SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND THE SUSTAINABLE DEVELOPMENT GOALS

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Building back and advancing the full implementation of the 2030 Agenda

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ABOUT FAMILY PLANNING NSW

Family Planning NSW is one of Australia's leading providers of sexual and reproductive health services. Our mission is to enhance the sexual and reproductive health and rights of our communities by supporting all people to have control over and decide freely on all matters related to their sexual and reproductive health throughout their life. Since 1926 we have provided independent, not for profit clinical services and health information to communities. Our work is underpinned by evidence and a strong commitment to sexual and reproductive health and rights.

We operate fixed and outreach clinics in metropolitan, regional, rural, and remote New South Wales (NSW) and are experts in contraception, comprehensive sexuality education, pregnancy options, sexually transmissible infections (STIs), common gynaecological problems including menstrual disorders, cervical cancer screening, breast awareness and women's and men's sexuality and sexual function.

As a registered training provider, we provide education and training activities for clinicians, disability workers, teachers, parents and carers, and other health education and welfare professionals. Our education services build the capacity of health, education, and community professionals to address the sexual and reproductive health needs of their communities and region.

Through our Research Centre, we partner with universities and other research organisations to grow the body of knowledge about sexual and reproductive health. We focus on translating research findings into clinical practice and teaching and providing guidance on best practice sexual and reproductive health programmes and services.

Internationally, we work in the Pacific to improve access to comprehensive sexual and reproductive health information and services. We collaborate with other family planning and health organisations in-country and promote a rights-based approach for all people to achieve sexual and reproductive health and wellbeing. We work closely with governments in the region to support the development and implementation of policy in sexual and reproductive health.

We are accredited by the Department of Foreign Affairs and Trade to conduct development assistance in the Pacific and work in Fiji, Kiribati, Marshall Islands, Micronesia, Papua New Guinea, Samoa, Solomon Islands, Timor Leste, Tonga, Tuvalu, and Vanuatu.

This report is focused on the work of Family Planning NSW's operations in Australia and the Pacific to help achieve the 2030 Agenda for Sustainable Development.

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ACRONYMS

AIHW	Australian Institute of Health And Welfare
ABS	Australian Bureau of Statistics
CSE	Comprehensive sexuality education
DVRS	Domestic violence routine screening
ECOSOC	Economic and Social Council
FGM/C	Female genital mutilation/cutting
FPNSW	Family Planning NSW
HLPF	High Level Political Forum for Sustainable Development
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
IUD	Intrauterine Device
LARC	Long-acting reversible contraception
LGBTIQ	Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex and Queer
MBS	Medicare Benefits Scheme
NSW	New South Wales
NCSP	National Cervical Screening Program
OCP	Oral contraceptive pill
RN	Registered Nurse
SDG	Sustainable Development Goal
STI	Sexually transmissible infection
SRHR	Sexual and Reproductive Health and Rights
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

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NOTE FROM THE CEO

Recognition of the fundamental importance of sexual and reproductive health and rights in the 2030 Agenda is critical if we are to achieve the 17 ambitious Sustainable Development Goals. The impacts of COVID-19 on health, economics, and people's lives are now evident in health and education programming and financing. As we build back from the COVID-19 pandemic, we must ensure that universal access to sexual and reproductive health and rights is prioritised, not forgotten.

This year, as part of our mandate to ensure that sexual and reproductive health and rights are recognised and advanced we are publishing our fourth Sustainable Development Goals progress report that highlights eight strategies to support the achievement of the 2030 Agenda both within Australia and the Pacific:

1. Increase access to long-acting reversible contraception (LARC)
2. Eliminate cervical cancer
3. Invest in comprehensive sexuality education (CSE)
4. Promote gender equality and end violence against women
5. Promote access to sexual and reproductive health services for vulnerable groups
6. Improve access to abortion care
7. Improve sexual and reproductive health data collection
8. Contribute to the evidence on and address the links between climate change and SRHR

Access to equitable and quality education, particularly comprehensive sexuality education, investment in national programs that challenge gender stereotypes and support gender equality, and consistent collection of national sexual and reproductive health data is needed to identify policy and programming priority areas. Without meaningful and quality data collection, it is difficult to identify greatest areas of need and allocate resources accordingly, particularly as we continue to deal with the effects of COVID on the health and education sectors.

The test of how Australia fares in meeting the 2030 Agenda will lie in the national approaches we develop to address violence against women and girls, promote gender equality as a societal norm, ensure access to comprehensive sexuality education for people across their lifespan, and engage those most vulnerable in the design and delivery of sexual and reproductive health programs and services.

Leaving no one behind is the central, transformative promise of the 2030 Agenda. We must work harder to eliminate the inequities of sexual and reproductive health outcomes within Australia, particularly for Aboriginal and Torres Strait Islander peoples, young people, people of diverse sexualities and genders, people with disability and people from culturally and linguistically diverse backgrounds. Additionally, we must continue to strengthen our partnerships with our Pacific neighbours and support their individual pursuit of the Goals.

We cannot meet the Sustainable Development Goals without realising the sexual and reproductive health and rights of all people.

Adj. Prof Ann Brassil

Chief Executive Officer
Family Planning NSW

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EXECUTIVE SUMMARY

Family Planning NSW's annual Sustainable Development Goals (SDGs) report has identified eight overarching sexual and reproductive health and rights (SRHR) strategies for Australia and the Pacific to support achievement of the SDGs.

Our 2022 report provides a situational analysis of Goals 4, 5 and 17 in Australia and the Pacific and highlights the centrality of sexual and reproductive health and rights to the achievement of the 2030 Sustainable Development Agenda. The report aligns each strategy with relevant SDGs and has a particular focus on our organisational content and key practice areas of expertise: contraception, cervical cancer, and comprehensive sexuality education. Each of these strategies includes recommendations that illustrate how to support the implementation of the SDGs.

The overarching ambition of this report is to highlight gaps and opportunities for SRHR interventions that would assist the implementation of the SDGs. This report also aims to influence domestic policy and funding that promotes awareness of how SRHR interventions can achieve the SDGs and provides a mechanism for civil society to provide structured feedback to government to ensure no one is left behind in the implementation of the SDGs.

While Australia fares well on SRHR on a national and global scale, there is still much work to be done. The eight strategies to address SRHR and support achievement of the 2030 Agenda for Sustainable Development are summarised in the following:

1. Increase access to long-acting reversible contraceptives (LARC)

Despite the evidence as to their effectiveness, use of LARC in Australia and the Pacific remains low. Increasing LARC uptake supports women and girls to decide whether or when to have children and enables them to engage in work and education by reducing unintended pregnancies.

Promotes SDGs 1, 3, 5, 8, 10, 13, 16

2. Eliminate cervical cancer

While Australia is on track to eliminate cervical cancer, participation in screening varies within vulnerable and marginalised populations. Further, cervical cancer remains a leading cause of death for women in many countries in the Pacific, preventing women from living long and healthy lives. Focus needs to remain on improving screening rates in under-screened populations in Australia and improving access to screening services in the Pacific.

Promotes SDGs 1, 3, 5, 10

3. Invest in comprehensive sexuality education (CSE)

There remains no consistent approach to CSE in Australia, and an alarming lack of CSE in the Pacific. Implementation of age-appropriate CSE promotes respectful relationships based on knowledge, consent, gender equality and better health outcomes, including lower rates of unintended pregnancy, STIs and gender-based violence.

Promotes SDGs 1, 3, 4, 5, 10, and 16

4. Promote gender equality and end violence against women

Discrimination and violence against women are common both in Australia and the Pacific. SRHR supports gender equality by the promotion of respectful relationships, empowering women to make decisions about work, education, relationships and whether or when to have children.

Promotes all SDGs as is a cross-cutting issue

5. Promote access to sexual and reproductive health services for vulnerable groups

Access to sexual and reproductive health services is important so that all community members can achieve good health outcomes. Achieving health equity requires ensuring universal healthcare access for all people, including those most disadvantaged. People who are socially or culturally marginalised may face additional challenges in accessing sexual and reproductive health services, contributing to health inequity.

Promotes SDGs 1, 3, 4, 5, 10, 11

6. Improve access to abortion care

Across Australia and the Pacific, many women face significant challenges accessing abortion care. Improving access to abortion care ensures better health outcomes, supports women and girls to decide whether or when to have children, and enables them to engage in work and education.

Promotes SDGs 3, 5, 8, 10

7. Improve sexual and reproductive health data collection

There are significant gaps in reliable data on key indicators that would improve governments' ability to identify areas of sexual and reproductive health need and to assess the effectiveness of existing strategies and policies.

Promotes SDGs 3, 16, 17

8. Contribute to the evidence on and address the links between climate change and SRHR

There are known links between climate change and SRHR, particularly around gender equality and access to family planning. Improving evidence on the links between SRHR and climate change would identify existing gaps and lead to SRHR strategies that reduce the impact of climate change.

Promotes SDGs 3, 5, 13, 16

The structure of this report

This report focuses on three of the five SDGs being reviewed at this year's High Level Political Forum on Sustainable Development. The report illustrates the ways in which sexual and reproductive health and rights strategies support achievement of these goals and provides pragmatic and detailed recommendations on how to do so.

The structure of the report should not be interpreted to mean that one strategy only supports one Goal. Just as all Goals must work together to achieve a sustainable future, so too must the identified strategies. A table linking the SDGs with these strategies, with specific recommendations, is provided at the end of this report.

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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Sexual and reproductive health and rights (SRHR) encompass all matters related to puberty, respectful relationships, sexuality, sexual health, fertility and birth. Specifically, SRHR recognises the right of all people to have control over, and make informed decisions on, matters related to their bodies, sexuality and reproduction, free from coercion, discrimination and violence.[1] In the Australian and global context, SRHR also includes the rights of people to have safe and accessible information and services for family planning and contraceptive choices and to make decisions on the number, spacing and timing of their children.

In 1994, the International Conference on Population and Development (ICPD) defined sexual and reproductive health as a state of complete physical, mental and social well-being, rather than merely the absence of illness and disease.(2) It affirmed that sexual and reproductive health is a fundamental human right, including the right to:

- reliable access to safe, effective and affordable methods of family planning
- health care and protection, including diagnosis and treatment for STIs including HIV
- health services that are comprehensive, accessible, private, confidential and respectful of dignity and comfort
- appropriate pregnancy, confinement and postnatal services
- inclusive services, regardless of gender, sexual orientation, age or disability
- education and information on sexual and reproductive health and rights
- decide freely and responsibly on the number, spacing and timing of children[2]

Since its inception, Family Planning NSW has prioritised SRHR advocacy, program development and clinical service provision. Our efforts include programs that work to eliminate preventable sexual and reproductive health differences between and within population groups in relation to contraceptive services, STIs, reproductive cancers including cervical cancer, violence against women and girls and the sexual and reproductive health needs of people across the lifespan.

This report builds on the work of the ICPD and recognises the importance of sexual and reproductive health and rights across all life stages and the interconnectedness of SRHR on poverty, nutrition, health and well-being, economic prosperity, education and the environment. Recognising the intrinsic value of SRHR and the interconnectedness of sexual and reproductive health and the social, economic and physical environment is essential to achieving the SDGs.

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THE SUSTAINABLE DEVELOPMENT GOALS

In 2015, United Nations member states agreed to the 2030 Agenda for Sustainable Development, which included 17 SDGs. The SDGs are a collection of global goals designed to be a "blueprint to achieve a better and more sustainable future for all". They address the global challenges we face, including those related to poverty, inequality, climate change, environmental degradation, peace and justice. The 17 SDGs are all interconnected with an aim to leave no one behind and have a deadline of 2030 to be achieved.

Each year, the High Level Political Forum on Sustainable Development meets in the United Nations Economic and Social Council. The Forum is a mandated space to follow up on the implementation of the 2030 Agenda, including the SDGs, and includes a space for countries to provide voluntary national reviews of their implementation of the Agenda.

Family Planning NSW has produced this 2022 report to highlight the centrality of SRHR to the achievement of the SDGs.

The report identifies eight strategies that support achievement of identified Goals being reviewed at this year's High Level Political Forum:

- Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.
- Goal 5: Achieve gender equality and empower all women and girls.
- Goal 14: Conserve and sustainably use the oceans, seas and marine resources for sustainable development.
- Goal 15: Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
- Goal 17: Strengthen the means of and implementation and revitalize the global partnership for sustainable development.

Achievement of the SDGs can only become a reality with strong support for sexual and reproductive health and rights.

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Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all

4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations

4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promote of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

Overview of goal

Access to quality education, information and sexual and reproductive health services are essential to protect the health and wellbeing of all people and are key drivers to ensure full and meaningful participation in all aspects of society, particularly for women and girls.[3-5]

SRHR promotes access to quality education and lifelong learning for all.[4] Early, unintended pregnancy, particularly for girls ages 15-19 years, limits educational opportunities for women and girls, with many often ceasing continuation of their learning.[6-10] In turn, this has significant longer term impacts on workforce participation, financial security and income generation.[6, 10]

Education is a key influencer for ensuring that women and girls are able to make informed decisions about all things related to their bodies.[4] Access to quality CSE empowers girls with essential information on SRHR. It is also a key enabler of gender equality as it informs men and boys' views on gender, their roles in health and respectful relationships and, importantly, the status of women in society.[11]

To achieve Goal 4's mission to 'ensure inclusive and equitable quality education and promote life-long learning opportunities for all' requires investment in an evidence-based national CSE curricula, investment in community-based programs for young people not engaged in formal education settings and ongoing inclusive and accessible educational opportunities for all people across the lifespan.

Comprehensive sexuality education

CSE is an age appropriate and culturally relevant approach to teaching and learning about sexuality and relationships, inclusive of the cognitive, emotional, physical, and social aspects they encompass.[12] While typically recognised as a youth-focused priority, it is essential that all people have access to evidence-based CSE material and education at all stages of life.

> *"Too many young people receive confusing and conflicting information about relationships and sex, as they make the transition from childhood to adulthood."*
>
> – UNESCO, 2018

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Ensuring access to timely, holistic, age-appropriate and evidence-based CSE promotes the wellbeing of individuals, leads to improved sexual and reproductive health outcomes, fosters gains in gender equality and promotes equitable social norms.[11, 13] Implementation of school-based CSE programs should align with evidence-based technical guidance published by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and should ensure that staff delivering this content are well-trained and supported.[12, 14]

There is long-standing concern that delivery of CSE, especially to young women and girls, encourages earlier debut of sexual activity. Evidence, however, has found that CSE has a positive impact on engagement in safer sex behaviours, such as increased condom and contraceptive use, and delayed sexual debut.[11] Additionally, evidence confirms that educational programs which explicitly address gender or power relations have a demonstrated positive impact on reducing unintended pregnancy and transmission of STIs.[11, 15]

On top of improving sexual and reproductive health outcomes, CSE has been shown to reduce violence against women, promote a gender equitable society and dispel traditional gender norms, many of which are harmful to young women and girls.[11, 15]

CSE is particularly important for people who are vulnerable and marginalised, including people with disability. Although the sexual and reproductive health needs of people with disability are similar to the general population, this community faces the additional challenge of being more vulnerable to violence, sexual assault and coercion.[11]

Status of CSE in Australia

Despite having a national school curriculum, the provision of CSE is inconsistent in Australia, resulting in many children and young people missing out on essential evidence-based foundational education.

Currently, there is only a small part of the national curriculum dedicated to sexuality education, with some components covered under the 'Health and Physical Education' unit. Despite its inclusion in the curriculum and support from young people for teaching it, schools in Australia deliver CSE (also known as relationships, sexuality and sexual health education) using a range of different strategies, with teaching content varying considerably across schools.[16]

> *"I am in Year 9, I'm sure many people in my year will be sexually active soon. However, we still haven't received any sexual education. Because of this, the chances of unsafe sex and maybe pregnancy are much higher. People, especially at my age, need to be informed properly."*
>
> Sexual Health Education in NSW: Student Needs Assessment, FPNSW, 2018

There remain a range of barriers that prevent CSE being taught in classrooms. Barriers include lack of confidence by teachers, limited political support within the education system, time constraints and a lack of support, training and resources by employer schools.[16-18]

Family Planning NSW's Sexual Health Education in NSW Student Needs Assessment found that students prioritised sexuality and relationship education as part of their learning, however, many identified significant gaps in content that has negatively impacted on their levels of satisfaction with the education received.[19] Gaps included content on gender identity, same sex attraction and sexual identity, influence of pornography and media representations of sex and sustaining healthy relationships.[19]

> *"I'm like stuck to the internet looking at research [about same sex attraction] because school doesn't teach enough, and you're really unable to talk to parents, because you know, they're just, it's just a no-go zone."*
>
> – Focus group participant (FPNSW, 2018 p.14)

A survey of NSW teachers and principals found that a lack of current and accessible resources impacts on teachers ability to deliver sexual health education to the extent that they would like to. Teachers also reported a lack of knowledge and confidence in teaching some sexual health content.[20] This is likely to be a reason why students' experiences of sexual health education in school still vary widely. Training and provision of resources has been shown to increase teacher confidence to address contemporary CSE issues, including social media and digital safety, sexting and pornography.[17]

There is significant need for consistent implementation of school-based CSE within Australia, which can be achieved through the development of a National CSE Framework, closely linked with the National Education Curriculum.

Formalised sexuality education within schools is well-placed to reach a vast majority of children and young people. However, for CSE to be successful, all people, including all young people who are disengaged from the formal education system, must have access to this essential education. CSE must be culturally safe, age-appropriate and relevant for all people, of all ages across all platforms and mediums. To truly provide equitable access, CSE must not be limited to being taught solely within schools, nor delivered only to young people.

Case Study: Opportunities for strengthening sexual health education in schools: Findings from a student needs assessment in NSW

Family Planning NSW recently conducted and published a study highlighting NSW students' views and experiences in relation to school based CSE. The study presented the findings from 1,603 Year 8-12 students and identified opportunities to strengthen school based CSE.

Findings from the study, include:

- school, parents, friends, and social media are students' primary sources of information on CSE topics, including sexual and reproductive health
- approximately one third of students reported wanting more information on topics related to relationships, reproductive health, consent and sexual decision-making, sexual harassment, abuse and bullying
- two-thirds of transgender and gender diverse students reported wanting more information on gender identity

These findings provide valuable insight about how to improve school based CSE within NSW, particularly regarding the influence of social media, parents and the internet. Students want to develop practical knowledge and skills to support their decision making in sexual health. However, there are gaps within the current curriculum and evidence-based comprehensive sexuality education is not consistently provided across all schools. Teachers play a vital role in providing accurate and trusted information to enable students to explain, contextualize and think critically about information they are exposed to via pornography and other media and support them in developing respectful, healthy and consensual relationships.

Case study: Strong Family Program

Aboriginal young people in Australia often experience poorer sexual and reproductive health outcomes than their non-Aboriginal counterparts.

To address some of the disparities, the 'Strong Family Program' was developed to deliver sexual and reproductive health education to Aboriginal communities in NSW. Alongside this long-standing program, we partnered with University of NSW (UNSW) as part of a broader research project titled 'What We Do Well' which explores the positive actions Aboriginal young people take to reduce their sexual risk and build sexual wellbeing.

Consisting of two main components, the research project applies a strengths-based framework to evaluate two existing sexual health promotion programs targeting Aboriginal young people.

A total of four community education sessions were delivered as part of our contribution to the research project, in partnership with the UNSW research team and Nepean Blue Mountains and South Western Sydney Local Health District representatives. These sessions were delivered to 12 Aboriginal and Torres Strait Islander young people who were being trained as peer interviewers and included key modules and sessions from the Strong Family Program.

Feedback from these community education sessions indicated that participants best enjoyed the sexual health education components of the peer interview training delivered by Family Planning NSW, including the topics of sexual relationships: staying healthy and solving problems and an introduction to sexual health services.

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Status of CSE in the Pacific

The provision of CSE in the Pacific is inconsistent, with definitions of CSE varying widely across the region.[21] In many countries, CSE is referred to as 'Life Skills Education' or 'Family Life Education'.[21] A summary of the core data on school-based sexuality education in Pacific countries can be found in Table 1.

Some Pacific countries integrate CSE within core subjects, such as science, biology, religious studies, and health. However, the inconsistent nature of delivery, combined with cultural influences and limited resources for curriculum development and teacher preparedness result in students not receiving essential education on all topics.

Research shows that the primary CSE topics delivered within schools across the Asia Pacific region include life skills, relationships and family life, rather than essential topics including contraception, abortion and legal frameworks, sexual identity and gender norms.[21] Very little CSE delivered in accordance with the UNESCO guidelines[12] is available in the Pacific, particularly for young Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex and Queer (LGBTIQ) people, young people with disability and young people who are disengaged from the formal education system.

Evidence shows that there is a significant need to strengthen evidence-based CSE teacher training in the Pacific to ensure teachers are well supported to deliver this in classroom settings.[21] This can be done as part of pre-service training, or as part of teacher's continuing professional development. Development of country specific teacher-training curriculum may contribute to better supporting teachers to effectively deliver CSE to their students. This should be complemented by regular in-service and refresher training to ensure teachers maintain knowledge and build on this as the body of evidence grows.[21]

> "Countries are increasingly acknowledging the importance of equipping young people with knowledge and skills to make responsible choices for their lives..."
>
> – International Technical Guidance on Sexuality Education, UNESCO, 2018

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Table 1. Summary of core data on 'in school' sexuality education by country (2019)

Pacific region	Law/policy year[1]	Mandatory at primary level[2]	Mandatory at secondary level[2]	Grade starting[3]	Teacher training[4]	Evaluated at primary level[5]	Evaluated at secondary level[5]
Fiji	P, 2016-20 P, 2014	Optional	Optional	Early Childhood Education	Yes	Yes	Yes
Kiribati	S, 2013-16 S, 2016-19 S, 2018-22	Optional	Optional	3	No	Yes	Yes
Papua New Guinea	S, 2011-20 P, 2014 P, 2014	Optional	Mandatory	3	Yes	No	Unsure
Samoa	L, P, 2019 P, 2011-16 P, 2011	Mandatory	Mandatory	1	Yes	Yes	Yes
Solomon Islands	P,S, 2005-10 P, 2010-15 S, 2016-30 P, 2017-30 S, 2016-20	Mandatory	Mandatory	1	Yes	Yes	Yes
Tonga	S, 2014-18 P,S 2019-25	No	Mandatory	9	Yes	N.A.	No
Tuvalu	S, 2016-19	Optional	Optional	1	No	N.A.	N.A.
Vanuatu	P, 2017-20 S, 2007-16	Optional	Optional	6	Yes	No	Unsure

Source: UNFPA, UNESCO, IPPF ESEAOR, 2020.(21)
1: Based on survey responses and literature review: L= Law/act; P=Policy; S=Strategy/plan
2: 'Please advise whether sexuality education is mandatory in your country'
3: 'What is the lowest grade level that sexuality education is introduced?'
4: 'Are teachers required to have training in sexuality education before teaching the subject in school?'
5: 'Has this curriculum been evaluated?'

Case Study: Family Planning NSW's CSE Program in the Pacific

Family Planning NSW is committed to providing age-appropriate, evidence-based comprehensive sexuality education (CSE) for people of all ages in the Pacific.

In partnership with the United Nations Population Fund (UNFPA), Family Planning NSW has been working with eight countries in the Pacific to improve in- and out-of-school CSE curricula, aligned with international standards.

For example, we have been working with the Kiribati Teachers College and Kiribati Ministry of Education since 2020 to review and update their upper secondary CSE curriculum and supporting master trainers to deliver CSE training as part of in-service training. This training has increased the confidence and competence of teachers to implement the CSE curriculum in Kiribati. The training has adopted a train-the-trainer model, ensuring that it is locally owned.

Outside of the classroom, we are currently working with Kiribati to develop out-of-school CSE curricula to be delivered by peer educators and reach young people, especially those who are vulnerable or do not attend formal education. The six-module package is based on international standards, using activity-based learning to ensure young people receive this critical information.

Similar packages are currently under development for Fiji, Marshall Islands, Micronesia, Samoa, Solomon Islands, Tonga, and Vanuatu.

Recommendations

We recommend that the Australian government:

1. develop a national comprehensive sexuality education curriculum that is aligned with the 2018 UNESCO technical guidelines, is well resourced and consistently delivered across Australia and includes modules for students with disability
2. continue to invest and support Ministries of Health and Education in the Pacific to develop, implement and improve the in- and out-of-school comprehensive sexuality education curriculums, including training and development for teachers and community educators
3. advocate for ongoing and continued implementation of the Transformative Agenda in regard to comprehensive sexuality education in Pacific schools and the wider community, including students with a disability

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Education and health outcomes

Participation and completion of secondary school enables young people to develop their skills and knowledge, including skills related to health literacy, which has a positive impact on improved health and wellbeing outcomes.[22]

Within Australia, there are similar rates of year 12 educational attainment (or equivalent) for both men and women. In 2017, 90% of young women and 84% of young men aged 20-24 years had completed Year 12 or equivalent qualifications[23] with more women (88%) staying in school until Year 12 compared to men (79%).[22]

Educational attainment rates in the Pacific are much lower, particularly for young women and girls. Data, where available, is limited and often not sex-disaggregated, making it difficult to determine the impacts of gender on educational attainment. Available data shows that in some Pacific countries, girls are less likely to reach the final grade of primary school and continue to secondary education. In Samoa, 92% of boys reach the final primary grade, compared to 84% of girls.[24] Similarly, in Tuvalu 54% of boys begin the last grade of primary school when compared to 49% of girls.[25]

There are strong links associated with educational attainment and health outcomes. Adults with higher levels of educational attainment, including tertiary education, have improved health outcomes and longer lifespans compared to those with lower education levels.[26,27] Additionally, comprehensive sexual and reproductive health education fosters engagement in health protective behaviours such as cervical,[28,29] breast[28,29] and colorectal cancer screening.[29]

Workforce participation: a result of increasing educational attainment

Workforce participation, ongoing employment and financial security cannot be a reality without access to education, particularly CSE, and realisation of SRHR. Factors such as unmet need for family planning, combined with traditional gender expectations and limited access to education, leave women and girls shouldering much of the responsibility for raising children and running families. Often, this results in limited or less secure employment, lower levels of education attainment and reduced individual income. The gender gap in overall workforce participation rates is a prime example of the influences of traditional gender expectations and perhaps women's access to education and in some instances, family planning.

Facilitating access to long-acting reversible contraception (LARC) enables women to engage in full and productive employment by reducing rates of unintended pregnancy.

The gender gap in overall workforce participation rates for those aged 20-74 years in Australia is 10.5%.[23] Within Australia, Aboriginal and Torres Strait Islander women face additional structural and unique challenges when joining the workforce, resulting in lower rates of workforce participation compared to Aboriginal and Torres Strait Islander men (51.5% and 65% respectively).[30] Similarly, Australian women with disability have lower rates of workforce participation when compared to men with disability (49.4% and 57.8% respectively).[31]

In Pacific countries, the traditional expectations of women and overall lower rates of women's education is demonstrated through the significantly higher gender gaps in workforce participation (Samoa: gap of 16%; and Fiji: gap of 34%).[32]

The result of girls not completing education is a lack of skills to enter the workforce. Economic independence is an enabler for both women and men to exercise control over their lives and make informed choices. At an individual level, the benefits of increasing women's workforce participation rate include additional financial security for women and their families, increased savings for retirement and the ability to contribute to a prosperous and sustained society.[33] Enabling women to work and engage meaningfully within the labour force and lowering the fertility rate, in turn allows families to invest more in their own child's health and education.[34]

Recommendations

We recommend that the Australian government:

4. invest in co-designed research that aims to identify barriers to educational attainment and develop strategies to ensure that health related education is not lost for people who do not complete Year 12
5. develop, implement, and evaluate social marketing campaigns that aim to increase awareness of and engagement with cervical screening in Australia
6. realise the link between investing in health and education, and workforce participation

Goal 5: Achieve gender equality and empower all women and girls

5.1 End all forms of discrimination against all women and girls everywhere

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

5.5 Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of the review conferences

Gender equality is recognised in the 2030 Agenda for Sustainable Development as a cross cutting theme, and for this reason SRHR must be thought of in the same way. Many studies have demonstrated the causal link between SRHR and gender equality, primarily achieved through the empowerment of women and girls.[35-37] At its core, SRHR empowers all people, particularly women and girls, to make decisions about their bodies, work, education and relationships.[4]

The achievement of gender equality should not be thought of as a 'women's issue' but, instead, should drive investment in women and girls, foster promotion of respectful relationships for all based on consent, and provide women and girls with the same opportunities as men and boys.

Gender equality is not experienced equally, nor in the same way, by all women and men. Intersections of identity, including sexuality, disability, race, geography and culture, can influence an individual's experience, resulting in differing levels of gender inequality. Lesbian, bisexual and trans women can experience multiple forms of discrimination and violence because of the intersection of their LGBTIQ status and gender.

More needs to be done to tackle harmful gender stereotypes. Countering gender-based violence and harmful gender norms requires a systematic and partnership-based approach that works with the whole community to address gender stereotypes. All people, no matter their sexual orientation or gender identity, have the right to access to sexual and reproductive health and to be free from violence and discrimination, enabling them to have full and effective participation in civic life.

Ending family, domestic, and sexual violence

Sexual and reproductive health is a fundamental human right as enshrined in multiple international outcomes, including the Beijing Declaration and Platform for Action and the International Conference on Population and Development.[38,39] These pledges mandate that women and girls have the right to access reliable, safe and effective methods of family planning, health care and protection, education and information relating to their sexual and reproductive health and rights.

Sexual and reproductive health and rights are intrinsically linked with a range of human rights and the impact of reproductive coercion and domestic and family violence, constitutes a violation of those rights. Realisation of these rights includes women being treated as equals and being allowed to make choices about their reproductive health, such as planning if and when they become pregnant.

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What is family, domestic and sexual violence?

- **Family violence:** violence that occurs between family members, including intimate partners
- **Domestic violence:** a type of family violence that occurs specifically between current or former intimate partners
- **Sexual violence:** sexual behaviours carried out against a person's will, without their consent. This can occur in the context of family or domestic violence, or by other people known or unknown to the victims

Source: AIHW. Family, domestic, and sexual violence. Canberra: 2021.

Access to sexual and reproductive health services is an essential aspect of healthcare for people experiencing family, domestic and sexual violence.

There are known links between domestic violence and sexual and reproductive ill-health. Women experiencing domestic violence, including reproductive coercion, require access to comprehensive sexual and reproductive health services including contraceptive methods that can be used discreetly without a partner's knowledge, including an intrauterine device (IUD), contraceptive injection and safe abortion care.

Access to timely and affordable emergency contraception is essential for women experiencing domestic and/or sexual violence. Emergency contraception available in Australia includes emergency contraceptive pills, available without a prescription at pharmacies, and the copper IUD. To reduce the need for emergency contraception, increased access to LARC, such as implants and IUDs, can reduce rates of unintended pregnancy and abortion.

Family, domestic, and sexual violence in Australia

On average, Australian women experience family, domestic and sexual violence at significantly higher rates than men.[40] The latest data from the Australian Bureau of Statistics shows concerning figures:

Women's exposure to family, domestic and sexual violence differs with regard to demographic and geographic factors, with women from rural and remote areas experiencing higher rates of family, domestic and sexual violence than women living in metropolitan areas.[41] Additionally, women aged between 18-34 years are more likely to experience intimate partner (4% compared to 1.5%) and/or sexual violence than their older counterparts (4.3% compared to 0.7%).[40]

Some groups of Australian women are at greater risk of experiencing family, domestic and sexual violence for a multitude of reasons. In particular the following are at increased risk: women in Aboriginal and Torres Strait Islander communities; young women; pregnant women; women with disability; women experiencing financial hardships'; people who identify as gender diverse; and, people who experienced abuse or witnessed domestic violence as children.[42] There are many reasons for the heightened risk and it is important that any policy response to family, domestic and sexual violence has specific interventions for these populations. For example, preventing and addressing family, domestic and sexual violence in Aboriginal and Torres Strait Islander communities includes the need for services that are designed by and for Aboriginal women.

The negative physical, social, and economic costs of violence against women are high. Domestic, family and sexual violence was the leading contributor of burden of disease among women aged 25-44 years when compared to other risk factors.[42] Additionally, family, domestic and sexual violence is one of the leading causes of homelessness for Australian women and children.[42]

Evidence suggests that women who are experiencing or have experienced violence make higher use of health-care services. Given that most women will access sexual and reproductive healthcare services during their life, these services in particular offer opportunities for identification and provision of a supportive response for women who have experienced violence.[43]

Reproductive coercion in the Australian context

Reproductive coercion refers to patterns of controlling and manipulative behaviours used by an individual to purposefully interfere with another's reproductive health and decision-making.[44] Impacts of reproductive coercion may include: unintended pregnancy and rapid repeat pregnancies; forced abortion; forced continuation of pregnancy; transmission of STIs; and, anxiety, depression and distress relating to pregnancy.[44-51]

There is no available national data on rates of reproductive coercion in Australia, however, some studies have utilised convenience sampling to inform estimates. A Family Planning NSW study estimates lifetime prevalence of reproductive coercion and abuse at 2.3%,[52] while a Queensland study provided an estimate of 5.9%.[53] Advocates and researchers highlight the need for Australian population-based research on reproductive coercion to identify people who are at greatest risk, as well as the direct and indirect impacts of these behaviours.[44]

> "Clinicians managing sexual and reproductive health consultations have a vital role to play in asking about and responding to reproductive coercion and abuse."
>
> – Carter et al., 2021

Addressing and responding to reproductive coercion is not part of current clinical practice in Australia. In the absence of robust national data, and guidance on best practice identification of reproductive coercion, sensitive clinical enquiry and individual case-finding is recommended.[44] Clinicians must be provided with training, resources and information about how to sensitively approach the topic of reproductive coercion with clients, as well as how to best respond to disclosures.

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Snapshot: Outcomes of routine screening for reproductive coercion in a family planning service

Family Planning NSW first introduced routine domestic violence routine screening in 2012 and added routine screening for reproductive coercion in 2018. To better understand the circumstances of reproductive coercion among women accessing family planning services, Family Planning NSW conducted a cross-sectional study to review the outcomes of screening.

Of the 7,943 women eligible for reproductive coercion screening, 5,497 were screened (69%) and 127 women (2.3%) disclosed experiences of reproductive coercion. Reproductive coercion was more likely to be disclosed among clients who were unemployed, had a disability or had more than one visit to a family planning service within one year.

Sexual and reproductive health clinicians are well placed to conduct reproductive coercion screening; however, they must have adequate training and access to resources to implement screening and respond to women who disclose reproductive coercion.

Family, domestic, and sexual violence in the Pacific

Family, domestic, and sexual violence (more commonly known as gender-based or intimate partner violence in the Pacific) is a significant public health issue. In 2018, up to 68% of women in Pacific Islands Countries reported having experienced gender-based violence[54], with country specific data found in the table below.

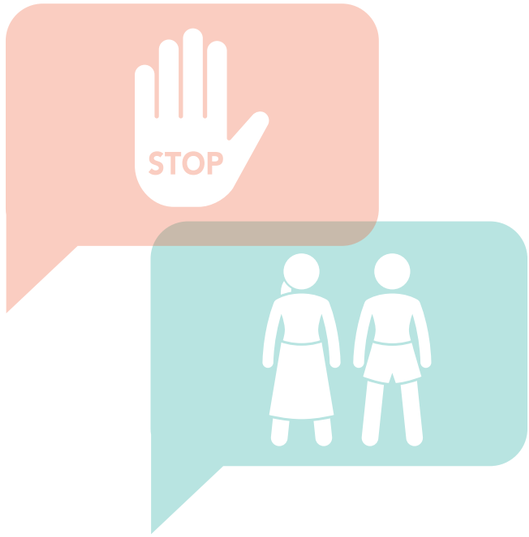
Table 2. Country prevalence estimates of intimate partner violence, 2018

Country	Lifetime experience of intimate partner violence – ever married/partnered women aged 15-49 years (%)	Past 12 months experience of intimate partner violence – ever married/partnered women aged 15-49 years (%)
Australia	23	2
Fiji	52	23
Kiribati	53	25
Micronesia	35	21
Papua New Guinea	51	31
Samoa	40	18
Solomon Islands	50	28
Timor-Leste	38	28
Tonga	37	17
Tuvalu	39	20
Vanuatu	47	29

Source: WHO.[55]

Women and girls from countries in the Pacific experience significantly higher rates of gender-based violence than the global average.[55] Additionally, evidence shows that women and girls with disability are up to three times more likely to experience physical and/or sexual violence than those without disability.[56]

Addressing family, domestic, and sexual violence requires a comprehensive and integrated approach that is grounded in human rights. In regard to prevention, education plays an important role in changing social norms that foster gender inequity and increase women's status in society.[57] It is essential that gender-based violence is not solely thought of as a women's issue, but that men and boys are engaged in education and other prevention strategies. Countries must also ensure they have strong laws that criminalise gender-based violence and health systems that are well positioned to support those who experience it.



Filling the data gaps

Although there is increasing research on family, domestic and sexual violence, many gaps remain. Specifically, there is no, or limited, data on the rates of domestic violence among at-risk population groups, making it difficult to target evidence-based supports to these people, both in Australia and the Pacific.

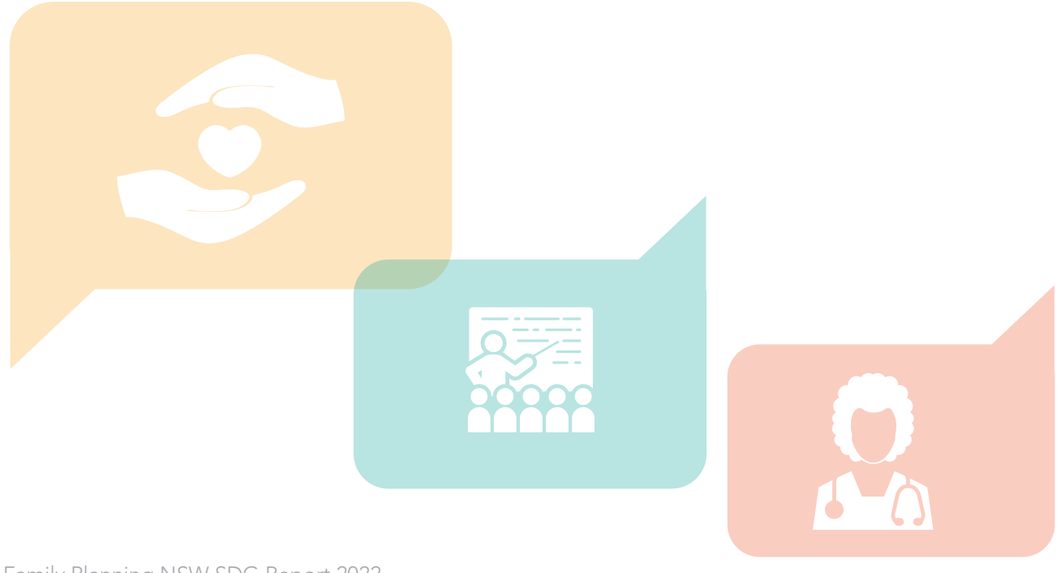
To support data collection, domestic violence routine screening should form part of clinical services, including sexual and reproductive health services where appropriate. Additionally, the development of a common and consistent set of definitions for family, domestic and sexual violence would assist to improve identification and measurement across data sets.

Case study: Policy Interventions in the Pacific

There is a lack of safe spaces in the Pacific for women to report or have open conversations about incidents of gender-based or intimate partner violence. One space that could provide that role is sexual and reproductive health clinics. Many clinicians, however, are not trained to counsel clients about gender-based violence disclosures.

Family Planning NSW has been working with UNFPA across 6 countries in the Pacific to upskill clinicians to provide comprehensive sexual and reproductive health services. As part of this approach, training on gender-based violence and on trauma informed care is part of the package. These topics are designed to provide clinicians with the skills to sensitively support disclosures of incidences of gender-based violence, and to support clinicians to reflect on how disclosures affect them.

Surveys conducted at the end of the training showed that clinicians now felt empowered to have these conversations with clients. While this training was an important first step, more is needed to ensure that a clinical culture of support is cultivated, and nurses and doctors in the Pacific have the tools and resources to create a safe space for disclosures.



Recommendations

We recommend that the Australian government:

7. develop and disseminate a consumer-focused campaign that aims to increase awareness of LARC
8. increase Medicare Benefits Scheme (MBS) rebates to doctors for insertion and removal of LARC
9. expand the current MBS to include registered nurses for insertion and removal of LARCs
10. provide funding to increase use of LARC in regional, remote and rural areas and priority populations
11. remain a leader on gender equality by investing in the education of women and girls, and implement public policy solutions that target gender equality and education outcomes
12. upskill General Practitioners and sexual and reproductive health clinicians in best practice to sensitively address and respond to reproductive coercion within clinical settings
13. implement a consistent, national approach to the collection of data on family domestic and sexual violence, and reproductive coercion routine data collection and reporting, and regular, population-based survey research
14. develop a consistent set of nationally recognised definitions for family, domestic and sexual violence
15. use the Australian Development budget to prioritise interventions that promote gender equality and the empowerment of women and girls, through education and workforce opportunities, in the Pacific

Eliminating harmful practices

Early, child and forced marriage

Early, child and forced marriage is a violation of children's rights and a direct child protection concern. Driven by gender inequality, early, child and forced marriage is a manifestation of deeply entrenched societal structures and stereotypes often related to sexuality and gender. Early, child and forced marriage is more prevalent in countries where gender inequality and discrimination against women and girls is deeply entrenched.

Over 650 million girls are married before 18 years of age globally.[58] If progress does not accelerate, 1.2 billion women alive in 2050 will have been a child bride.[59] Governments need to be accountable and responsible in protecting children; particularly those who have signed up to the Convention on the Rights of the Child.

While there is very little information on the prevalence of early, child and forced marriage in Australia, and no publicly available government data on early, child and forced marriage in Australia, the National Children's and Youth Law Centre estimates 250 cases have occurred since 2012.[60] Experts assert that this number is likely underreported.[60]

Some detrimental effects of early, child and forced marriage and early union include complications during childbirth which may result in death, STIs such as HIV and sexual and gender-based violence.[61] In most instances, married girls are often forced to leave school to shoulder household responsibilities, which robs them of their rights to education.[61]

Ending early, child and forced marriage is critical in achieving eight of the 17 SDGs including those related to poverty, health, education, nutrition, food security, inequality and economic growth. Ending early, child and forced marriage requires work across all sectors and at all levels.

Most policy measures that aim to address early, child and forced marriage focus on prohibition, as opposed to prevention. While prohibition is essential given the significant human rights implications of early, child and forced marriage, prevention is critical. Early, child and forced marriage can be prevented through the delivery of evidence-based holistic CSE that provides young girls and their families with skills and information about their rights regarding relationships and health. Timely and universal support must be provided to all families, teachers, health professionals and community workers to facilitate the provision of CSE and identify children at risk before early intervention is required.[60]

A child and adolescents' right to access sexuality education is recognised as a basic human right in both the annual report of Special Rapporteur on the right to education to the UN General Assembly in 2010 and General Comment No. 4 of the Committee on the Rights of the Child.

Additionally, access to quality education, including CSE that is inclusive of sustainable development, gender equality and human rights, is enshrined within the 2030 Agenda for Sustainable Development. It is essential that CSE is holistic and encompasses learning around gender equality, informed consent and respectful relationships, gender-based and sexual violence and human rights.[11]

Female genital mutilation/cutting

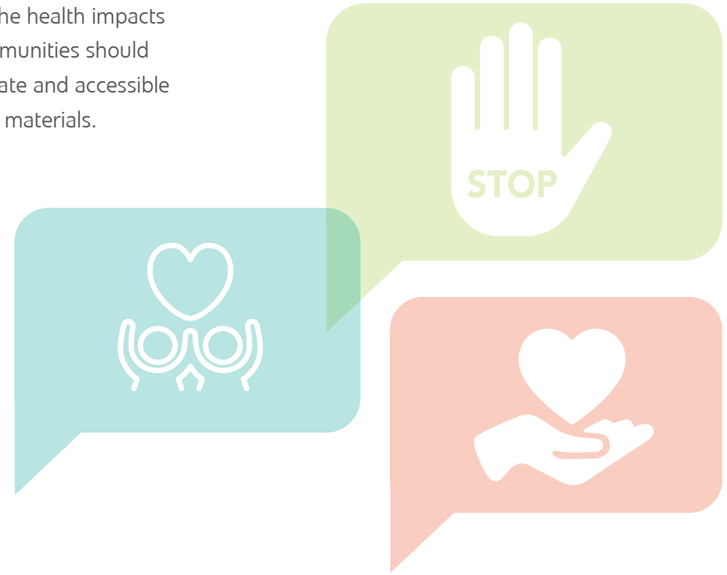
Female genital mutilation/cutting (FGM/C) is an illegal cultural practice that occurs in more than 40 countries around the world, including Australia, with an estimated 200 million women and girls having experienced the practice.[62] FGM/C describes procedures that involve partial or total removal and/or alterations of the external female genitalia, or injury to female genital organs for non-medical reasons, and is typically performed on girls aged 0-18 years.[62,63] FGM/C has significant physical and mental health effects including menstrual problems, haemorrhage, urination problems, psychological trauma and death.[62,64-67]

Information on the prevalence of FGM/C in Australia is limited, however, the Australian Institute of Health and Welfare estimate over 53,000 women and girls living in Australia may have experienced FGM/C.[62] There is significant need to invest and encourage the collection and reporting of FM/C data in primary, secondary and tertiary healthcare settings. Embedding FGM/C data collection into existing methods, such as within the National Perinatal Data Collection, is recommended.[62,68]

Culturally and linguistically diverse communities from FGM/C practicing countries would benefit from being provided with education on the legal status of FGM/C in Australia and the health impacts associated with the practice. Communities should have access to culturally appropriate and accessible resources, education and support materials.

One such support method is the use of bilingual community educators, who have been pivotal in supporting and educating newly arrived families about Australian legalisation and adverse health effects of the practice on women and young girls.[69] Bilingual community educators are well placed to facilitate access to health and support services for women and girls living with FGM/C.

Further, clinicians and specialist sexual and reproductive health professionals need training on how to provide culturally safe services in response to clinical presentations of FGM/C. Clinicians also need access to education and resources to help them identify children and young people with FGM/C (or at risk of FGM/C), to enable appropriate referral, reporting and support.[70]



Case Study: Female Genital Mutilation/Cutting in Australia

Currently, there are no published estimates of the prevalence of FGM/C within Australia. This case study provides an overview of findings from the Family Planning NSW Feasibility Study for a National Female Genital Mutilation Data Collection report. The study includes data collection from a literature review, national online survey, in-depth interviews and consultations with relevant FGM/C experts around Australia, review of existing FGM/C data collection in Australia and the trial of FGM/C data collection at Family Planning NSW clinics. Based on these findings, recommendations for proposed data collection, including how and where data should be collected, are provided.

The literature shows that while FGM/C continues to gain more public attention, increased funding is needed to facilitate best practice within this area of health care. The establishment of an FGM/C data collection system is essential in identifying the gaps in service provision and to gain a clearer insight into FGM/C within the Australian context.

Online survey results detailed that while FGM/C data is currently collected by health professionals in some locations, the collection of data is ad hoc and is often dependent on an individual health professional. The results highlight the need for continuing professional development for health professionals on effective FGM/C communication strategies to ensure accurate data collection. Survey participants detailed the need for appropriate referral pathways to support health impacts of FGM/C as well as the establishment of a robust network of expert health professionals, appropriately skilled in the particularities of FGM/C, that is easily accessible and adequately publicised.

To support women affected by, or are at risk of, FGM/C, funding bodies should support the mandatory collection of FGM/C data collection and data reporting to state and territory health departments.

In-depth interviews with relevant FGM/C experts around Australia also supported the online survey findings and pointed to the need for consistent health professional training and capacity strengthening to establish and maintain robust data collection system, particularly in eliciting information on sensitive topics like FGM/C. In-depth interviews underscored the importance of a robust national FGM/C data collection system as an important step in gaining a clearer picture of the extent and impacts of FGM/C in Australia as well as ensuring adequate and ongoing funding.

While some hospitals are currently collecting information on FGM/C in their antenatal and obstetrics databases, it is not a mandatory requirement. Review of existing practices indicate that with an established protocol, nationally collected FGM/C data is feasible in Australia. The FGM/C data collection trial conducted at Family Planning NSW demonstrated that an FGM/C data collection is feasible in primary and secondary health care, if appropriate training is provided. Additionally, increased community awareness that Family Planning NSW staff are educated about FGM/C may lead to increased attendance and/or disclosure by women affected by FGM/C at our clinic sites.

Recommendations

We recommend that the Australian government:

1. develop a national comprehensive sexuality education curriculum that is aligned with the 2018 UNESCO technical guidelines, is well resourced and consistently delivered across Australia and includes modules for students with disability

16. fund a national program that supports the employment of bilingual community educators specifically trained in sexual and reproductive health and rights, located in community health centres

17. invest in training, information and resources for sexual and reproductive health clinicians that addresses clinical presentations of FGM/C and appropriate responses

Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development

17.18 By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely, and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

17.19 By 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries

Overview of goal

Strong, revitalised and committed global partnerships, along with significant improvements in SRHR data, are needed for Australia and the Pacific to meet the ambition of the 2030 Agenda. To best direct sustainable development and SRHR efforts, comprehensive data sets are needed to inform implementation and evaluation. Improved data collection mechanisms, and therefore data sets, will not only contribute to improving the health of populations, but also contribute to monitoring progress towards achievement of the SDGs.

Improve sexual and reproductive health data

The SDGs, particularly Goal 17 (targets 17.18 and 17.19), highlight the need for enhanced capacity-building in developing countries to increase the availability of high-quality, timely and reliable data. While there has been some work towards improving data collection in Australia and the Pacific, data and research on SRHR remains poor, and sometimes absent.

Australia faces significant gaps in reliable data on key SRHR indicators that would improve government's ability to address identified areas of health need and assess the effectiveness of existing strategies and policies.

There is currently no national data collection in Australia on contraceptive use, pregnancy intention or induced abortion, and derived data on the number of and indications for induced abortions is limited.

Gathering SRHR data informs health policy, practice and programming, allowing services to effectively target groups in need. Alarmingly, there is little to no available disaggregated data, which often means marginalised and vulnerable communities are left out of policy and health strategy development and implementation.

For example, while Australia fares well on the global scale regarding cervical screening and mortality, there is no national data available on the uptake of cervical screening by women with disability, or by people from culturally and linguistically diverse backgrounds. Consequently, anecdotal evidence demonstrates that these population groups have lower screening participation rates and may be at increased risk of cervical cancer. It is essential we have this data to ensure that the SRHR needs of these communities are met.

Snapshot: Cervical Cancer in Australia

In 2018-19, the Australian Institute of Health and Welfare (AIHW) reported that 3.1 million people aged 25-74 years participated in the National Cervical Screening Program (NCSP), an estimated participation rate of 46% eligible women.[71, (1)] In 2017, 839 Australian women were diagnosed with cervical cancer and 229 women died from the disease in 2019.[72]

Despite a comprehensive national approach to cervical screening, cervical cancer remains disproportionately high for some vulnerable and marginalised populations in Australia. The morbidity rate of cervical cancer among Aboriginal and Torres Strait Islander women is more than two times the rate of non-Indigenous women, and the mortality rate 3.8 times that of non-Indigenous Australians.[73]

Similarly, women living in lower socioeconomic or rural, regional, and remote areas typically have lower rates of cervical screening, and on average have a higher incidence of cervical cancer when compared to metropolitan areas. There is a clear trend of cervical cancer incidence with increasing remoteness and increasing socioeconomic disadvantage.[74]

(1) *Participation in the NCSP cannot be accurately reported due to the recent implementation of the new program. Accurate participation rates are expected after five years of program implementation.*

Snapshot: Cervical Cancer in the Pacific

Cervical cancer remains a leading cause of illness and death for women in many countries in the Pacific. The burden of cervical cancer in the Pacific is extensive with age standardised incidence rates ranging from 8.2 to 50.7 and age standardised mortality rates from 2.7-23.9 per 100,000 women per year.[75]

Despite an abundance of evidence that regular cervical screening saves women's lives, prevents illness and promotes a prosperous society,[76] routine screening in the Pacific is scarce.[77]

Cervical cancer mortality and incidence, by country

	New cases			Deaths		
Country	Number	Rank (by number of cases)	Rate (%)	Number	Rank (by number of deaths)	Rate (%)
Australia	920	23	0.46	327	21	0.68
Fiji	136	3	9.1	92	2	11.2
Papua New Guinea	1,077	3	8.9	650	3	8.9
Samoa	10	13	2.7	6	12	2.8
Solomon Islands	65	3	10.7	40	3	13.0
Vanuatu	22	3	9.5	19	2	12.8

Source: International Agency for Research on Cancer.[78]

In the Pacific, there is a significant lack of SRHR data. Data that does exist is often based on outdated sources. Research is required in the Pacific to create a better baseline of SRHR need, which can help to identify gaps, needs and opportunities, inform the design of programmes and determine successes. UNFPA has identified the need for improved monitoring of SRHR commitments, including the need for support for information and data collection and analysis.[79]

Surveillance and research into sexual and reproductive health has been largely stand-alone and not integrated into national health information systems, which impacts on service and program planning at national level. The current research gaps and limited understanding hinder interventions being grounded in local evidence. In-depth knowledge and understanding of sexual and reproductive health in the Pacific context is lacking.

The Secretariat of the Pacific Community and the Pacific Sexual and Reproductive Health Research Centre have outlined important research areas including:

- research on the determinants of sexual health and well-being
- determining the effectiveness and efficiency of programs and services
- exploring the particular vulnerabilities and needs of groups with high-risk behaviours
- challenges and barriers to uptake of contraception
- health care workers as sexual and reproductive health service providers

Recommendations

We recommend that the Australian government:

18. implement a consistent, national approach to the collection of data on contraception, pregnancy (including pregnancy intention) and abortion through routine data collection and reporting and regular, population-based survey research
19. collect additional demographic characteristics of women attending for cervical cancer screening to improve targeting of resources to particular regions and populations
20. invest in targeted approaches to increase accessibility of the NCSP to vulnerable and marginalised groups
21. support Pacific governments to implement national strategies, policies and guidelines for prevention and screening of cervical cancer in line with WHO guidelines
22. support research activities in the Pacific that both increase the people-to-people links between Australian and Pacific researchers, and provide important data to inform project designs

Case study: Induced abortion in Australia 2000-2020 (monograph)

At present, there is no national data collection on the incidence of induced abortion in Australia. Available data regarding abortion at both the national and state level comes with a variety of unique limitations including difficulties with completeness and comprehensiveness, as with the MBS and PBS data. Abortion notification systems are a valuable opportunity to collect rich and accurate data about induced abortion in Australia. If timely release of accurate and standardised data can be assured, these data have significant value for planning and evaluation purposes.

In 2021, Family Planning NSW released a statistical report on key findings about abortion in Australia, from publicly available data. Abortion rates for Australia and New Zealand between 2015-2019 are estimated to be approximately 15 abortions per 1,000 women. This rate is consistent with that reported for other high-income countries and is less than the worldwide abortion rate. It is estimated that 41% of unintended pregnancies in Australia and New Zealand over this period ended in abortion, compared to 43% in high-income countries and 66% in middle-income countries. These estimates indicate that abortion rates in Australia have consistently declined from 20 per 1,000 women in the period 2005-09, to 17 per 1,000 in in 2010-14, and 15 per 1,000 in 2015-19. Reports from abortion notification systems in Western Australia and South Australia also demonstrate a generally decreasing trend in abortion rates in their respective jurisdictions in the decade to 2018. Since the introduction of medical abortion in Australia, the rates of surgical abortion have decreased but has been at least partially balanced by increases in medical abortion.

The vast majority of abortions in Australia continue to be carried out prior to 14 weeks' gestation, with 91% and 94% of abortions being completed by this stage in South Australia and Western Australia respectively. While the number of induced abortions carried out at 20+ weeks' gestation remains low in all jurisdictions where data are available, rates of abortions at this stage of pregnancy are generally increasing, with those in Victoria increasing from 1.72 to 2.74 abortions per 1,000 live births between 2001 and 2019.

ADDITIONAL COMMENTS ON SDGS 14 AND 15

Goal 14: Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15: Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

More than 3 billion people rely on the oceans for their livelihoods, and more than 80% of world merchandise trade by volume is carried by sea.[80] In Australia, oceans are a cultural space, and there are direct impacts on changes to ocean acidification such as coral bleaching. In the Pacific, the ocean is also a cultural space, with many communities relying on the ocean for their livelihoods.

Deforestation and forest degradation, continued biodiversity loss, and the ongoing degradation of ecosystems are having profound consequences for human well-being and survival.[80] Australia has one of the most diverse ecosystems in the world, with unique flora and fauna that requires protection. Aboriginal Australian's have a cultural connection to the land, recognising the need to respect and live in harmony with nature. Cultures in the Pacific also have a strong connection to land, with many traditional practices that use land in sustainable and meaningful ways.

Ensuring life below water and life on land has human impacts and requires a human solution. It is critical that all parts of the community, including women and girls, are empowered to meaningfully engage in these solutions. Implementation of these goals will take concerted efforts to build the economic, social, and environmental practices that can support their achievement. Women and girls are a key stakeholder in achieving these goals but are often not engaged in decision making processes. It is critical, therefore, that women and girls are empowered to have their views expressed and that their voices are heard. The achievement of sexual and reproductive health and rights underpins their ability to contribute to this discourse.

CONCLUDING REMARKS

This report has identified links between sexual and reproductive health and rights, and the Sustainable Development Goals that are the focus for the 2022 High Level Political Forum on Sustainable Development – Goals 4, 5, 14, 15, and 17.

Education is a key to ensuring universal access to quality SRHR. In particular, the introduction of comprehensive sexuality education for all ages will ensure that people have the information and tools to protect their health and realise their rights, being empowered to make their own decisions.

SRHR is an enabler of gender equality, itself an enabler for the achievement of all Goals. Goal 5 has specific targets related to SRHR ,and as this report has illustrated, there remain many gaps in implementation to ensure achievement of these targets. We continue to advocate a specific focus on the most marginalised communities to meeting the ambition that no one is left behind.

To ensure we are tracking our successes, we need to have quality, disaggregated data that informs where interventions are working, and where more focus is required.

We need to recognise that achievement of goals related to water and land can only be achieved if all in society are able to engage on an equal standing. With less than a decade left to achieve the Sustainable Development Goals, the pace of implementation must increase. For the agenda to succeed in the timeframe, SRHR must be prioritised and recognised as an enabler of gender equality and therefore underpinning the success of the whole agenda.[4]

As a nation, Australia must do more to close the gap between vulnerable and marginalised Australian communities and support our neighbours in the Pacific to ensure that SRHR is embedded into national policy and practice.

SUMMARY OF RECOMMENDATIONS

Sustainable Development Goal	Report Recommendations	SRHR Strategy
Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.	**1.** Develop a national comprehensive sexuality education curriculum that is aligned with the 2018 UNESCO technical guidelines, is well resourced and consistently delivered across Australia and includes modules for students with disability **2.** Continue to invest and support Ministries of Health and Education in the Pacific to develop, implement and improve in- and out-of-school comprehensive sexuality education curricula, including training and development for teachers and community educators **3.** Advocate for ongoing and continued implementation of the Transformative Agenda regarding comprehensive sexuality education in Pacific schools and the wider community, including students with a disability **4.** Invest in co-designed research that aims to identify barriers to educational attainment and develop strategies to ensure that health related education is not lost for people who do not complete Year 12 **5.** Develop, implement and evaluate social marketing campaigns that aim to increase awareness of and engagement with cervical screening in Australia **6.** Realise the link between investing in health and education, and workforce participation	1. Increase access to long-acting reversible contraception (LARC) 3. Invest in comprehensive sexuality education (CSE) 7. Improve sexual and reproductive health data collection

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Sustainable Development Goal	Report Recommendations	SRHR Strategy
Goal 5: Achieve gender equality and empower all women and girls.	**1.** Develop a national comprehensive sexuality education curriculum that is aligned with the 2018 UNESCO technical guidelines, is well resourced and consistently delivered across Australia and includes modules for students with disability **7.** Develop and disseminate a consumer-focused campaign that aims to increase awareness of LARC **8.** Increase Medicare Benefits Scheme (MBS) rebates to doctors for insertion and removal of LARC **9.** Expand the current MBS to include registered nurses for insertion and removal of LARCs **10.** Provide funding to increase use of LARC in regional, remote and rural areas and priority population **11.** Remain a leader on gender equality by investing in the education of women and girls, and implement public policy solutions that target gender equality and education outcomes **12.** Upskill General Practitioners and sexual and reproductive health clinicians in best practice ways to sensitively address and respond to reproductive coercion within clinical settings **13.** Implement a consistent, national approach to the collection of data on family domestic and sexual violence, and reproductive coercion routine data collection and reporting, or regular, population-based survey research	**1.** Increase access to long-acting reversible contraception (LARC) **3.** Invest in comprehensive sexuality education (CSE) **4.** Promote gender equality and end violence against women **5.** Promote access to sexual and reproductive health services for vulnerable groups **6.** Improve access to abortion care **7.** Improve sexual and reproductive health data collection

Sustainable Development Goal	Report Recommendations	SRHR Strategy
Goal 5: Achieve gender equality and empower all women and girls. (cont...)	**14.** Develop a consistent set of nationally recognised definitions on family, domestic and sexual violence **15.** Use the Australian Development budget to prioritise interventions that promote gender equality and the empowerment of women and girls, through education and workforce opportunities, in the Pacific **16.** Fund a national program that supports the employment bilingual community educators at community health centres, specifically around the area of sexual and reproductive health and rights **17.** Invest in training, information and resources for sexual and reproductive health clinicians that addresses clinical presentations of FGM/C and appropriate responses	
Goal 17. Strengthen the means of implementation and revitalize the global partnership for sustainable development.	**18.** Implement a consistent, national approach to the collection of data on contraception, pregnancy (including pregnancy intention) and abortion through routine data collection and reporting or regular, population-based survey research **19.** Collect additional demographic characteristics of women attending for cervical cancer screening to improve targeting of resources to particular regions and populations **20.** Invest in targeted approaches to increase accessibility of the NCSP to vulnerable and marginalised groups **21.** Support Pacific governments to implement national strategies, policies and guidelines for prevention and screening of cervical cancer in line with WHO guidelines **22.** Support research activities in the Pacific that both increase the people to people links between Australian and Pacific researchers, and provide important data to inform project designs	**2.** Eliminate cervical cancer **7.** Improve sexual and reproductive health data collection

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REFERENCES

1. Temmerman M, Khosla R, Say L. Sexual and reproductive health and rights: A global development, health, and human rights priority. The Lancet. 2014;384(9941):e30-e1.
2. United Nations Population Fund. Report of the International Conference on Population Development. Cairo: UNFPA; 1994.
3. United Nations Population Fund, The Danish Institute for Human Rights, Human Rights Office of the High Commissioner. Reproductive Rights are Human Rights. New York: UNFPA; 2014.
4. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher - Lancet Commission. The Lancet. 2018;391(10140):2642-92.
5. Ghebreyesus TA, Kanem N. Defining sexual and reproductive health and rights for all. Lancet. 2018;391(10140):2583-5.
6. Yazdkhasti M, Pourreza A, Pirak A, Abdi F. Unintended Pregnancy and Its Adverse Social and Economic Consequences on Health System: A Narrative Review Article. Iran J Public Health. 2015;44(1):12-21.
7. Australian Human Rights Commission. The rights and needs of young parents and their children. A summary of findings from the Children's Rights Report 2017. Sydney: Australian Human Rights Commission; 2017.
8. Australian Human Rights Commission. Children's Rights Report 2017. Sydney: Australian Human Rights Commission; 2017.
9. Mann L, Bateson D, Black K. Teenage pregnancy. Australian Journal for General Practitioners. 2020;49:310-6.
10. Sonfield A, Hasstedy K, Kavanaugh M, Anderson R. The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children. New York: Guttmacher Institute; 2013.
11. United Nations Educational Scientific and Cultural Organization. Emerging evidence, lessons and practice in comprehensive sexuality education: A global review. France: UNESCO; 2015.
12. United Nations Educational Scientific and Cultural Organization. International technical guidance on sexuality education: An evidence-informed approach. Switzerland: UNESCO; 2018.
13. Guttmacher Institute. Informational handouts on comprehensive sexuality education, youth-friendly services, gender issues and sexual rights. New York; 2014.
14. Australian Association for Adolescent Health. Comprehensive Sexuality Education: Position Paper 2018.
15. Rollston R, Wilkinson E, Abouelazm R, Mladenov P, Horanieh N, Jabbarpour Y. Comprehensive sexuality education to address gender-based violence. The Lancet. 2020;396(10245):148-50.
16. Smith A, Schlichthorst M, Mitchell A, Walsh J, Lyons A, Blackman P, et al. Sexuality Education in Asutralian Secondary Schools, Monograph Series No, 80. Melbourne: La Trobe University, the Australian Research Centre in Sex, Health & Society; 2011.
17. Burns S, Hendriks J. Sexuality and relationship education training to primary and secondary school teachers: An evaluation of provision in Western Australia. Sex Education. 2018;18(6):681-8.
18. Pound P, Langford R, Campbell R. What do young people think about their school-based sex and relationship education? A qualitativev synthesis of young people's views and experiences. BMJ Open. 2016;6(9):1-14.
19. Family Planning NSW. Sexual Health Education in New South Wales Schools: Student Needs Assessment. Ashfield; 2018.
20. Family Planning NSW. NSW Sexual Health in Schools, Needs Assessment Report. Unpublished; 2015.
21. UNFPA, UNESCO, IPPF ESEAOR. Comprehensive Sexuality Education in Asia and the Pacific Region Regional Review 2019 Background Report. Bangkok: UNFPA; 2020.
22. Australian Institute of Health and Welfare. Secondary education: school retention and completion. Canberra: AIHW; 2021.
23. Australian Bureau of Statistics. Gender Indicators, Australia. Canberra; 2020.
24. UNESCO Institute of Statistics. Education and Literacy Samoa. 2021.
25. UNESCO Institute of Statistics. Education and Literacy Tuvalu. 2021.
26. Raghupathi V, Raghupathi W. The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015. Archives of Public Health. 2020;78(1):20.
27. Zajacova A, Lawrence EM. The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. Annu Rev Public Health. 2018;39:273-89.
28. Damiani G, Basso D, Acampora A, Bianchi CB, Silvestrini G, Frisicale EM, et al. The impact of level of education on adherence to breast and cervical cancer screening: Evidence from a systematic review and meta-analysis. Preventive medicine. 2015;81:281-9.
29. Willems B, Bracke P. The education gradient in cancer screening participation: a consistent phenomenon across Europe? International journal of public health. 2018;63(1):93-103.
30. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey, 2014-2015. Cat. no. 4714.0. Canberra: ABS; 2015.
31. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings 2015. Cat. no. 4430.3. Canberra: ABS; 205.
32. Asian Development Bank. Gender Statistics: The Pacific and Timor-Leste. Philippines; 2016.
33. United Nations Population Fund. Working paper: Linking women's economic empowerment, eliminating gender-based violence and enabling sexual and reproductive health and rights New York; 2020.
34. Canning D, Schultz TP. The economic consequences of reproductive health and family planning. The Lancet. 2012;380(9837):165-71.
35. Grose RG, Chen JS, Roof KA, Rachel S, Yount KM. Sexual and Reproductive Health Outcomes of Violence Against Women and Girls in Lower-Income Countries: A Review of Reviews. The Journal of Sex Research. 2021;58(1):1-20.

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36. George AS, Amin A, de Abreu Lopes CM, Ravindran TKS. Structural determinants of gender inequality: why they matter for adolescent girls' sexual and reproductive health. BMJ. 2020;368:l6985.

37. Hartmann M, Khosla R, Krishnan S, George A, Gruskin S, Amin A. How Are Gender Equality and Human Rights Interventions Included in Sexual and Reproductive Health Programmes and Policies: A Systematic Review of Existing Research Foci and Gaps. PLOS ONE. 2016;11(12):e0167542.

38. United Nations. Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. United Nations.; 1996.

39. United Nations Population Fund. ICPD and Human Rights: 20 years of advancing reproductive rights through UN treaty bodies and legal reform. UNFPA; 2013.

40. Australian Institute of Health and Welfare. Family, domestic and sexual violence. Canberra: AIHW; 2021.

41. NSW Bureau of Crime Statistics and Research. Domestic violence statistics for NSW. Sydney; 2021.

42. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia, 2018. Canberra: AIHW; 2018.

43. García-Moreno C, Amin A. The sustainable development goals, violence and women's and children's health. Bulletin of the World Health Organization. 2016(94):396-7.

44. Carter A, Bateson D, Vaughan C. Reproductive coercion and abuse in Australia: what do we need to know? Sex Health. 2021;18(5):436-40.

45. Miller E, McCauley HL, Tancredi DJ, Decker MR, Anderson H, Silverman JG. Recent reproductive coercion and unintended pregnancy among female family planning clients. Contraception. 2014;89(2):122-8.

46. Miller E, Jordan B, Levenson R, Silverman JG. Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. Contraception. 2010;81(6):457-9.

47. Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science & Medicine. 2010;70(11):1737-44.

48. Northridge JL, Silver EJ, Talib HJ, Coupey SM. Reproductive Coercion in High School-Aged Girls: Associations with Reproductive Health Risk and Intimate Partner Violence. Journal of pediatric and adolescent gynecology. 2017;30(6):603-8.

49. Latimer RL, Vodstrcil LA, Fairley CK, Cornelisse VJ, Chow EPF, Read TRH, et al. Non-consensual condom removal, reported by patients at a sexual health clinic in Melbourne, Australia. PLOS ONE. 2018;13(12):e0209779.

50. Willie TC, Callands TA. Reproductive coercion and prenatal distress among young pregnant women in Monrovia, Liberia. Health Care for Women International. 2018;39(9):968-74.

51. Willie TC, Alexander KA, Caplon A, Kershaw TS, Safon CB, Galvao RW, et al. Birth Control Sabotage as a Correlate of Women's Sexual Health Risk: An Exploratory Study. Women's Health Issues. 2021;31(2):157-63.

52. Cheng Y, Wilson EG, Botfield JR, Boerma CJ, Estoesta J, Peters LJ, et al. Outcomes of routine screening for reproductive coercion in a family planning service. Sexual Health (Online). 2021;18(5):349-57.

53. Price E, Sharman LS, Douglas HA, Sheeran N, Dingle GA. Experiences of Reproductive Coercion in Queensland Women. Journal of Interpersonal Violence. 2019:0886260519846851.

54. United Nations Population Fund. Women who experience intimate partner violence, 2000-2018: UNFPA Asia and the Pacific region. 2018.

55. World Health Organization. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva; 2021.

56. Spratt J. A Deeper Silence: The unheard experiences of women with disabilities and their sexual and reproductive health experiences: Kiribati, the Solomon Islands and Tonga. Suva, Fiji; 2012.

57. AusAID. Pacific Violence Against Women Agenda: Guidance on Violence Against Women Programming Across the Pacific. Canberra; 2011.

58. UNICEF. Child marriage: Latest trends and future prospects New York; 2018.

59. UNICEF. Ending child marriage: Progress and prospects. New York; 2014.

60. Jelenic T, Keeley M. End child marriage: report on the forced marriage of children in Australia. Sydney: National Children's and Youth Law Centre 2013.

61. Nour NM. Child marriage: a silent health and human rights issue. Rev Obstet Gynecol. 2009;2(1):51-6.

62. Australian Institute of Health and Welfare. Discussion of female genital mutilation/cutting data in Australia. Canberra: AIHW; 2019.

63. World Health Organization. Care of women and girls living with female genital mutilation: a clinical handbook. Geneva; 2018.

64. Berg RC, Odgaard-Jensen J, Fretheim A, Underland V, Vist G. An updated systematic review and meta-analysis of the obstetric consequences of female genital mutilation/cutting. Obstet Gynecol Int. 2014;2014:542859.

65. Johnsdotter S, Essén B. Cultural change after migration: Circumcision of girls in Western migrant communities. Best Pract Res Clin Obstet Gynaecol. 2016;32:15-25.

66. Elnashar A, Abdelhady R. The impact of female genital cutting on health of newly married women. Int J Gynaecol Obstet. 2007;97(3):238-44.

67. World Health Organization. Health risks of female genital mutilation. Geneva; 2019.

68. Family Planning NSW. Feasibility study to establish a national Female Genital Mutilation (FGM) data collection. Ashfield; 2014.

69. Diversity House Institute. Child protection in action: FGM. Sydney: Clearinghouse; 2011.

70. Zurynski Y, Phu A, Sureshkumar P, Cherian S, Deverell M, Elliott EJ. Female genital mutilation in children presenting to Australian paediatricians. Archives of Disease in Childhood. 2017;102(6):509.

71. Australian Institute of Health and Welfare. Cancer screening programs: quarterly data. Canberra: AIHW; 2020.

72. Australian Institute of Health and Welfare. Cancer data in Australia. Canberra: AIHW; 2021.

73. Australian Institute of Health Welfare. Cancer in Aboriginal & Torres Strait Islander people of Australia. Canberra: AIHW; 2018.

74. Australian Institute of Health Welfare. Cervical screening in Australia 2019. Canberra: AIHW; 2019.

75. Obel J, Souares Y, Hoy D, Baravilala W, Garland SM, Kjaer SK, et al. A systematic review of cervical cancer incidence and mortality in the Pacific Region. Asian Pacific journal of cancer prevention : APJCP. 2014;15(21):9433-7.

76. Hall MT, Simms KT, Lew J-B, Smith MA, Brotherton JML, Saville M, et al. The projected timeframe until cervical cancer elimination in Australia: a modelling study. The Lancet Public Health. 2019;4(1):e19-e27.

77. McPherson GS, Fairbairn-Dunlop P, Payne D. Overcoming Barriers to Cervical Screening Among Pacific Women: A Narrative Review. Health Equity. 2019;3(1):22-9.

78. Population Fact Sheets [Internet]. World Health Organization. 2020. Available from: https://gco.iarc.fr/today/fact-sheets-populations.

79. UNFPA. Regional interventions action plan for Asia and the Pacific 2018-2021. UNFPA; No date.

80. United Nations Economic and Social Council, editor Progress towards the Sustainable Development Goals: Report of the Secretary-General2021; New York: United Nations Economic and Social Council