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International Teen Reproductive Health and Development: The Canadian First Nations Context

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Abstract

Women's well-being is dependent on access to reproductive health care. Around the world, however, many women do not have adequate access to this essential health service. Barriers to accessing reproductive health services are especially problematic for Canadian First Nations youth, especially those living in rural and remote communities. This article explores the unique challenges of and approaches to teen reproductive health and sustainable development internationally. The international context of reproductive health and sustainable development can inform and set the context for a discussion of Canadian First Nations teens' reproductive health. Of special interest is how the United Nations and the international community approached sensitive issues and generated consensus among many different countries, cultures, religions, and customs.

French Abstract

DÉVELOPPEMENT ET SANTÉ REPRODUCTIVE DES ADOLESCENTES À L'ÉCHELLE INTERNATIONALE : LA SITUATION DES PREMIÈRES NATIONS DU CANADA

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Résumé

Le bien-être des femmes repose sur l'accès aux soins de santé reproductive. Cependant, de nombreuses femmes de partout dans le monde n'ont pas un accès adéquat à ce service de santé essentiel. Les obstacles à l'accès aux services de santé reproductive sont particulièrement problématiques pour les jeunes des Premières Nations du Canada et les adolescentes qui vivent dans des collectivités rurales et éloignées. Cet article explore les défis uniques que représentent le développement durable et la santé reproductive des adolescentes à l'échelle internationale ainsi que les diverses approches à cet égard. La situation internationale du développement durable et de la santé reproductive peut éclairer et définir le contexte de la discussion sur la santé reproductive des adolescentes des Premières Nations du Canada. Il est particulièrement intéressant de relever la façon dont les Nations Unis et la communauté internationale ont abordé les questions de nature délicate et sont parvenus à un consensus malgré les différents pays, cultures, religions et coutumes.

Spanish Abstract

SALUD REPRODUCTIVA Y DESARROLLO DE LAS ADOLESCENTES EN EL ÁMBITO INTERNACIONAL: CONTEXTO DE LAS PRIMERAS NACIONES CANADIENSES

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Resumen

El bienestar de las mujeres depende de su acceso a la atención en el campo de la salud reproductiva. Sin embargo, son muchas las mujeres en todo el mundo que no disponen de un acceso adecuado a estos servicios esenciales de salud. Los factores que dificultan el acceso a los servicios de salud reproductiva son

especialmente problemáticos para las jóvenes de las Primeras Naciones canadienses y para las adolescentes que viven en localidades rurales y alejadas. En este artículo se analizan los retos y enfoques exclusivos de la salud reproductiva de las adolescentes y el desarrollo sostenible a escala internacional. El contexto internacional de la salud reproductiva y del desarrollo sostenible puede aportar información y establecer el contexto para un debate sobre la salud reproductiva de las adolescentes de las Primeras Naciones canadienses. Resulta especialmente interesante la forma en que las Naciones Unidas y la comunidad internacional plantean las cuestiones sensibles y generan un consenso entre los distintos países, culturas, religiones y costumbres.

Keywords

Indigenous health, reproductive health, First Nations health, teen health, international health

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International Teen Reproductive Health and Development: The Canadian First Nations Context

Women's well-being is dependent on access to reproductive health care. This includes sexual education, family planning, pre- and post-natal care, and other community and social supports. Reproductive health is not only essential to the well-being of women; it is also important to the health of their children, community, and country. Around the world, however, many women do not have adequate, or even any, access to this essential health service. This is also true for Canadian teenagers, who may face a variety of significant barriers to accessing such services. These barriers are especially problematic for First Nations youth and those teens living in rural and remote communities.

Barriers to reproductive health experienced by women around the world are related to several factors. Obviously, as other articles in this journal have shown, this includes economic status and available health care systems. It is also related to culture, custom, and gender equality. Moreover, the barriers to accessing reproductive health and gender equality are magnified for teenagers, who may also experience additional obstacles that are specifically age-related.

The profound interconnection between reproductive health, gender equality, poverty, and well-being is on the international agenda. Its presence there has resulted in efforts focused on teenaged girls. In fact, the international context of reproductive health and sustainable development can inform and set the context for a discussion of Canadian First Nations teens' reproductive health and access to related services. Of special interest is how the United Nations (UN) and the international community approached sensitive issues and generated consensus among many different countries, cultures, religions, and customs.

This article explores the unique challenges of, and approaches to, teen reproductive health and sustainable development internationally. First, I discuss the international and national context of reproductive health services. Next, I present case studies of successful reproductive health programs in countries with colonized Indigenous populations. Finally, I ask what parts of the international reproductive health and sustainable development enterprise can be applied in the context of Canadian First Nations teenagers.

International Context

In mid-2008, the world population stood at 6.7 billion, nearly a 9 percent increase from the 6.0 billion in 1999. The next milestone, 7 billion, will likely be surpassed in 2011 or 2012. During the 20th century, nearly 90 percent of human population growth took place in countries classified by the United Nations (2005) as less developed (i.e., all countries in Africa, Asia except Japan, Latin America and the Caribbean, and Oceania except Australia and New Zealand). Overall, women gave birth to an average of about 2.6 children in 2008. However, this figure varies substantially from region to region and country to country. In more developed countries, for instance, women average 1.6 live births over their lifetimes; whereas, in the least developed countries, excluding China, women average 3.2 births, twice that of the wealthier countries. In the 50 least developed countries (as defined by the United Nations), the number is even higher at 4.7 births per woman (Population Reference Bureau, 2008).

According to the United Nations Population Fund (UNFPA, n.d.b), reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and related disability, sexually transmitted infections including HIV, gender-based violence, and other problems related to reproductive health and sexual behaviour. For example, maternal mortality is the leading cause of death among all women and girls of reproductive age. Worldwide, 1 in 92 women are estimated to die from pregnancy-related causes. Still, the gap between most developed countries and least developed countries is vast. In the most developed countries, the risk of maternal mortality is 1 in 6,000 and in the least developed countries it is 1 in 75 (Population Reference Bureau, 2008). Ninety-nine percent of maternal deaths occur in the developing world; most of them – a staggering 74 percent – are preventable (UNFPA, 2007a). Put differently, over 1,500 women and girls die every day from complications related to pregnancy and childbirth. This translates to around 550,000 annual worldwide deaths related to pregnancy and childbirth (United Nations Human Rights Council [UNHRC], 2009). Maternal mortality is linked to such factors as the frequency and type of prenatal care and the type of care at birth (Population Reference Bureau, 2008).

According to UNFPA (n.d.f), at least 200 million women want to use safe and effective family planning methods, but they are unable to do so because they lack access to information and services or they lack of support of their husbands and communities. Moreover, over 50 million of the 190 million women who become pregnant each year have abortions. Many of these abortions are clandestine and performed under unsafe conditions. Evidently, the need for voluntary family planning is growing fast. It is estimated that this “unmet need” will grow by 40 percent during the next 15 years. Universal access to services allowing couples to exercise their full reproductive rights remains elusive: One study found that family planning services are routinely made available to women at a reasonable cost in only 14 of 88 developing countries.

However, the level of unintended pregnancy is lowest in countries with the most access to effective methods of contraception and where women play a major role in family decision-making. Moreover, differing patterns of contraceptive use may not reflect women’s personal preferences as much as political and economic decisions made by governments in order to emphasize certain ideological preferences. Patterns of contraceptive use also reflect the attitudes of medical professionals, cost, and the limited range of methods offered in some countries, or an uneven availability of contraceptive supplies (UNFPA, n.d.f).

Additionally, in many countries, poverty and profound gender inequalities limit women’s ability to plan their pregnancies and exercise reproductive rights. Gender-based violence encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls, and harmful traditional practices. Violence against women reflects and reinforces inequities between men and women. It also compromises the health and security of its victims. Violence may have profound effects – direct and indirect – on a woman's reproductive health. Such effects include unwanted pregnancies, restricted access to family planning information and contraceptives, sexually transmitted infections (STIs), and unsafe abortion (UNFPA, n.d.a).

What Teenagers and Young Adults Face

Reproductive health barriers experienced by women around the world are magnified for teenagers and young adults because young people often face greater barriers in trying to get the information or care they need. Their reproductive health is an important element of international reproductive health and sustainable development.

Each year, an estimated 14 million teenagers between the ages of 15 and 19 years give birth. Uncounted others are even younger when they have babies. While teenaged pregnancy is declining worldwide, high rates in many countries persist, mostly where poverty and poor health are endemic. On average, one-third of women in developing countries give birth before age 20. The average fertility rate (number of births per 1,000 young women) among 15- to 19-year-olds in the least developed countries is more than 5 times greater than that of the most developed countries (UNFPA, 2007a).

The future is compromised for most teenaged mothers. Many will face poverty; ill health; abuse; unprotected sex, which carries the risk of contracting a STI or HIV; frequent pregnancies; and an end to education. There are comparatively few positive life options for teenaged mothers. Their children are more likely than those of older mothers to be malnourished and have developmental problems. The United Nations Population Fund (UNFPA, 2007a) estimates that one million babies born to teenaged mothers will not survive their first year. Internationally, more than 1.5 billion people are between the ages of 10 and 25; more than half of them live in poverty, on less than \$2 per day. They often lack access to the technology and information that can make a difference in their lives. Many also face social inequality, poor schools, gender discrimination, unemployment, and inadequate health systems (UNFPA, n.d.g).

Becoming a mother carries risks for all women, regardless of age. However, there are many factors that make teenaged childbearing especially hazardous. The majority of deaths among 15- to 19-year-old girls worldwide result from problems related to pregnancy and childbirth. Each year, nearly 70,000 teenaged girls die for such reasons and at least 2 million more are left with chronic illness or disabilities that may bring them life-long suffering. Each year 2.2 to 4 million teenage girls resort to unsafe abortions. Pregnancy and childbirth are most dangerous for younger girls who are not yet physiologically mature. Girls between the ages of 15 and 19 are twice as likely to die during pregnancy or childbirth as compared to women in their 20s. Physically immature and often with few resources, the youngest first-time mothers are most at risk. For those under 15, the risk of death during pregnancy or childbirth is five times higher than for those 15- to 19-years-old (UNFPA, 2007a).

Most teenage girls are giving birth for the first time with sparse knowledge and limited or non-existent health care and support. Very few teens are empowered enough to access such critical sexual and reproductive health services. They have the least exposure to sexual and reproductive health information and are less able to prevent or cope with unwanted pregnancy. Compared to older women, teenaged girls are more likely to give birth without a skilled attendant, which further compounds their risks. Many receive no prenatal care, especially those in developing countries (UNFPA, 2007a).

Poor girls are far more likely to give birth early. Rural teenaged girls are more likely to be poor, have less education, less access to reproductive health services, and to marry young; consequently, they are much more likely to become pregnant at a young age. Within urban areas, poor girls living in slums have higher

fertility rates than those living outside of these areas. For many girls living in poverty and social deprivation, becoming pregnant and having a child may not seem to make much of a difference to long-term success (UNFPA, 2007a).

Worldwide, only 17 percent of sexually active teenagers use contraceptives. Many are unaware that condoms offer dual protection from unwanted pregnancy and sexually transmitted infections, despite the fact that they are especially vulnerable to STIs including HIV. Even if they want to use condoms, they may not have ready access to them or are unable to negotiate their use (UNFPA, n.d.e).

Indigenous Peoples Face Additional Challenges

In addition to the global challenges facing women and particularly teenaged girls, Indigenous peoples are also unique with respect to their reproductive health. Globally, Indigenous people number an estimated 300 to 370 million in more than 70 countries (United Nations Permanent Forum on Indigenous Issues [UNPFII], 2003). They maintain social, cultural, economic, and political characteristics distinct from those of the dominant societies in which they live. Worldwide, centuries of systematic marginalization have rendered them one of the poorest and most vulnerable groups today, despite their resiliency. Many are victims of racial discrimination and social exclusion. Moreover, Indigenous peoples are often deprived access to basic services, such as education and healthcare (United Nations Development Fund for Women [UNIFEM], n.d.).

Most Indigenous groups share the demographic profile of developing countries, where youth aged 10 to 24 years comprise the largest segment of the population. In addition, these groups tend to be poor, rural, and excluded from meaningful economic development (Farrell, Rosen, & Terborgh, 1999). While they constitute approximately 5 percent of the world's population, Indigenous people make up 15 percent of the world's poor. Furthermore, they make up about one-third of the world's 900 million extremely poor rural people (UNPFII, 2003). Indigenous peoples experience less access to economic opportunities and employment. Sometimes these circumstances lead to an increased vulnerability to prostitution and substance abuse (Farrell et al., 1999).

Indigenous teens and youth experience the same barriers to reproductive health services that other youth face. However, they encounter additional obstacles by virtue of being Indigenous. For instance, globally many Indigenous youth, especially girls, speak only their native language and experience difficulties functioning in mainstream culture (Farrell et al., 1999). Low levels of literacy and schooling compound this problem, especially for girls. In Guatemala, for example, 53.5 percent of Indigenous teens aged 15 to 19 have not completed primary education, as compared to 32.2 percent of non-Indigenous youth (UNPFII, 2003). Furthermore, Indigenous youth are more likely to experience marginal political and legal status, which serves to fuel racism and discrimination as well as exacerbate poverty and lack of access to health services. Regularly encountering social and institutional discrimination, many Indigenous teenagers may be reluctant to use available reproductive health services, often for fear of persecution or human rights abuses. Moreover, they may be more comfortable with their own health systems and traditional providers than with Western medicine. In addition, Indigenous peoples often live in less geographically accessible places. If they are poor and live in a rural area, access to services may be limited. If they are urban, they may face cultural exclusion and discrimination.

These and other conditions translate into Indigenous youth being a group with a large unmet need for reproductive health services. Cultural and geographic isolation make Indigenous youth even less knowledgeable about reproduction and pregnancy than other youth. Indigenous youth are more vulnerable to STIs, HIV, and maternal complications resulting from poverty and discrimination, their young age, and lack of knowledge (Farrell et al., 1999). In Bolivia, for example, the infant mortality rate among the Indigenous population is close to 75 per 1,000, as compared to 50 per 1,000 for the non-Indigenous population (UNPFII, 2003). Yet, traditional culture and low educational attainment make Indigenous youth more likely to marry and give birth at an early age. Fertility is usually highly regarded in traditional cultures and girls often feel great pressure to become pregnant early (Farrell et al., 1999).

The Case of Canadian First Nations Teenagers and Young Adults

Over the last thirty years, fertility rates among all 15- to 19-year-olds in Canada declined. In 1980, Canadian teenagers between the ages of 15 and 19 gave birth at a rate of 27.6 per 1,000 and in 1985 it was at 23.7 per 1,000 (Matick-Tyndale, McKay, & Barrett, 2001). In 1996, the teenaged birth rate was 22.1 per 1,000, and, by 2006, it fell significantly to 13.7 per 1,000, representing a 38 percent decline from 1996 (McKay & Barrett, 2010). The fertility rate of First Nations women of all ages, though still almost double that of other Canadian women, has also been declining since the 1960s. Across the country, the fertility rate among First Nations women fell from 6.1 in the 1960s to 2.7 children per woman by 2006 (Guimond & Robatille, 2008).

However, birth data contained in the Indian Register, maintained by the Department of Aboriginal Affairs and Northern Development Canada [AANDC], tells a different story. Indeed, the fertility rate of First Nations teenage girls under the age of 20 has remained high since 1986 at about 100 births per 1,000 women. The fertility rate of First Nations teenage girls is 7 times higher than that of other Canadian teenagers. Registered Indian girls aged 15 to 19 years have a 1 in 10 fertility rate with the highest rates in the Prairies, including 1 in 8 in Manitoba, which is high even by international standards. According to international demographic statistics collected by the United Nations in 2006, First Nations teenage girls in Canada have a fertility level comparable to that of teenage girls in the least developed countries, such as Nepal, Ethiopia, and Somalia. For First Nations teenage girls under 15 years of age, the rate is estimated to be as much as 18 times higher than that of other Canadians (Guimond & Robatille, 2008).

We also need to consider the infant mortality rate to get a picture of the overall population growth. For over a century, the infant mortality rate among Canada's Aboriginal populations was twice that of the non-Aboriginal population. However, in 2000, Health Canada stated that the infant mortality rate among all First Nations peoples in Canada dropped to 6.4 per 1,000 live births, almost on par with the infant mortality rate of 5.3 per 1,000 live births for Canada (cited in Public Health Agency of Canada [PHAC], 2008). Focusing only on First Nations teenagers living on-reserve in the year 2000, the infant mortality rate, which has been steadily decreasing among First Nations people since 1979 (when it peaked at 27.6 deaths per 1,000 live births), was reported as 6.2 per 1,000 live births (Social Union, 2003). Another source found that, in 1999, the First Nations infant mortality rate for that year was 8.0 per 1,000 live births (compared to 5.5/1,000 live births for Canada as a whole) (Stout & Harp, 2009). As one might expect, these numbers have been called into question based on issues related to data collection. The PHAC's (2008) Perinatal Health Report points out that:

The argument that First Nations, Inuit and Métis populations have a sub-optimal perinatal health status requiring serious public health attention is difficult to make partly because of inadequate and poor quality surveillance information ... Note the high rates of stillbirth in the North American Indian population ([which is] approximately two-to-three-fold higher than among the French and English) ... Nevertheless, there is evidence to suggest that even these mortality statistics for First Nations, Inuit and Métis populations are underestimates of true rates because of an under-registration of births at the borderline of viability. (p. 20)

Moreover, Aboriginal health indicators and health data in general are widely regarded as inadequate and incomplete in Canada. Most of the Aboriginal maternal health data available exists in the form of circumstantial health indicators, for example, age, income level, or family or marital status (Stout & Harp, 2009). Yet, it is generally agreed that, despite the steady decline, the infant mortality rate for First Nations people remains higher than that found in the general population. For example, one recent study in British Columbia concluded that infant mortality rates were more than double the rate for First Nations people than for non-First Nations people. Post-neonatal mortality rates were found to be 3.6 times higher. First Nations infants were also more likely to be born pre-term than non-First Nations infants in both rural and urban areas of that province (Luo et al., 2004). Finally, the mortality rate for First Nations infants is consistent with that found among the lowest income groups in urban Canada, where there is a 1.6 times greater risk of infant death compared to high income groups (Social Union, 2003).

It has been argued that the high rate of teenaged pregnancy in many First Nations communities may be one explanatory factor for elevated levels of infant mortality among these communities (Dion Stout, Kipling & Stout, 2001). As noted by the authors of the aforementioned British Columbia study, excess infant mortality among First Nations people is due to higher post-neonatal mortality and, in particular, deaths due to preventable causes. What this suggests is a need for improved socio-economic and living conditions (Luo et al., 2004) and improved access to reproductive health services.

Teenage pregnancy in Canada is highest among disadvantaged socio-economic groups and is a particular health concern for First Nations. Owing to the economic situation of their guardians, children of teenaged mothers are more likely to live in poverty. In 2001, 80 percent of First Nations teenaged mothers lived in a household with a total income of less than \$15,000 per year, compared to 27 percent of First Nations mothers aged 20 years or older (Guimond & Robataille, 2008). This situation is compounded by high rates of lone parenting in First Nations communities. In 2001, 15.5 percent of Registered Indian women 15 to 24 years of age were lone mothers (Hull, 2004; see also Quinless, 2013, in this issue). Many of these lone mothers also had children with unstated paternity, often resulting in incorrect or no Status Indian registration for their children and the loss of accompanying benefits (see Clatworthy, 2004). By way of elucidation, registration as a Status Indian under the *Indian Act* is based on the status registration of both parents; numerous benefits are attached to Registered Indian status, including health and education programs.

Teen pregnancy can lead to a life of poverty that perpetuates an ongoing cycle of social problems, which were discussed in detail in earlier articles in this Journal. By the way of a summary, such social problems include substance abuse, child neglect, family violence, and a greater risk of child removal by social

services. The outcomes can be cyclical, with children of teen parents more likely to be victims of abuse and neglect and three times more likely to be incarcerated in their late teens and early twenties than children of mothers who delay childbearing. Most children of teenaged parents will have children when they become teenagers themselves (Anderson, 2002).

Under these circumstances, better access to reproductive health care would seem to constitute one important step towards ensuring better outcomes for affected Aboriginal teenagers. Many First Nations persons living on-reserve point to barriers when accessing the general health care system, not to mention reproductive health services. Reported barriers include extensive wait-times, services not covered by benefits, a shortage of doctors or nurses in the area, transportation costs, inadequate services, or lack of cultural sensitivity. The situation is more difficult for those persons living in rural and remote areas, where teenaged First Nations girls are among the most vulnerable with respect to accessing reproductive health services. Often lacking information concerning their sexual and reproductive health, they may not know where to turn. They face unexpected costs, significant travel time, and other expenses in order to access reproductive health services that are sometimes located hundreds of kilometers from their home communities. Small and isolated communities may lack services and birth control supplies. In particular, First Nations youth may experience difficulty obtaining contraception in the North (Aboriginal Nurses Association of Canada [ANAC], 2002).

Many additional factors have been noted as to why reproductive health service delivery to Aboriginal women requires improvement, including overt and covert racism, cultural insensitivity, and residence in areas with few services or in small communities with little privacy (ANAC, 2002). Aboriginal women have also indicated that health care providers frequently do not ensure the fully informed consent of Aboriginal women - achieved by providing full information in plain language and allowing a person to consider this information and make an informed decision about care (Native Women's Association of Canada [NWAC], 2007).

Certainly, some mothers who give birth to children in their teens have made successful lives for themselves and their children. However, teen pregnancy has consequences for the teenaged parent, the teen's child, the community, and Canadian society. Statistically, teen parents are less likely to complete their education, more likely to experience isolation and homelessness, less likely to develop good parenting skills, and more likely to transfer their own history of childhood abuse and neglect to their children (PHAC, 2000). These are issues of concern for all communities regardless of race or ethnicity, political orientation, income, or education level. These are concerns on the international stage as well as the national. Learning from international responses regarding youths' access to reproductive health services is the basis of the next section.

International Developments

The genesis of international agreements on reproductive health and sustainable development can be traced back to 1968. In that year, the United Nations Human Rights Conference recognized that parents have a right to determine family size and timing, as well as adequate to the education and information needed to exercise this right. These rights were later codified in the UN's (1979) *Convention on the Elimination of Discrimination against Women* and the "Plans of Action" produced by the 1974 (United

Nations World Population Conference, 1974) and 1984 (United Nations International Conference on Population, 1984) World Population Conferences.

During the 1980s and 1990s, the women's health movement increasingly challenged various population programs' continuing emphasis on reducing fertility rates rather than improving reproductive health. During the 1990s, a series of important United Nations conferences emphasized that the well-being of individuals, and respect for their human rights, should be central to all sustainable development strategies. Particular emphasis was given to reproductive rights as a cornerstone of sustainable development (UNFPA, n.d.f). As a result, the previous population control approach gave way to a new perspective that placed reproductive rights and health at the center of population plans at the 1994 International Conference on Population and Development (ICPD) at Cairo (UNFPA, 1995).

The importance of reproductive health and rights for meeting development goals has been increasingly recognized by the international community. High fertility augments poverty by slowing economic growth and skewing the distribution of consumption against the poor. Reducing fertility – by reducing infant mortality, increasing education, and improving access to services, especially reproductive health and family planning – counters these effects (UNFPA, 2008). In short, the international community has agreed that reproductive health is a basic human right and a fundamental precursor to sustainable development. But, without access to relevant information and high quality services, that right cannot be exercised.

The international commitments discussed below recognize that attaining the goal of sustainable, equitable development requires that individuals are able to exercise control over their sexual and reproductive lives.

The Cairo Programme of Action

The ICPD at Cairo, convened under the auspices of the United Nations in 1994, was the largest intergovernmental conference on population and sustainable development ever held. More than 180 states took part in negotiating a Programme of Action in the area of population and sustainable development for the next 20 years. It was the first international conference that did not specifically address women's issues, but they were, nonetheless, the main focus. The ICPD Programme of Action (UNFPA, 1995) forms the basis for achieving population and development objectives within a framework of human rights and gender equality.

The ICPD Programme of Action endorsed a new strategy that emphasized the integral link between population and sustainable development. It also focuses on meeting the reproductive health needs of individuals, rather than achieving demographic targets. The key aspect of this new approach is empowering women and providing them with more choices through expanded access to education and health services, skills development and employment, and involvement in governance processes at all levels (UNFPA, 1995).

The ICPD Programme of Action defines reproductive health as implying:

... that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (UNFPA, 1995, p. 40)

The ICPD Programme of Action also defines international reproductive health and rights objectives:

- a. To ensure that comprehensive and factual information and a full range of reproductive health care services, including family planning, are accessible, affordable, acceptable and convenient to all users;
- b. To enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so;
- c. To meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities. (UNFPAD, 1995, p. 41)

With respect to teens and youth, the objectives of the ICDP Programme of Action are as follows:

- a. To address adolescent [teen and youth] sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group;
- b. To substantially reduce all adolescent [teen and youth] pregnancies. (UNFPA, 1995, p. 50)

It also includes goals regarding improving education, particularly for girls, as well as further reducing levels of infant, child, and maternal mortality. One of the primary goals of the ICPD Programme of Action is to make family planning universally available by 2015 as part of a broadened approach to reproductive health and rights (UNFPA, 1995).

The ICPD Programme of Action recognizes that violence against women is inextricably linked to gender-based inequalities. When women and girls are expected to be generally subservient, their behaviour in relation to their health, including reproductive health, is negatively affected. Principle 4 of the ICPD Programme of Action recognizes that advancing gender equality, equity, the empowerment of women, eliminating all kinds of violence against women, and ensuring women's ability to control their own fertility are cornerstones of population and sustainable development programs. The human rights of women and girls are an inalienable, integral, and indivisible part of universal human rights (UNFPA, 1995).

Teenagers and Youth

In its advocacy and programming, the UNFPA focuses on key messages that can empower both women and men at different stages of their lives. Girls are empowered to delay pregnancy until they are physically and emotionally mature; boys are motivated to be sexually responsible partners. The UNFPA seeks to reorient the health education and services of signatory countries to meet diverse needs.

The UNFPA's objectives include encouraging development of programs that meet the special needs of teenagers and youth, especially young women, in accessing high-quality reproductive health services. Countries are directed to provide teenagers and youth with reproductive health information that helps them attain a level of maturity required to make responsible decisions. In particular, information and services should be made available to teenagers and youth in order to help them understand their sexuality and protect them from unwanted pregnancies, STIs, and the subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and share responsibility with women in matters of sexuality and reproduction (UNFPA, 1995).

Countries must, while recognizing the role of parents and guardians, ensure that programs and attitudes of health care providers do not restrict teenagers and youth from accessing the appropriate reproductive health services and information they need. These services must safeguard their rights to privacy, confidentiality, personal respect, and informed consent, but also respect cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory, and social barriers to reproductive health information and care for teenagers and youth (UNFPA, 1995).

Programs should integrate education and counselling in the areas of gender relations and equality, violence against teens, responsible sexual behaviour and family-planning practice, family life, reproductive health, and STIs, including HIV and AIDS prevention. Sexually active teenagers and youth require family-planning information, counselling, and services. Those who become pregnant require special support from their families and community during pregnancy and early parenthood. Programs for teenagers and youth are most effective when they are fully involved in identifying their reproductive and sexual health needs and in designing the programs (UNFPA, 1995).

Among the reasons for high rates of teenaged childbearing, the UNFPA (1995) Programme indicates poor educational and economic opportunities, sexual exploitation, and pressures to engage in sexual activity as important factors. In both developed and developing countries, teenagers with few apparent life choices have little incentive to avoid pregnancy and childbearing; low-income teenagers are especially vulnerable.

The UNFPA explains the connection between adolescent reproductive health, gender equality, and sustainable development:

Strategically investing in adolescent [teen] girls produces a double dividend. Enabling the adolescent girls of this and the next several generations to have greater control over their reproductive rights and to delay childbearing and family formation will contribute to greater fertility decline. Investing in their education, livelihoods, and health is critical to this end, but also has other effects: When girls stay in school, develop productive skills, protect their health, and have smaller families, young women will be stronger economic actors, individual children

will benefit from increased investment, families will enjoy greater economic prospects, and future generations will be less likely to live in poverty. The “dividend” is thus maximized. With even a few years to develop their potential, adolescent girls can change their lives, their communities, and their countries. (UNFPA, 2007a, p. 12)

As noted by the UNFPA, for young, poor parents, each additional child creates further strain on an already small budget for nourishing, educating, and keeping their children healthy. Failing to help teenaged girls delay pregnancy until they are physically, emotionally, and financially ready leads to higher health care and social welfare costs, a less educated and skilled workforce, limited socio-economic development, dependency of young mothers on male providers, gender inequality, fewer opportunities to rely on a growing youth population to help accelerate economic development, and reduced prospects for eradicating poverty (UNFPA, 2007a).

In sharp contrast, preventing unwanted teenaged pregnancy and investing in girls’ education, health, and livelihoods, means:

- Promoting young women’s human rights and rectifying pervasive gender inequalities;
- Supporting adolescent girls to grow up happy, healthy, and empowered;
- Saving lives – decreasing unnecessary maternal, infant, and child mortality and illness;
- Ensuring more babies will be born to mothers who are better prepared to care and provide for them;
- Improving the economic potential of families – breaking the cycle of intergenerational poverty; and
- Producing positive ripple effects for communities and societies, including improved productivity, reduced expenditures, and economic growth. (UNFPA, 2007a, p. 12)

Indigenous Peoples

The UNFPA conference and the subsequent ICPD Programme of Action brought together many diverse countries, cultures, and religions (UNFPA, 1995). Accordingly, the implementation of the ICPD Programme of Action is to be consistent with participating countries’ national laws and developmental priorities, with full respect for the various religious beliefs, ethical values, and cultural backgrounds of its peoples.

The ICPD Programme of Action is widely considered a breakthrough that reached at least partial consensus on population and sustainable development, where agreement had not previously been achieved. Despite reservations registered by many participating countries, particularly in relation to domestic religious and cultural values and concerning abortion, the ICPD Programme of Action has facilitated numerous population and reproductive health development successes among participants (Cook, Dickens, & Fathalla, 2003). The ICPD Programme of Action’s cross-cultural approach, emphasis on respect, and facilitation of local initiatives are key contributing factors to these successes.

In that vein, since the 1990s, increasing emphasis was given to securing the rights of historically marginalized groups, including Indigenous communities around the world. As noted earlier, compared to the general population of their countries, Indigenous peoples have higher rates of infant and maternal mortality, less access to education and health services, and limited participation in government and social systems. Accordingly, the UNFPA (1995) objectives respecting Indigenous peoples are as follows:

- a. To incorporate the perspectives and needs of Indigenous communities into the design, implementation, monitoring, and evaluation of the population, development, and environment programmes that affect them;
- b. To ensure that Indigenous people receive population- and development- related services that they deem socially, culturally, and ecologically appropriate; and
- c. To address social and economic factors that act to disadvantage Indigenous people. (p. 37)

In considering the population and development needs of Indigenous people, states are mandated to recognize and support their identity, culture, and interests and to enable them to participate fully in the economic, political, and social life of the country, particularly where their health, education, and well-being are affected. In particular, governments and societal institutions should recognize the distinct perspective of Indigenous people on aspects of population and development and, in consultation with Indigenous people and collaboration with other concerned organizations, should address their specific needs for reproductive health services. All human rights violations and discrimination, particularly all forms of coercion, must be eliminated (UNFPA, 1995).

The ICDP Programme of Action appeals for greater respect for religious and cultural beliefs of persons and communities, while simultaneously facilitating reproductive health and rights as key components of gender equality and development.

Other International Developments

Numerous other international agreements both pre- and post-ICPD contain principles that reinforce its Programme of Action. The constellation of rights recognized at Cairo was reaffirmed at 1995's World Summit on Social Development (WSSD) (UN, 1995) and the Fourth World Conference on Women (UN, 1995). At both events, participating countries were urged to include population factors in all sustainable development strategies and to act to eliminate gender-based violence and harmful traditional practices.

When combined with the Cairo Programme, the Beijing Conference (UN, 1995) is considered to have established sexual and reproductive health and rights as being fundamental to human rights and sustainable development. The following key concepts are said to have emerged from these two world events:

- a. Sexual and reproductive health and rights, especially a woman's fundamental right to control and make decisions about her body and sexuality, are an integral part of development and human rights.

- b. Good sexual and reproductive health, beyond the focus on demographics and family planning, are a prerequisite for socio-economic progress and sustainable development. Ensuring universal access to comprehensive sexual and reproductive health information and services, especially for women and adolescents, must be a priority goal for national programs.
- c. Population policies and family planning programs must uphold the principles of voluntary and informed choice and not impose coercive measures that violate fundamental human rights, especially of women.
- d. Mainstreaming a gender perspective in all policies, programs, and activities is essential to improving outreach and impact and making better use of existing resources.

Partnership with civil society, in particular with non-governmental organizations specialized in sexual and reproductive health, and with women's groups should become an integral element of government policy and programme planning, implementation, and monitoring (Alcala, 1995).

The Beijing Platform (UN, 1995, 106(e, I)), the WSSD Programme (UN, 1995, 36 (h)), and *Convention on the Elimination of Discrimination Against Women (CEDAW)* (United Nations, 1979, 12.1)) confirmed the need for universal access to a full range of safe and reliable family planning methods, which are not illegal, as part of comprehensive sexual and reproductive health care to be put in place by all participating countries by the year 2015.

The Beijing Platform (UN, 1995, 107 c) also confirmed the protection and promotion of the rights of teenagers to sexual and reproductive health information and services, as well as the goal of reducing the number of teenaged pregnancies. *CEDAW* (UN, 1979), the *International Covenant on Economic, Social and Cultural Rights* (UN General Assembly, 1966), and the *Convention on the Rights of the Child* (UN, 1989) all recognize the rights of female and male adolescents to sexual and reproductive health education and services. Both WSSD (UN, 1995, 5(g)) and the Beijing Platform (UN, 1995, 106(f), 108(1)) also called for the promotion of male responsibility in sexual and reproductive behaviour.

At the Beijing Conference, Indigenous women collectively issued a Declaration of Indigenous Women (Beijing Declaration of Indigenous Women, 1995) to call world attention to their particular realities. These realities include the cumulative impacts on human rights or gender discrimination combined with other forms of discrimination, such as those based on race or ethnicity. They noted that Indigenous women are all too often targets of forced pregnancy, sexual assault, forced sterilization, domestic abuse, and denied legal rights and protection. Poverty and limited access to economic resources, education, and health services have further contributed to the erosion of their economic and social rights (UNIFEM, n.d.).

Derived from numerous conventions and programmes, the following general principles guiding state conduct emerged:

In collaboration with non-governmental organisations, women's groups and other institutions of civil society develop a comprehensive national strategy for providing universal and equitable

access for all to primary health care, including sexual and reproductive health, with special attention to girls and women, without distinction as to race, national origin, sex, age, language, ethnicity, culture, religion, disability, socio-economic class, Indigenous identity, marital, family or other status. (Alcala, 1995, p. 3)

And,

[To] develop integrated service, information and educational programmes for adolescents that address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDs. (Alcala, 1995, p. 40)

Appendix A offers a chart generated by the UNFPA that highlights key international reproductive health human rights principles and their sources.

Millennium Development Goals. In adopting the United Nations (2000) *Millennium Declaration*, the international community committed itself to an ambitious goal: cutting in half the number of people living in absolute poverty by 2015. The Millennium Development Goals (MDGs), which are based on the Declaration, set out specific targets for life expectancy, education, housing, reproductive health, and gender equality, among others (United Nations Development Program [UNDP], n.d.). The MDGs are interrelated, requiring an integrated push for progress on all targets simultaneously. They are considered the starting point for eradicating poverty, safeguarding human rights and security, and achieving sustainable development. They recognize that reproductive health is a particularly powerful driver for improving lives.

The UNFPA's work in the fields of reproductive health and rights, women's empowerment, and population issues are considered to be at the core of the achievement of the MDGs and poverty eradication. The MDGs recognize that universal access to education and reproductive health care are crucial steps that can help individuals break cycles of poverty. Reproductive rights are central to women's empowerment, and empowered women are a key for opening the door to healthier and more productive families, communities, and countries (UNFPA, 2008).

The MDGs, the Cairo Programme of Action, and the Beijing Platform converge in their affirmation of women's human rights, including their reproductive rights, and the recognition that solving the world's most pressing problems demands the full participation and empowerment of women. The first seven MDGs are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal – global partnership for development – is about the means to achieve the first seven. The list of goals presented below is the new official MDG Framework that incorporates four additional targets and other indicator improvements adopted at the 62nd General Assembly of the United Nations in 2007 (UN, 2007).

MDG 1: Eradicate extreme poverty and hunger

MDG 2: Achieve universal primary education

MDG 3: Promote gender equality and empower women

MDG 4: Reduce child mortality

MDG 5: Improve maternal health

MDG 6: Combat HIV/AIDS, malaria, and other diseases

MDG 7: Ensure environmental sustainability.

MDG 8: Develop a global partnership for development. (UNDP, n.d.)

The MDGs recognize that universal access to reproductive health is imperative to reducing poverty because it increases the possibility of higher investment in human development, sustainable livelihoods, and food security. Investment in teenagers' reproductive health is critical for reducing poverty and achieving the MDGs. Women's ability to decide freely the number and timing of children is critical to their empowerment and expanded opportunities for work, education, and social participation. Enabling girls to delay pregnancy, ending discrimination against pregnant girls, and providing support to teenaged mothers can help ensure that they complete their education. It can also improve prospects for the family, helping to break the cycle of intergenerational poverty.

At the September 2005 World Summit, the goal of universal access to reproductive health was endorsed at the highest level and recognized as crucial to the attainment of the MDGs. Reproductive rights were recognized as valuable ends in themselves and essential to the enjoyment of other fundamental rights. Special emphasis was given to the reproductive rights of women and teenaged girls, as well as to the importance of sex education and reproductive health programmes. World leaders resolved to achieve universal access to reproductive health by 2015, promote gender equality, and end discrimination against women by adopting the Summit Outcome recommended by the General Assembly. Leaders agreed to integrate the goal of access to reproductive health into national strategies in order to attain the MDGs goals of ending poverty, reducing maternal death, promoting gender equality, and combating HIV/AIDS (UNFPA, n.d.h).

More recently, on the 17th of June 2009, the UN's Human Rights Council adopted a landmark resolution on "preventable maternal mortality and morbidity and human rights" (United Nations General Assembly, 2009). In this resolution, governments expressed grave concern for the unacceptably high rates of maternal mortality and morbidity, acknowledged it as a human rights issue, and committed to enhancing their efforts to protect the lives of women and girls worldwide. Through the Human Rights Council resolution, governments recognise that the elimination of maternal mortality and morbidity requires the effective promotion and protection of women and girls' human rights, including their rights to enjoy the highest attainable standard of sexual and reproductive health.

Indigenous Teenaged Reproductive Health Approaches. Efforts to reach international Indigenous groups with reproductive health programs, especially young Indigenous people, encountered a number of obstacles. Such impediments included language barriers, geographic accessibility, and social and cultural differences between Indigenous groups and the mainstream population (Farrell et al., 1999). The UNFPA is concerned that Indigenous communities often do not have access to reproductive health services, screening for HIV/AIDS and other sexually transmitted

diseases, or protection from gender-based violence. It would have such considerations included in broader investment programmes (UNFPA, 2007b).

In a 2007 speech at the United Nations Permanent Forum on Indigenous Issues, the Director of the Asia and the Pacific region at the UNFPA outlined some of the challenges faced during the encounter between UNFPA's mandate and Indigenous peoples. In addressing the challenge of restoring human dignity, maintaining their identity, and participating in the promise of a better political and economic life, it was observed that Indigenous peoples and ethnic minorities often bear the greatest burden of poverty. This implies that Indigenous populations, particularly women, are isolated not just economically, but politically and culturally. At the cultural level, the challenge is in striking a balance between respect for Indigenous cultures and mainstream reproductive health and gender equality. Thus, it is critical that high quality reproductive health information and services are provided in a culturally sensitive, accessible, and equitable manner (UNFPA, 2007b).

The Permanent Forum on Indigenous Issues has recommended that all relevant United Nations entities, as well as regional health organizations and governments, “fully incorporate a cultural perspective into health policies, programmes and reproductive health services aimed at providing Indigenous women with quality health care, including emergency obstetric care, voluntary family planning and skilled attendance at birth” (UNPFII, 2006, p. 2). Certainly, the issue of reproductive health services in Indigenous communities is a sensitive one, given their marginalization in many countries.

What follows are case studies of a few successful, culturally-relevant reproductive health initiatives involving international Indigenous populations.

Alukura, Central Australia. Alukura is an Arrernte word meaning “a woman’s camp.” Alukura was established following extensive consultation with Indigenous women throughout central Australia. It is a women’s health and birthing centre designed by the Central Australian Aboriginal Congress (an independent, community-controlled health service) in the 1980s to address the concerns of Aboriginal women in Central Australia. These women had a vision for a broad “one-stop” women’s health service, including pregnancy and birthing, screening, and children’s services. In Central Australia, women’s health and issues and the Grandmothers’ Law are intricately connected. So, a “women’s only,” separately located health service, is essential to ensure adequate access to health care (Bell, 2001).

Alukura provides a comprehensive woman’s screening service and a program for prenatal and postnatal care to optimize the health of mother and child in-utero and for the first 6 weeks of life. The goal of this program is to reduce infant mortality and improve birth weights. This program includes a visiting obstetrician and gynaecologist for a weekly clinic and Alukura midwives attending client births in nearby hospital facilities. Alukura also runs the Young Women’s Community Health Education Program with two educators offering sexual health education to young women aged 12 to 20 years in schools, youth organisations, and town camps in remote communities and at Alukura (Alukura, n.d.b).

Alukura services include the provision of culturally appropriate care – prenatal, intrapartum, postnatal, and women’s health. A full-time medical officer, midwives, women’s health nurse, liaison officer, educators, traditional grandmothers, and support staff are employed. A women’s health clinic offers treatment and advice on contraception, family planning, STIs/HIV, etc., while the midwifery-led maternity service offers prenatal education and prenatal, birthing, and postnatal care at Alukura and

Alice Springs Hospital. It also provides policy and advocacy in relation to Indigenous women's health in central Australia (Alukura, n.d.a).

Mooditj Program, Western Australia. Mooditj – the local Aborigine word for “solid” – is a community-based sexual health and life skills program for Aboriginal youth aged 11 to 14 years. It is the winner of the 2006 Healthway Excellence in Health Promotion Award. Developed by the Family Planning Association of Western Australia (FPWA), the program makes learning about sexual health an engaging experience for Aboriginal children entering puberty (May, n.d.).

The Mooditj Program is an integrated approach to sexual health, connecting sexual health, physical, mental, and emotional well-being with the impact of environmental and social influences. It aims to increase knowledge, enhance personal skills, and offer a platform permitting youth to feel comfortable talking about sexual health with trained community Mooditj leaders.

Mooditj is underpinned by an extensive consultation and sustainable development process with Indigenous Australians and those working with Indigenous youth from over 200 Western Australia regional and rural communities. Consultation results identified a need for a culturally-specific sexual health program for this age group. This finding was supported by the 2003 Indigenous Health Statistics report on increasing rates of the prevalence of STIs, abuse and relationship violence, teenage pregnancy, and high risk-behaviour among Aboriginal children and youth. The program was piloted in 10 rural and metropolitan communities around Western Australia, as well as with an after-school program and a camp, involving over 150 young people.

FPWA runs four-day Mooditj “leader training workshops” in communities across Western Australia. Participants have included social workers, police officers, teachers, Indigenous elders, health workers, and community members. Mooditj leader training programs focus on building confidence in delivering the program to young people. The program is supported by an easy-to-follow manual.

Mooditj is reported to have met with a great deal of enthusiasm from all over Western Australia, the Northern Territory, South Australia, and New South Wales. It has generated much interest from Aboriginal workers, government departments, regional service providers, and organisations working with Indigenous populations. To date, FPWA has trained over 300 Mooditj leaders, with many running ongoing Mooditj groups in their local communities (May, n.d.).

Delivered over ten sessions, Mooditj employs art, puppets, role-plays, and informal discussions to explore a wide range of “sensitive” topics, ranging from self-identity, emotions, and positive relationships to sexual issues and rights. The main findings from the Mooditj impact evaluation for February to August 2008 involved positive lifestyle outcomes, healthy sexual behaviour outcomes, and community impacts. These include the following:

- Interactive participation in Mooditj Young People Groups;
- Increased school attendance during and shortly after Mooditj;
- Improved hygiene;

- Increased respect for self and others;
- Increased self-esteem;
- Increased discussion of sexual health issues;
- Increased knowledge of pregnancy issues;
- Reported increased contraception use, mainly condoms and Implanon;
- Increased knowledge of STIs; and
- Increased attendance at clinics for STI testing and sexual health needs (Powell, 2008).

The Lilac Tent, Bolivia. Bolivia is home to some 35 different Indigenous groups, many of whom live in remote mountainous areas. Bolivia's Lilac Tent is an innovative rural health and family planning campaign in a place where family planning was previously a taboo subject. Messages on reproductive health became a normal part of public discussion due to numerous campaigns undertaken across Bolivia, which had a high rate of maternal mortality and an estimated 38 percent of maternal deaths caused by unsafe abortions (Center for Communications Programs, n.d.a). The Lilac Tent is the fourth component of a widespread communication and advocacy campaign designed specifically to service Bolivia's Indigenous population.

Political support for the initiative intensified when Victor Hugo Cardenas, then Vice President, and his wife, Lidia Catari, active representatives of the Indigenous populations of Bolivia, advocated reproductive health on television, in radio spots, and during personal appearances. The Lilac Tent ran from October 1998 through May 1999 and expanded the reach of the three previous campaigns to rural areas of Bolivia as part of the National Rural Reproductive Health Communication Strategy. In six months, three lilac-coloured tents, with reproductive health materials designed for teenagers and adults, reached about 40,000 people in 15 communities.

At every stop, 2,000 to 4,000 spectators participated. Community leaders vied to support Lilac Tent activities; dynamic community involvement helped inspire a sense of ownership and empowerment among participants. The tents housed videos, live music, theater, dance groups, mimes, games, puppet shows, print materials, and interactive learning devices. Each tent operated in coordination with local political leaders, health providers, schoolteachers, students, and performers in the communities. The UNFPA and other agencies also provided support.

Designed and implemented by consensus with public, private, and community groups, these communication campaigns had a major impact. Whereas in 1978 family planning was condemned, health centers were closed, and leaders sent to jail, today Bolivia embraces a nationwide reproductive health program. The country's contraceptive prevalence rate for modern methods more than doubled from 12.2 percent in 1989 to 25.2 percent in 1998 (Center for Communications Programs, n.d.a).

The purpose of the Lilac Tent was to generate community mobilization efforts and strengthen local capacity for reproductive health activities. Each tent was designed for a specific region of the country:

highlands, valleys, and plains. Messages and materials were adapted to reflect the local language, culture, and customs. For example, safe motherhood materials used in the highland region depicted women giving birth in the traditional squatting position and were translated into the Indigenous Aymara language. Adaptations of materials were based on extensive ethnographic studies and field-testing carried out by Bolivian non-governmental organizations (NGOs). The tent was intended primarily for rural teenagers and young couples, although market days and local holidays provided broader exposure of reproductive health messages to adults. The messages disseminated during the Lilac Tent's tour dealt specifically with reproductive health, including STI prevention, safe motherhood, and informed decision-making. There were also messages on environmental conservation, children's rights, and women's rights.

Before the arrival of the Lilac Tent in each town, NGOs in charge of each tent worked with local authorities to advocate continued support for reproductive health activities in their communities. Artistic resources from the community were invited to join the activities during the tent's three-day stop in each town. Concurrently, community radio operators were trained to disseminate reproductive health information. As part of the training, the radio operators received prototype scripts and a reproductive health message toolkit for local production.

The arrival of the tent in each town was marked by a carnival-style atmosphere. Balloons, posters, and flyers were distributed before and during the tent's visit. Community radio operators advertised the tent on air, and vehicles with megaphones announcing the event made their way through town. Local schools participated in reproductive health mural painting contests sponsored by the Lilac Tent.

After participating in Lilac Tent activities, more than 90 percent of the audience was able to define sexual and reproductive health. Ninety percent were also able to identify health centers as points of information and reproductive health services. Nearly 70 percent of participants were able to identify risk factors for obstetrical emergencies, and 73 percent said reproductive health decisions should be made with their partner. Seventy percent mentioned contraceptive methods as a way to plan their families. Finally, the number of people who wanted information on family planning and prenatal care increased by 21 percent and 33 percent, respectively (Center for Communications Programs, n.d.b). More than 200,000 people were touched in 21 municipalities, with 34,710 men and women actively engaged in formal learning. It was reported also that the infant mortality rate in participating areas improved and use of contraceptives increased (Strug, 2005).

All municipal governments, local authorities, and NGO representatives made available human, financial, or logistical resources to carry out tent activities. Furthermore, local governments pledged to carry out projects to improve reproductive health in their regions. Forty-two national organizations collaborated with the Lilac Tent through the National Reproductive and Sexual Health Forum. Approximately 80 institutions at the departmental level and 315 local organizations were involved in planning and implementing the Lilac Tent (Center for Communications Programs, n.d.b).

Guatemalan Association for Sex Education, Guatemala. With support from the Population Council, the Guatemalan Association for Sex Education (AGES) trained bilingual primary school teachers to conduct reproductive health classes in Mayan languages in rural Indigenous communities. Teachers were trained to conduct three 10-hour courses on topics such as birth spacing, reproductive

physiology and contraception, pregnancy, birth, gender, and violence. Fifty-six certified teachers (predominantly Indigenous) taught a total of 496 courses to 11,171 Indigenous persons. Although this intervention was not specifically targeted at Indigenous youth, many young people participated. Following the training, contraceptive use in the participating communities increased by 3 percent, representing an 18 percent increase in the use of all family planning methods (Farrell et al., 1999).

Project Concern International, Guatemala. Since 1974, Project Concern International (PCI) has worked with Mayan communities also in rural Guatemala. PCI's focus is on providing integrated women and children's health care, with an emphasis on reproductive health and family planning. Integral to PCI's programming in Guatemala is the importance of strengthening the capacity of local organizations to provide improved health care in rural communities. This strategy was successful in Santiago Atitlan, where PCI developed the local leaders' capacity to provide health care services, community and clinic-based family planning counselling, and provision of family planning methods in a village of nearly 40,000. PCI successfully integrated birth spacing activities with infant health interventions and was successful in promoting the concept of child spacing to Guatemala's rural, Indigenous population (PCI, 2004).

The NGO that was established out of this program, Rxiin T'namet (meaning "clinic of the people"), continues to provide much-needed health care services in the area. The lessons learned in Santiago Atitlan contributed to PCI's successful expansion of this project to improve service delivery for a total target population of 250,000 in six departments (or regions) of Guatemala (PCI, 2004).

In August 2000, PCI inaugurated the first Casa Materna in Guatemala. Casa Materna is located in Huehuetenango, with 80 percent Indigenous Mayan inhabitants. It has one of the highest maternal death rates to be found in Central America. A local NGO, the Association of Midwives (ACOMASMI), was consulted and integrated into the project. This was instrumental in achieving behaviour change related to family planning and reproductive health, which was attributed to the fact that ACOMASMI recruits and trains Indigenous Mayan community health workers and midwives for outreach and educational activities. Casa Materna, which originally offered monitoring services to women with high obstetric risks, has since become a strategy and a program in itself designed to reduce maternal death in Huehuetenango and neighbouring areas. Casa Materna is now a center for women's integrated health with a variety of interventions all directed to improve women's health. These interventions include the following:

- Offering curative, as well as preventive health services, to a target population of over 200,000 mainly rural women of reproductive age;
- Providing attention, food, and lodging to women in high obstetric risk;
- Training institutional, as well as community workers (mainly midwives and health promoters), on women's health issues;
- Contributing to research on sexual and reproductive health topics;
- Creating an institutional space for women's health advocacy;

- Supporting local NGOs implementing sexual and reproductive health projects in rural communities;
- Providing a pharmacy that offers essential medicines, as well as contraception; and
- Providing free contraceptive methods, including voluntary surgical contraception (PCI, 2004).

PCI has also been able to expand its sexual and reproductive health portfolio to include working with adolescents on sexual and reproductive health in order to increase knowledge and choices in this group for the reduction of teenage pregnancy and STIs. PCI in Guatemala has been recognized for its active promotion of women's health as a human right, particularly within Indigenous women's groups who otherwise would have no access to information and services (PCI, 2004).

International Synopsis

The importance of reproductive health and rights, with respect to meeting international development goals, has been increasingly recognized by the international community and endorsed at the highest levels. Reproductive rights have been recognized as valuable ends in themselves. They are essential to the enjoyment of other fundamental rights. Special emphasis has been placed on the reproductive health and rights of teenaged girls. Reproductive rights include the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so. It also includes the right to attain the highest standard of sexual and reproductive health, as well as the right to make decisions concerning reproduction free of discrimination, coercion, and violence.

A rights-based approach to reproductive health and development means that:

- Individuals have the right to control their sexual and reproductive lives and make reproductive decisions without interference or coercion, which includes family planning;
- Governments must ensure equal access to health care for everyone and address the unique health needs of women, men, and teenagers. Reproductive health services should be accessible to all groups, including teenagers and Indigenous people; and
- Governments are obliged to make comprehensive reproductive health services available and remove barriers to care. States are to address the rights of the most vulnerable people to reproductive health.

There is international consensus that advancing women's rights, in general, and reproductive health and rights, in particular, is a necessary precondition for halving the number of people living in poverty. It is seen as being fundamental to successfully achieving all other MDGs. The UNFPA focuses on ensuring that adolescent reproductive health and rights are included in national agendas. The priority is reaching the most vulnerable. Although teenaged reproductive health is a sensitive subject in many countries, UNFPA endorses the use of culturally sensitive approaches to gain support for providing young people with the resources they need to protect their reproductive health. Culture helps to mould the ways

people live with each other and influences their understandings of, and approaches to, development. Culturally sensitive programming is essential for achieving the ICPD and MDG goals for development in conformity with human rights. Furthermore, culturally sensitive approaches are tools to help build ownership within communities (UNFPA, 2008).

In particular, governments and civil society are mandated to recognize the distinct perspective of Indigenous people on aspects of population and sustainable development and, in consultation with Indigenous people, to address their specific needs for reproductive health services. Certainly, the issue of reproductive health services in Indigenous communities is a sensitive one, given their marginalization in many countries. In this context, the UNFPA Programme is notable for its rejection of all forms of coercion in population policies.

The success of culturally relevant approaches to reproductive health is illustrated by the examples of Indigenous reproductive health programming discussed above. Underpinned by extensive consultation and development with the Indigenous people they serve and usually involving myriad governments, local authorities, and NGO representatives, in addition to the communities, programme messages and materials were adapted to reflect the local language, culture, and customs. These examples are illustrative of the idea that, by taking into account different worldviews, religions, and cultures, culturally sensitive and human rights approaches to reproductive health encourage local solutions, which, in turn, ensure ownership and sustainability of development efforts.

Canada's First Nations

Given the reproductive health status and accompanying poor socio-economic indicators for many among Canada's First Nations population, particularly teenaged mothers, much of the international experience on reproductive health and development could be applied domestically. Certainly, this journal issue helps to demonstrate the strong interconnection among reproductive health, gender equality, and the fight against poverty in the context of teenaged and young First Nations mothers. Further, a good deal of holistic thinking on these issues has taken place internationally.

While First Nations teenage pregnancy is associated with numerous challenges and consequences, it is equally important to recognize the greater context in which this discussion takes place. Given a legacy of colonialism, oppression, and attempts at assimilation of First Nations peoples, including residential schools, forced sterilization, and the sixties scoop, First Nations reproductive health is an understandably sensitive topic.

As noted by the National Aboriginal Health Organization (NAHO, 2008),

Colonialism is also cited as a determinant of health for pregnant First Nations women (Moffitt, 2004, p. 323), including the residential school system; the imposition of Western medicine; government legislation; epidemics; and various other processes that undermined Aboriginal cultures and societies (National Aboriginal Health Organization, 2004, p. 7-8). Because of this, the discourse around birth and pregnancy often becomes part of the greater dialogue of self-determination and rights for First Nations people and communities. (p. 8)

In addition, community and cultural attitudes may also play a role in adolescent and teen fertility rates. They may act as a disincentive to accessing reproductive health services:

Traditionally, all children are considered a gift from the Creator, and thus any critical response to pregnancy can be seen as disrespectful. Many Aboriginal adults also had children young, and so youth pregnancy is a norm that community members may be reluctant to address. (Anderson, 2002, p. 16)

Clearly, the discussion is fraught with pitfalls. Yet, as Aboriginal Nurses Association of Canada (ANAC, 2002) observes:

Children are gifts from the Creator and deserve to grow in families and communities that show them unconditional love, teach them respect and prepare them for life. For many Aboriginal people, this is a challenge. Parents struggle to make ends meet or to deal with unemployment and the loss of traditional livelihoods. Family support may be lacking, and many adults today do not feel that they had a positive experience as children that would prepare them to be good parents. (p. 45)

And, as pointed out by Guimond and Robitaille (2008),

There is a strong temptation to use culture as an explanation, not to say justification, for early motherhood among First Nations teenage girls: they have children early because that's the way it is in traditional First Nations culture. Given the consequences of early motherhood, however, the very idea of a teenage mother not being able to provide her child with a healthy environment conducive to physical, emotional, intellectual and spiritual development is diametrically opposed to the spirit of traditional culture, which places the child at the centre of family and community life. (p. 51)

It is clear that, in both developed and developing countries, youth and teenagers with few apparent life choices and those with low-incomes are most vulnerable. Often they are also the ones who may have little motivation to avoid pregnancy and childbearing. As noted by the UNFPA (2007a), teenaged pregnancy is costly, in myriad ways. It brings lost potential. Not only are there health risks, pregnancy places a heavy toll on a girl's chances in life.

Becoming a mother before developing the personal resources for effective parenthood – being educated, gaining comprehensive health knowledge, starting work and participating in the community – constrains a girl's life options and endangers her children. She will develop less social capital and is more likely to be poor, to be a single parent or to get divorced, or to have more children than she wants. The outcome will be worse if she does not have a strong support system, as she will struggle to secure her family's safety, health, and livelihood. (UNFPA, 2007a, p. 11)

Some First Nations communities appear to be increasingly concerned about teen reproductive health, whether because of the number of unwed mothers, lack of paternal responsibility, breakdown in community supports (Bobet, 2005), or increased personal mobility and changing family structures (Assembly of First Nations [AFN], 2006). This increased concern over teenaged pregnancy among First

Nations communities is not about not valuing parenting or not wanting babies, rather, as ANAC (2002) points out,

... because in the current world having children early is hard on the parents, especially the mothers and the children. Most of us young parents are not prepared for the responsibility of raising children, and we often don't have family support close by – parents, grandparents, aunts and uncles – that we once had to help in this taxing job. Many, many young parents today are single mothers with little money. Having children usually ends our education early, so our families stay poor. Family problems like alcohol and drug abuse, violence and neglect can result. (p. 105)

As noted previously, some First Nations teenaged mothers made successful lives for themselves and for their children. This is not to say, however, that teenage pregnancy has no individual or social consequences. It often can negatively impact the teenaged parent, her child, her extended family, her Nation, and society. Statistically, we know that teenaged parents are less likely to complete their education, more likely to experience isolation and homelessness, less likely to develop good parenting skills, and more likely to transfer their histories of childhood abuse and neglect to their child. The social cost of teenaged pregnancy also includes higher rates of lone parenting, incarceration, poverty, and children taken into state care. All of these factors have lifelong impacts.

First Nations teenage girls face particular challenges because the traditional supports that were formerly part of their culture are no longer consistently there (PHAC, 2000). First Nations communities, as a whole, face circumstances that are disenfranchising. As we have seen both internationally and domestically, poor girls are far more likely to give birth during their teen years than girls who are better off. We also know that rural and Indigenous teenaged girls are more likely to be poor, have less education, have less access to reproductive health services, and, thus, are much more likely to become pregnant at a young age. Internationally, most Indigenous groups share the demographic profile of developing countries, where youth aged 10 to 24 years make up the largest portion of the population. Such groups tend to be poor, rural, and left out of the process of economic development, and, as Guimond and Robatille (2008) point out, First Nations adolescent fertility rates are more similar to those of developing countries than to other Canadian teenagers. Despite the steady decline, the infant mortality rate for First Nations people remains higher than that found in the general population. As noted earlier, the death rate for First Nations infants is consistent with that found among the lowest income groups in urban Canada, at 1.6 times a greater risk as compared to high income groups.

If we accept these statistics as accurately revealing that the reproductive health of Canada's First Nations appears to have more in common with developing countries than with non-Aboriginal Canadians, we might choose to ask ourselves:

Why do Aboriginal Canadian, Maori New Zealander, Aboriginal Australian and Native American babies born today share a pattern of premature morbidity and mortality rather than the expected healthy life-course of the non-Indigenous baby in the next crib? [And then reflect that] Despite marked improvements in the average indicators of health in Western nations, good health is not enjoyed by all. Our Indigenous citizens suffer substantial and systematic

inequalities that cannot be accounted for by individual make-up or behaviour. (Cass, 2004, p. 597)

One response to this state of affairs might be the general economic situation of teenage mothers, meaning that their children grow up in conditions of poverty more often. This is true of most teenaged mothers, but the situation is exaggerated for First Nations teenaged mothers. As discussed earlier, not only are First Nations teenaged mothers more likely to live in a family with a total income of less than \$15,000 per year, compared to First Nations mothers 20 years or older, First Nation's teenaged girls are significantly more likely to have grown up in the household of a teenaged mother, live in poverty, be subjected to state custody of children than are other non-Aboriginal Canadian teenaged mothers.

It is in this context that international principles offer a more holistic understanding of the interconnections between reproductive health, sustainable development, socio-economic progress, and the well-being of nations. Investments in teenagers and youth, including education, training, and reproductive health, are critical for reducing poverty. Yet, despite the commitment to develop a comprehensive national strategy for providing universal and equitable access to sexual and reproductive health, with special attention to girls, without distinction as to Indigenous identity, and in collaboration with civil society, First Nations adolescents and teenagers are still among the most vulnerable Canadians when trying to access reproductive health services:

Although in Canada advancements are being made in health services delivery specific for Aboriginal women, significant inequities remain in relation to the general population (Health Canada, 1999). There are few intervention programs for Aboriginal girls, and many of those that exist are delivered in culturally inappropriate ways (Steenbeek, 2004). (Banister & Begoray, 2006, p. 76)

Clearly, approaches to First Nations teen reproductive health should involve the youth themselves. Elders and the communities must be involved in developing the approach. Programs must respect Aboriginal culture and be presented to teenagers in their preferred language (PHAC, 2000). The inclusion of both male and female experience is vital.

By taking into account different worldviews, religions, and cultures, culturally sensitive approaches to reproductive health encourage local solutions that, in turn, ensure ownership and sustainability of development efforts. As a society, Canadians have a common responsibility of creating conditions in which all teenagers have opportunities for healthy personal development. As noted in a recent UNFPA (2007a) publication:

Adolescent girls hold the key to a world without poverty. With the right skills and opportunities, they can invest in themselves now and, later, in their families. If they are able to stay in school, postpone marriage, delay family formation, and build their capacity, they will have more time to prepare for adulthood and participate in the labour force before taking on the responsibilities of motherhood. They and their future children can be educated and healthy. One family at a time, they can help fuel the economic growth of their countries. (p. 1)

Canada is experiencing a demographic slowdown in general population replacement (the current fertility rate of about 1.54 children per woman, but the rate needs to be at 2.1 to ensure more than mere replacement), while a youthful Aboriginal population is growing at a rapid rate. Improving the reproductive health and well-being of First Nations teens and youth will facilitate increased access to education and greater labour market success for First Nations people. It will improve Canada's ability to meet its labour market needs as the mainstream workforce continues to age (Mann, 2007).

This is addressed by the UNFPA (2007a):

As youth populations reach their peak in developing countries, a historic opportunity to accelerate human development and economic growth is created: the demographic dividend. As higher proportions of young people enter their productive years with lower fertility rates, they have relatively fewer dependents to support. With the right policies and investments to develop young people's human capital and create jobs, they will earn more income. Under-investment, however, will exacerbate current problems, including un- and under-employment, crime and violence, and will miss the unique opportunity afforded by the demographic dividend. (p.12)

The ultimate goal is to maximize the number of children in Canada who are thriving, as well as the number of teenagers that enjoy reproductive well-being and futures full of possibilities. As proclaimed by the Beijing Platform, *"the girl child is the woman of tomorrow."* Given current Canadian demographics, now, more than ever, is the time to realize that First Nations girls are Canada's women of tomorrow. The toolbox for linking reproductive health and sustainable development in a culturally sensitive manner has already been filled by the international community. It falls to us to use those tools in building a better future.

Appendix A

Human Rights	Establishing Agreement	Rights-Based Actions
Right to life and survival	UDHR, article 3 ICCPR, article 6 CRC, article 6	Prevent avoidable maternal deaths End pre-natal sex selection and female infanticide Screen for cancers that can be detected early and treated. Ensure access to dual-protection contraceptive methods
Right to liberty and security of the person	UDHR, article 25 ICESCR, article 12 CEDAW. Articles 11, 12 and 14	Eliminate female genital cutting Encourage clients to make independent reproductive health decisions
Right to marry and establish a family	CEDAW. Articles 11, 12 and 14	Prevent early or coerced marriages
Right to decide the number and spacing of one's children	UDHR, article 12 ICCPR, article 17 ICESCR, article 10 CEDAW, article 16 CRC, article 16	Provide access to a range of modern contraceptive methods Help people choose and use a family planning method
Right to the highest attainable standard of health	ICESCR, article 12 CEDAW, articles 12 and 14 CRC, article 24	Provide access to affordable, acceptable, and comprehensive reproductive health services
Rights to the benefits of scientific progress	UDHR, article 27 ICESCR, article 15	Fund research on women's as well as men's health needs Provide access to obstetric care that can prevent maternal deaths
Right to receive and impart information	UDHR, article 19 ICCPR, article 19 CEDAW, articles 10, 14, 16 CRC, articles 12, 13 and 17	Make family planning information freely available Offer sufficient information for people to make informed reproductive health decisions.

Source: UNFPA (n.d.c).

Key:

UDHR: *Universal Declaration of Human Rights*

ICCPR: *International Covenant on Civil and Political Rights*

CRC: *Convention on the Rights of the Child*

ICESCR: *International Covenant on Economic, Social and Cultural Rights*

CEDAW: *Convention on the Elimination of Discrimination against Women*

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