussion on young people. Including communities and families into right-based discourse and approaches relating to young people has had some success.

For programmes to have strong relevance and impact, acknowledging and understanding the nuances and impacts of gender is imperative.[[81]](#endnote-81)

Understanding that young women, for example, are particularly vulnerable and face many burdens and challenges with respect to their sexual and reproductive rights, shifts how programmes and activities are set up. In many countries, for example, child marriage is widespread, and identifying and providing services and information to young married women may be extremely difficult.

Sexual and gender-based violence (SGBV) must be addressed, given its drastic implications on young women’s health and lives. SGBV is not just about physical manifestations of violence, but cultural and structural as well. Including an analysis of unwanted pregnancies, forced or coerced abortions, sex-selection and male preference, access to nutrition, access to livelihoods and employment, safe environments, and economic dependence are all integral to comprehensive SGBV interventions. This includes ensuring that young men and boys play active roles in understanding and safeguarding their own sexual and reproductive health, and that they have safe spaces to question traditionally held notions of ‘manliness’ and ‘machismo’ and build alternative visions allows for the rejection of existing gender norms that are linked to cycles of power and violence.

LGBTIQ youth are largely overlooked during the design and implementation of programmes and activities, with few initiatives that support their sexual and reproductive health and rights. Given the significant stigma, myths and discrimination that still exist, access by young LGBTIQ persons to their rights and health care is precarious. In addition, their lives are often difficult with their communities, families, and friends often rejecting them. In some cases they are forced to conform to a gender binary, or are raped and forcibly married to ‘correct’ their behaviour. To ignore the immediate need to ensure that there are safe spaces for young LGBTIQ people is to overlook a crucial dimension of sexual and reproductive health and rights. Interventions that affirm the sexualities, gender identities and expressions, the rights and integrities of young LGBTIQ persons are critical.

**V. Way Forward: Suggestions for the New Development Framework**

This is an exciting time and place to be in. On the one hand, we have the largest ever number of young people in the world. On the other, the call for social justice has never been stronger across the world. In such times of seismic changes, we have the opportunity to transform power relations and to create a more equal, just and equitable world. For this to materialise, we need to take bold and concrete steps, and look at addressing issues of inequality and inequity as basic building blocks of development work.

The new development framework must take into consideration not only development outcomes but also rights outcomes.

**Specific recommendations from this paper with regards to young people, sexuality, families, rights and well-being**

For Donors, UN agencies and international organisations:

1. Given that data on the sexual and reproductive behaviour and access to SRH services of adolescents and young people is limited across global south countries, it is important to allocate funding and support for ethical and gender-sensitive research to provide evidence for policy making and programming related to SRHR of adolescents and young people. Data should be disaggregated according to age, sex and other socio economic indicators.

2. Ensure that accountability mechanisms are in place and adhere to the highest standards of transparency in order to monitor progress in achieving SRHR, social equality and equity, and acheiving universal access to sexual and reprodutive health.

3. Unequivocally endorse, sustain and scale up resources and official development aid (ODA) for the implementation of comprehensive SRHR interventions for adolescents and young people in the Global South regions.

4. Ensure universal access to quality education and eliminate gender disparities in both primary and secondary education.

5. Provide universal acess to comprehensive sexuality education and youth-friendly sexual and reproductive health services.

6. Address the unmet need for contraception among adolescent and young people through the provision of contraceptive information, as well provide access to range of contraceptive methods. Make all efforts to substantially reduce the number of adolescent pregnancies.

7. Provide access to safe abortion information and services and remove barriers such as gestational limits, parental and spousal consent, mandatory waiting periods and counseling.

8. Put mechanisms in place to eliminate all forms of harmful practices such as child marriages, FGM, Honour Killing impacting adolescents and young girls.

9. Advocate for ensuring universal access to youth friendly SRH services and CSE in the Secretary General’s Report and other outcome documents in the lead-up to ICPD+20.

10. Review, amend and implement laws, policies and programmes to address the needs and realities of adolescents, young people and LGBTIQ persons and at all times uphold the principles of human rights , gender equality, and equity and push for progressive rights based SRHR laws and policies.

11. Ensure the capacity enhancement of young people and civil society to effectively engage with governments and participate in the ICPD Beyond 2014 processes at country, regional level and global level; Young people’s SRHR issues are genuinely and cross-sectionally integrated across all UNFPA-proposed thematic meetings and regional meetings in the lead-up to the ICPD+20 review processess.

12. Address the vulnerabilities of women and young people due to migration, climate change, disasters, conflict and displacement, and adopt concrete measures to mitigate their impact.

**To Civil Society Organizations:**

1. Advocate to Governments to ensure adolescents and young people’s increased access towards sexual and reproductive health information and services, commodities including HIV Testing and Counselling, medical male circumcision, contraceptives, Anti-Retroviral Therapy and maternal health care.

2. Prioritize advocacy and education on reform of laws and policies on traditional and cultural practices and norms that threaten the sexual and reproductive health and rights of young people including female genital mutilation/cutting, traditional sexual initiation rites, child-marriage, gender- based violence and all other forms of sexual exploitation.

3. Create spaces where civil societies can engage meaningfully, and share existing platforms with young women and girls, as these are influential in shaping the post 2015 development framework. Their participation should be part of a whole, comprised of multi-layered partnership building with other actors in the movement.

4. Actively engage in monitoring governments in their international commitments to SRH and hold them accountable

5. Monitor national budgets to ensure that the appropriate funds are allocated for SRH services of young people and adolescents.

**Specific recommendation for the new development framework:**

**The new development framework needs to recognise the unfinished agenda with regards to sexual and reproductive health and sexual and reproductive rights and ensure that this is a key development issue to be prioritised by governments, donors and UN agencies post-2105.**

**VI. ANNEX: DEFINITIONS**

**Children and Adolescents:** The United Nations defines children as persons between the age group of 0-18 years old, while the World Health Organisation defines adolescents as persons between 10-19 years of age. There are about 1.2 billion adolescents worldwide and one in every five people in the world is an adolescent.[[82]](#endnote-82)

**Young people and Youth:** The United Nations defines youth as persons between the ages of 15 and 24, and young people between the ages of 10 and 24 years. Approximately 18% of the global population is between the age of 15-24 years, which is nearly 1.2 billion youth.[[83]](#endnote-83)

**Sex:[[84]](#endnote-84)**the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as some individuals possess both, they tend to differentiate humans. In general, in many languages, the term ‘sex’ is used to mean ‘sexual activity’, but the above definition is preferred for technical purposes in the context of discussions of sexuality and sexual health.(WHO, Draft Working Definition, October 2002)

**Sexuality:** a central aspect of being human throughout life, which encompasses sex, gender identity and role, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.(WHO, Draft Working Definition, October 2002)

**Affirmative framework on sexuality:**views sexuality positively, as a part of life that has the potential to offer excitement, pleasure, comfort, intimacy and all the joys that sexuality can offer. Sexuality has a dark side as well, and this approach also works towards preventing and addressing discrimination and violence that are the reality of many people’s sexual lives (e.g., people who do not conform to gender and sexual norms, rape survivors, sex workers). An approach that affirms sexuality as being integral and of value to people’s lives also makes demands for human rights; just as women’s rights and reproductive rights are human rights, so must sexual rights be claimed as human rights. This is reflected in theevolving articulation of sexual rights that includes rights to be free from discrimination, coercion and violence; and rights based on positive ethical principles, such as those of bodily integrity (my body is mine), personhood (the right to make one’s own choices), equality (between and amongst men, women and transgender people) and respect for diversity (in the context of culture, provided the first three principles are not violated).”[[85]](#endnote-85)

An affirmative framework uses the principle of consent rather than procreation or marriage to determine what is acceptable sexual behaviour. Consent, in simple terms, means that a person has willingly, of her/his own free choice, agreed to participate in an activity, with adequate knowledge [and understanding] of its possible consequences. It also recognises that people bring their own meanings to different sexual acts—that is to say, what for one may be highly erotic, for another might be utterly disgusting.[[86]](#endnote-86),[[87]](#endnote-87) This means that a judgemental attitude towards people’s gender and sexual expressions that are practised consensually is also a form of violence in and of itself.[[88]](#endnote-88)

**Sexual health:** a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.(WHO, Draft Working Definition, October 2002)

**Sexual rights:** human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

• the highest attainable standard of sexual health, including access to sexual and reproductive health-care services;

• seek, receive and impart information related to sexuality;

• education on sexuality;

• respect for bodily integrity;

• choose their partner;

• decide to be sexually active or not;

• consensual sexual relations;

• consensual marriage;

• decide whether or not, and when, to havechildren; and

• pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others. (WHO, Draft Working Definition, October 2002)

**Reproductive Rights:**Embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (UN Programme of Action adopted at the [International Conference on Population and Development, Cairo, 5-13 September 1994,](http://www.un.org/popin/icpd/conference/offeng/poa.html) Para 7.3).

**Reproductive health:**A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (UN Programme of Action adopted at the International Conference on Population and Development,Cairo, 5-13 September 1994, Para 7.2a).

**ENDNOTES:**(Kindly note that the citations will be cleaned upwhen we finalise this.)

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10. Growing up global: The Changing Transitions to Adulthood in Developing Countries (National Research Council, 2005). [↑](#endnote-ref-10)
11. These factsheets, developed by ARROW in partnership with ASTRA, EIPR, LACWHN and the World YWCA, will be available for distribution at the Global Youth Forum. [↑](#endnote-ref-11)
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