

Sexual and reproductive health and gender-based violence in Kiribati:

A review of policy and legislation



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Acronyms

ANC	Antenatal care
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive sexuality education
DFAT	Department of Foreign Affairs and Trade (Australia)
GBV	Gender-based violence
GBVIE	Gender-based violence in emergencies
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IAWG	Interagency Working Group for reproductive health in crisis
ICPD	International Conference on Population and Development
IWDA	International Women's Development Agency
KCCP	The Kiribati Climate Change Policy
KFHA	Kiribati Family Health Association
KSDIS	Kiribati Social Development Indicator Survey
KV20	Kiribati 20-Year Vision 2016-2036
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer ¹
MFAT	Ministry of Foreign Affairs and Trade (New Zealand)
MHMS	Ministry of Health and Medical Services
MISP	Minimum Initial Service Package
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MWYSSA	Ministry of Women, Youth, Sport and Social Affairs
NCAF	National Curriculum and Assessment Framework
NCD	Non-communicable disease
NYP	National Youth Policy
PacLII	Pacific Islands Legal Information Institute
RH	Reproductive health
RRRT	Pacific Community Regional Rights Resource Team
SDGs	Sustainable Development Goals
SGBV	Sexual and gender-based violence
SHIP	Shared Implementation Plan to Eliminate SGBV in Kiribati
SPC	The Pacific Community (formerly Secretariat of the Pacific Community)
SRH	Sexual and reproductive health
SRHiE	Sexual and reproductive health in emergencies
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
TTM	Te Toa Matoi
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHRC	United Nations Human Rights Council
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WHO	World Health Organization
YFHS	Youth-friendly health services

1 It is recognised that LGBTIQ is contested as a descriptor, with some activists rather promoting a focus on the diversity of sexual orientation and gender identity and expression (SOGIE) in any community. However, LGBTIQ is most commonly used in policy documents in the Pacific region and is therefore what is used in these reports

Executive summary

In 2015, the United Nations set an ambitious agenda of Sustainable Development Goals (SDGs) to address poverty, injustice, and environmental destruction. Through the SDGs, nations committed to gender equality and health and, notably, established universal access to sexual and reproductive health and rights (SRHR) as a global target. Additionally, and relatedly, the SDGs include a specific target to ‘eliminate all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation’ (UN General Assembly, 2015). While laws and policies alone cannot achieve these targets, scholars and practitioners agree that an enabling legal and policy environment continues to play an important role in advancing SRHR and eliminating gender-based violence (GBV).

Review of the policy and legal landscape for realising SRHR and preventing and responding to GBV is a high priority for the Pacific region. Governments in the Pacific have committed to international and regional strategies to address SRHR and GBV, but there is a need to analyse existing national legislative and regulatory frameworks to identify the ways policy and legislation may work to support SRHR and prevent GBV, or conversely may undermine appropriate services and responses. For instance, many Pacific countries have plural legal systems that draw upon multiple sources of law, which may lead to conflict between statutory and customary law. This can particularly impact policies and laws related to SRHR and GBV (McGovern et al. 2019; Garcia-Moreno et al. 2015). Consequently, UNFPA Pacific commissioned a review of SRH and GBV related legislation and policy in six Pacific countries – Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. This report summarises findings from the review undertaken for the Republic of Kiribati and offers key legislative and policy recommendations to help promote SRHR and reduce GBV in Kiribati.

Background

Kiribati is composed of 33 islands from three island groups: the Gilbert Islands, the Line Islands, and the Phoenix Islands, scattered over 3.5 million square kilometres of the Pacific Ocean. Kiribati’s low topography has made the country especially vulnerable to the early impacts of climate change. The increasing population, limited access to fresh water supplies, distance between islands and remoteness of some communities create service planning and delivery challenges. When Kiribati became independent in 1979, the Constitution of Kiribati became the supreme law. Kiribati’s plural legal system is based on the Constitution, statutory law, received laws (English common law) and customary law (where this is consistent with the Constitution and statutory law). Any customary rule or law that may undermine sexual and reproductive health (SRH) or protection from GBV is therefore void if it conflicts with the Constitution or statutes. At the international level, Kiribati is party to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD). These distinct factors all impact policies and legislation related to SRHR and GBV in Kiribati.

Methods

The purpose of this study was to identify and analyse policies and legislation related to SRHR and GBV in Kiribati. The study consisted primarily of a desk-based review, which examined national legislation, policies, peer-reviewed literature, and other published reports relevant to SRHR and GBV in Kiribati. Document search and retrieval occurred from April 2020 to October 2020. The second stage of the review involved a content analysis of the included documents. The analysis focused on key domains and corresponding indicators adapted from themes under SDG Indicator 5.6.2 and commitments under international frameworks and conventions (such as the 1994 International Conference on Population and Development Programme of Action), and including those relevant to priority populations outlined in the CRPD and CRC.

Key findings

Gender equality and non-discrimination

- The *Constitution* of Kiribati states that every person is entitled to fundamental rights and freedoms whatever their sex, race, place of origin, political opinions, colour, or creed. However, the *Constitution* does not address discrimination based on gender, marital status, sexual orientation, or disability.
- While the *Constitution* does not fully address discrimination, the *Employment and Industrial Relations Code* (2015) mandates that an employer shall not discriminate based on sex, pregnancy, marital status, sexual orientation, family responsibilities, HIV/AIDS status, or disability. Furthermore, the Code mandates that employers pay men and women equal pay for work of equal value.

SRHR

- Kiribati's legislative and policy frameworks partially contribute to an enabling environment to promote SRHR, but gaps remain. For instance, while the *Ministry of Health and Medical Services Strategic Plan 2016-2019* and *Kiribati Development Plan 2016-2019* both include objectives and indicators related to SRH, no stand-alone SRH plan or strategy exists.²
- In the domain of sexual health, there is no national HIV or sexually transmitted infections (STIs) legislation in Kiribati, however strategic plans guide the national response to HIV and STIs, and have enabled the availability of voluntary counselling and testing (VCT) and HIV treatment and care. However, there is no legislative protection of personal information regarding HIV status in employment or other settings.
- Review findings suggest a need to strengthen policy to support increased access to the human papillomavirus (HPV) vaccine for adolescent girls. Indeed, Kiribati introduced a national HPV vaccination schedule in 2010, but coverage remains low.
- While legislative and policy frameworks do not restrict access to contraception and family planning services, there is a need to update policy guiding provision of these services with the *Ministry of Health and Medical Services Strategic Plan 2016-2019* no longer current.
- This desk review found substantial policy and legislative gaps in the provision of comprehensive sexuality education (CSE) in Kiribati. Kiribati lacks legislation mandating the integration of CSE into the national school curriculum. Additionally, while the mandated national educational framework includes health education, findings indicate a lack of focus on both SRH (beyond limited references) and gender in the health education curriculum.
- Improving maternal health is a policy priority under the *Ministry of Health and Medical Services Strategic Plan 2016-2019*. The *Kiribati Development Plan 2016-2019* also establishes increasing the proportion of births attended by skilled health personnel as a key performance indicator.
- Abortion is illegal unless it is performed to save the life of a pregnant woman under the *Penal Code* (1997). While the Ministry of Health and Medical Services report that some health facilities provide services for the prevention of unsafe abortion and management of post-abortion care services, this is not mandated in law or policy.

2 Please note that Kiribati has a draft RMNCAH Policy in August 2022 when this report is being published. The policy was not available at the time of policy and legislative review.

GBV

- There is substantial evidence of policy and legislative progress to reduce GBV in Kiribati. The *National Approach to Eliminating Sexual and Gender-Based Violence in Kiribati: Policy and Strategic Action Plan 2011-2021* operates as the overarching strategy on GBV and notably outlines the establishment of multisectoral referral mechanisms through the creation of SafeNet. Additionally, the *Te Rau N Te Mwenga Act* (2014) criminalises domestic violence and comprehensively defines domestic violence as inclusive of physical, sexual, psychological, and economic violence. The Act also notes that domestic violence may involve the exploitation of power balances or patterns of abuse over many years.
- Findings, however, indicate key gaps in the policy and legal regime around sexual violence and GBV. For example, the *Penal Code* (1977) criminalises rape, but narrowly defines rape as sexual intercourse and does not describe other forms of sexual violence. Spousal rape is not explicitly included in the Code's definition of rape, and there are also gaps in defining consent.
- The *Ministry of Health and Medical Services Strategic Plan 2016-2019* includes improving access to health care services for GBV victims as an objective, indicating support for a strong health sector response to GBV. The Plan also outlines a strategic action to implement Standard Operating Procedure of Eliminating Sexual and Gender-Based Violence policy. However, relevant policies and plans noticeably lack specific integration of the needs of LGBTIQ people, people with disabilities, and sex workers (noting that LGBTIQ people and sex workers have not been identified as key populations by government).

SRH and GBV in key populations

- Adolescents and youth: While most relevant legislation in Kiribati lacks specific consideration of young people, certain policies and laws help promote the SRHR, and reduce GBV experienced by, adolescents and youth. For example, the legal minimum age for marriage is 21 years (18 with parental/guardian consent), and both parties must consent to marriage. Education is compulsory for boys and girls aged six to 15 years, and a student cannot be disciplined on grounds of being pregnant or a parent. Finally, the Ministry of Health and *Medical Services Strategic Plan 2016-2019* explicitly discusses addressing the needs of youth under its objective to improve health care services for GBV victims.
- People with disabilities: There is limited SRH or GBV related legislation or policy addressing the needs of people with disabilities in Kiribati. Important national plans related to SRH and GBV (e.g. *Ministry of Health and Medical Services Strategic Plan 2016-2019*) do not mention or consider the distinct needs of people with disabilities. Kiribati is a signatory to the CRPD, and a key focus of the *National Disability Policy and Action Plan (2018-2021)* is to ensure all Kiribati legislation complies with CRPD. The Plan notes the need to develop a National Disability Inclusion Act, but this has yet to be passed into legislation.
- LGBTIQ people: Findings indicate that the legislative and policy environment inadequately supports LGBTIQ people in Kiribati. Key Kiribati policy measures related to SRH and GBV largely exclude issues relating to sexual orientation, gender identity, and expression. Furthermore, the *Penal Code* (1977) criminalises consensual sex between men, which may limit men's access to SRH services and protection from GBV. The law is silent on the status of same sex relationships between women, and on the rights and protections for other gender and sexually diverse groups.
- Sex workers: There are very limited policy provisions related to SRH and GBV for sex workers in Kiribati, and sex workers are not mentioned in key relevant plans such as the *Ministry of Health and Medical Services Strategic Plan 2016-2019*. While prostitution is not criminalised, the *Penal Code* (1977) prohibits soliciting in a public place and operating brothels, which may make it more difficult for sex workers to access SRH services and protection from GBV.

Humanitarian and disaster contexts

- Review findings indicate progress towards policy support for SRH in disaster and emergency contexts in Kiribati. While policy and legislation do not explicitly require the Minimum Initial Service Package (MISP), the Government of Kiribati made a commitment to integrate the MISP in disaster management plans and response efforts at the Nairobi ICPD25 conference. The *Kiribati Joint Implementation Plan for Climate Change and Disaster Risk Management 2019-2028* is also gender responsive, although it is important to flag that the Plan does not specifically include or refer to SRH.
- Despite the lack of specific policy and legislative provisions in Kiribati that require alignment with the Minimum Standards for Prevention and Response to GBV in Emergencies (GBViE), the overall policy landscape provides an enabling environment for this alignment with key policies recognising the intersection between emergencies and GBV, and the need to strengthen prevention and response in emergency contexts. For example, the *Kiribati COVID-19 Development Response Plan* includes a focus on strengthening GBV responses to mitigate the impact of COVID-19.

Conclusion and recommendations

This desk review suggests that Kiribati has made substantial progress towards creating a legislative and policy environment that protects women and girls from GBV, and good progress towards an environment that enables universal access to SRH. While implementation analysis was beyond the scope of this review, it is recognised that Kiribati faces unique service delivery challenges (including its geographical remoteness and small population). However, ensuring accountability for the implementation of current policy and legislation would significantly contribute to an enabling environment that supports SRHR and reduces GBV in Kiribati. Accountability could be strengthened by: ensuring monitoring and evaluation systems are robust and responsive, ensuring regular reporting against national and international commitments, and supporting research into barriers to implementation and the identification of solutions.

In addition, this preliminary desk review suggests specific actions that could be undertaken to strengthen policy and legislation in Kiribati.

General recommendations

- Revitalise efforts to revise the *Constitution* to guarantee protection from discrimination based on gender, gender identity and expression, and sexual orientation.
- Review and repeal legislation that is contradictory to Kiribati's international human rights obligations, such as the CRC, CEDAW, and CRPD. Any legislative reform should be approached comprehensively and involve consultation with civil society and key population groups, including gender impact assessment to understand possible unintended consequences.
- Strengthen data collection mechanisms to support the monitoring and evaluation of policy and legislative implementation to ensure annual targets are met and allow evidence-based reform (e.g. ensuring health management and information systems collect data on GBV and SRH, ensuring interoperability of administrative data systems and collection of GBV service data, strengthening capacity in data management, access, interpretation and use).

SRHR recommendations

- Draw on national family planning guidelines to strengthen indicators related to SRHR in future Ministry of Health and Medical Services strategic plans. This could include incorporating specific targets for the availability of different contraceptive methods at all service delivery points.
- Consider legislative reform to ensure access to contraception in all government run service delivery points.
- Support research to better understand the low contraceptive prevalence rate in Kiribati, with a particular focus on adolescents and young women, to inform policy and practice.
- Strengthen policy responses at the intersection of SRHR and GBV, since research reveals that Kiribati women experiencing GBV were less likely to be using family planning, more likely to report their last pregnancy as unintended and more likely to have more children than women who had not experienced partner violence (Secretariat of the Pacific Community, 2010). This could include policy in relation to bi-directional referral pathways between violence response services and health services, and service provider training.
- Review primary and junior secondary school curricula to ensure that CSE content is based on contemporary best practice.
- Encourage collaborations between the Ministry of Health and Medical Services, Ministry of Women, Youth, Sport and Social Affairs, and Ministry of Education to monitor enforcement of legislation to prevent disciplining or exclusion of pregnant students, to support young mothers to return to school, and to develop indicators relevant to menstrual hygiene management for inclusion in Ministry of Education policy.
- Revise the current indicator in the *Ministry of Health and Medical Services Strategic Plan* relevant to cervical smears and HPV testing to incorporate coverage of HPV vaccination.
- Strengthen collection, collation, and analysis of STI data across the country to inform policy and practice.
- Incorporate provisions for post-abortion care into health policy and practice guidelines, basing this on research into the prevalence, contexts, and impact of unsafe abortion in Kiribati.
- Consider reform of legislation that currently criminalises some sexual activity between consenting adults, and ensure legislation addresses discrimination based on sexual behaviour, sexual orientation, gender identity and expression.
- Develop strategies to ensure access to comprehensive SRHR services and information for all LGBTIQ I-Kiribati.
- Consider legislative reform to provide access to paternity leave, complementary to maternity leave, for personnel in government positions.
- Work with WHO to clarify the minimum standard of capacities required for a birth attendant to be assessed as 'skilled', and ensure this is reflected in policy. Monitor and report against efforts to improve the quality of services provided by antenatal care (ANC) clinics and through emergency obstetric care.
- Consider revision of future Ministry of Health and Medical Services strategic plans to incorporate actions to ensure SRHR services and information are inclusive of people with disabilities.

GBV recommendations

- Consider revising legislation that defines rape as an act only committed against women and girls to incorporate sexual violence against men and boys. Consider revising the *Penal Code* to incorporate a comprehensive definition of rape, including marital rape and all forms of sexual violence.
- Support research to better understand the experiences of women and girls who sell sex to inform revisions to policy and practice, including identifying strategies to prevent GBV, improving access to SRHR, and assessing whether there is a need to strengthen protection legislation in Kiribati. In addition, support research to better understand the experiences of men and transgender I-Kiribati who sell sex.
- Ensure that the next policy and action Plan on GBV includes specific actions to reduce violence against women and girls with all forms of disabilities, including the disability that can be a consequence of violence.
- Support efforts towards recognition of LGBTIQ people in Kiribati to ensure that the next policy and action Plan on GBV, and future Ministry of Health and Medical Services strategic plans, address the need for specific violence prevention and response services for LGBTIQ I-Kiribati.

Humanitarian and disaster recommendations

- Embed the MISP for SRH in disaster risk management and response policy and plans. Capitalise on current efforts to strengthen the governance and coordination of disaster risk management and response in Kiribati to prioritise the MISP within a health cluster.
- Ensure the MISP is also situated in broader Ministry of Health and Medical Services policy in ways that strengthen health systems as part of sexual and reproductive health in emergencies (SRHiE) preparedness and readiness.
- Ensure that current efforts to strengthen the governance and coordination of disaster risk management and response in Kiribati is inclusive of a protection cluster, and that a GBViE working group is prioritised within such a cluster.
- Ensure GBViE standards are embedded in policy and legislative frameworks, and that any protection cluster develop guidance relevant to preventing and responding to GBV for government and non-government agencies.
- Ensure that the roles and responsibilities outlined under the governance mechanisms currently under development include SRH and GBV.
- Consider revising the *Joint Implementation Plan for Climate Change and Disaster Risk Management 2019-2028* to include the indicator for 5.4 to include the number of family health clinics trained in SRHiE and GBViE, and to incorporate the MISP and GBV minimum standards.
- Include measures to prevent sexual exploitation, abuse and harassment in emergency contexts, including of and by workers in the response.

1 Introduction

1.1. Background and objectives

In 2016, the member states of the United Nations adopted 17 Sustainable Development Goals (SDGs) to address poverty, discrimination, abuse, preventable deaths and environmental destruction. Universal access to sexual and reproductive health and rights (SRHR) is among the global targets of the SDGs, reflected primarily under the goals for health and gender equality (UN General Assembly, 2015). SDG Targets 3.7 and 5.6 in particular call for universal access to SRHR, in line with the 1994 International Conference on Population and Development (ICPD) Programme of Action, the Beijing Platform for Action and their respective review conferences, as a precondition for achieving gender equality and empowering all women and girls (UNFPA, 1995; United Nations, 1995).

The SDGs also include a specific target to ‘eliminate all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation’ (UN General Assembly, 2015). This is consistent with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UN General Assembly, 1979), to which Kiribati acceded in 2004, and the Declaration on the Elimination of Violence Against Women (UN General Assembly 1993). Legislation criminalising violence against women scaffolds the right of women to live free from violence. While recognising that laws alone are not enough to eliminate violence, legal sanctions can act as a deterrent and legislation can be responsive to victims by providing protection and access to support services (Klugman, 2017). The realisation of SRHR requires that women and girls live free from violence, with research repeatedly demonstrating the close and consistent relationship between exposure to violence and sexually transmitted infections, unintended/unplanned pregnancy, abortion, an increased number of sexual partners, and women not having reproductive autonomy (Grose et al., 2021). In addition, particular violations of women’s SRHR (including but not limited to forced sterilisation, forced abortion, forced pregnancy, and denial of sexual and reproductive health (SRH) services) may in themselves constitute forms of violence against women.

Many nation states, including a number in the Pacific, have plural legal systems in which multiple sources of law are drawn upon simultaneously, for example customary or religious law alongside statutory law. These plural systems can in some cases lead to contradiction in the interpretation or enforcement of laws and can undermine constitutional and statutory provisions that seek to address discriminatory or harmful practices. This is particularly evident in relation to gender justice, SRHR, and violence against women (McGovern et al., 2019; Garcia-Moreno et al., 2015). In some countries, constitutional laws and legal structures sustain and foster discrimination in relation to sexual and reproductive health (SRH) and gender-based violence (GBV), for example undermining women’s ability to freely enter or leave marriage, requiring third-party authorisation to access services, restricting access to particular health services (such as safe abortion care), and by not recognising all forms of GBV. Legislative review has been recommended to address high rates of GBV and discrimination faced by women and minority groups in the Pacific (Chetty & Faletua, 2015).

Stigmatisation and criminalisation of some sexual behaviour and SRHR services and entitlements influences people’s health-seeking behaviour (UNFPA, 2019). This in turn impacts on demand for SRH services including family planning (UNFPA, 2019). Given the scope of factors that shape individuals’ health care-seeking behaviour, it is vital to “promote policies, laws and initiatives that support nonstigmatizing, culture- and gender-responsive SRHR programmes and services” (UNFPA, 2019, p.26).

While governments in the Pacific have committed to international and regional strategies to address SRHR and GBV, there is a need for further analysis of current barriers and enablers arising from existing national legislative and regulatory frameworks. The ability to achieve universal access to SRHR and elimination of GBV hinges on a supportive legal and policy environment.

A review of SRH and GBV related legislation and policy has been undertaken in six Pacific countries including Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu. These reviews contribute to UNFPA's work in the Pacific that aims to support countries to meet human rights commitments, progress towards the SDGs, ICPD 1994 Programme of Action and ICPD25 national commitments, and commitments related to the UN High-level Meeting on Universal Health Care (2019).

Specifically, these desk reviews sought to address the following questions:

1. What national laws, regulations and policies exist in each of the six Pacific countries that govern (a) access to sexual and reproductive health; and (b) prevention of and protection from gender-based violence?
2. What are the key factors influencing universal access to sexual and reproductive health and prevention of and response to gender-based violence that may emerge as a result of existing legislative and policy frameworks in each of the six Pacific countries?
3. What are the legislative and policy gaps in the protection and promotion of the right to SRH and the elimination of GBV in each of the six Pacific countries?

This report provides a summary of findings from the review undertaken for Kiribati, and key recommendations for legislative reform and policy strengthening in relation to SRHR and GBV in Kiribati.

1.2. Methods

This study was primarily a desk-based review and analysis of policies and legislation related to (a) sexual and reproductive health and rights and (b) gender-based violence in Kiribati. The review encompassed national legislation, policies, peer-reviewed literature and other published reports relevant to SRHR and GBV in Kiribati (see references for full list of sources).

Legislation is used throughout the report to refer to legally enforced and enforceable Acts, Bills, subsidiary regulations and orders made under the Acts and the *Constitution*. Policies refer to Government documents that provide a policy statement, position or guidance and broadly includes policies, plans and strategies.

The documents were identified through a systematic search of relevant databases including Scopus, HeinOnline, AGIS, and other online sources including Pacific Islands Legal Information Institute (PacLII) databases. Refer to search terms in Annex 1.

Document search and retrieval was undertaken over the period April to October 2020.

Government of Kiribati websites were searched for up-to-date policies, legislation and reports, some linking directly back to PacLII. General internet searches were conducted to capture any other relevant reports and grey literature. UNFPA Pacific and country focal points were contacted to provide assistance in accessing any policy documents, legislation or relevant reports not accessible online. Documents were categorised by type, as shown in Table 1, and analysed for relevance.

Table 1: Documents reviewed during the development of the Kiribati report

Source		Results	Omitted	Reviewed
Databases	Scopus	305	262	43
	HeinOnline	8	0	8
	AGIS	2	1	1
	Index to Legal Periodicals and Book (H.W. Wilson)	0	0	0
Book chapters			3	
Grey literature			37	
Total				92

The second stage of the review involved a content analysis of the included documents. Analysis was completed according to key domains and corresponding indicators (refer to Table 5 under Section 3, 'Summary of Findings') adapted from:

- Themes under SDG Indicator 5.6.2 (Number of countries with laws and regulations that guarantee full and equal access for males and females aged 15 years and older to sexual and reproductive health care, information and education) including access to maternity care, contraception and family planning, comprehensive sexuality education [CSE] and information, sexual health and wellbeing).
- Commitments under international frameworks and conventions, particularly the 1994 Programme of Action of the ICPD and respective review conferences and the CEDAW, general recommendations 19 (1992) & 35 (2017) provisions intersecting with SRHR.

While it is beyond the scope of this report to review commitments in relation to all international and regional instruments to which Kiribati is party, the report does consider commitments relevant to priority populations as outlined in the CRPD (to which Kiribati acceded in 2013), and the CRC (to which Kiribati acceded in 1995).

1.3. Limitations

There are a number of limitations of this review that need to be considered when interpreting findings and recommendations:

- The review is focused on the existence (or otherwise) of SRH and GBV policy and legislation. It was beyond the scope of the review to explore the implementation, enforcement and effectiveness of the documented policy and legislation.
- The documentation search was limited to documentation available online and in English. While effort was made to access documents referred to in literature but not available online, through UNFPA country focal points, it was not possible to complete a more comprehensive search of hard-copy or other documents not publicly accessible in the available time.
- The study did not cover all available implementation level documentation such as practice guidelines or sub-national documents that may have included more specific guidance on SRH and GBV (though the 2015 national family planning guidelines were reviewed, given their specific relevance to this report).

- There are likely to be initiatives at a country level to address particular priorities and gaps in current national policy and legislation, including sub-national initiatives. As the scope of this review is on national level legislative, policy and strategic planning documentation, such initiatives may not be captured here.
- While the review did incorporate GBV legislation and policy in so far as it intersects with SRHR, it cannot be considered a comprehensive GBV legislative review in its own right. The review did not comprehensively cover for example access to justice, sentencing and policing.

2 Country profile

2.1. Background

Kiribati gained independence from Britain in 1979 and is a sovereign republic. The country is made up of 33 islands from three island groups: the Gilbert Islands, the Line Islands and the Phoenix Islands. According to the 2015 census, Kiribati has a population of 110,136 (National Statistics Office, 2016). The coral atolls are dispersed over a vast body of ocean though half of the population lives in South Tarawa on the atoll of Tarawa. The official languages are Kiribati and English although the latter is spoken mainly in the capital.

Kiribati has a young population: 55 per cent of the nation's population is under 25 years of age (National Statistics Office, 2016). Religion plays a key role in the lives of the people. The dominant religion is Roman Catholicism (57 per cent), followed by the Kiribati Protestant Church and Kiribati Uniting Church (31 per cent combined), and the Church of the Latter-Day Saints (5 per cent) (National Statistics Office, 2016).

Kiribati has an export-oriented economy dominated by fishing, copra and the public sector. A significant portion of the government's revenue (approximately 41 per cent) comes from international aid (Piggott-McKellar, McNamara & Nunn, 2020). Kiribati's long history of seafaring, where people find employment on international merchant and fishing ships, also contributes to its economy (Borovnik, 2007).

The low topography of Kiribati has made the country particularly vulnerable to the early impacts of global warming and rising sea levels. The Kiribati Climate Change Policy (KCCP) makes clear that '[c]limate change is one of the greatest threats to Kiribati and the I-Kiribati people, their security and survival.' (Government of Kiribati, 2019a, p. 1). An increasing population and limited access to fresh water supplies and other natural resources are additional challenges, which only increase the need to urgently address the effects of climate change on Kiribati.

2.2. Legal frameworks

2.2.1. The Constitution

Kiribati adopted a constitution based on Western democratic principles in 1979, which was amended in 1995, 2016 and 2018 ('the *Constitution*'). Under the *Constitution*, the legislature, executive and judiciary form the three pillars of government. Governments are elected for four-year terms and the executive is made up of the president, who is the head of state, and the vice president. This model of government has elements of both the Westminster model and the presidential system, but also includes elements from the traditional maneaba (meeting house and governing) system.

The *Constitution* defines Kiribati as a sovereign democratic republic based on a multi-party system. Sources of law in Kiribati include: the 'Constitution and Acts of the Parliament; English common law and equity; pre-Independence British Acts continued after Independence and not replaced; [and] customary law' (UNDP Pacific, Regional Rights Resource Team Pacific Community (SPC) & Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009, p. 4). The rural population live in villages and the village system is structured vertically along patriarchal lines (Borovnik, 2007). Villages and communities are 'governed by the *Botaki n Unimwane*, a Council of Elders who represent the family (*utu*) or clan, and by the *maneaba* or community council' (Government of Kiribati, 2019b, para 2).

The *Constitution* 'prohibits discrimination on the basis of race, national origin, or colour, and the Government observes these prohibitions in practice' (U.S. Department of State, 2007, p. 840) and Section 3 of the *Constitution (Amendment) Act 1995* states that every person in Kiribati is entitled to fundamental rights and freedoms whatever his race, place of origin, political opinions, colour, creed or sex. However, the *Constitution* does not specifically mention people with disabilities in the sections on 'Fundamental Rights and Freedom of the Individual' and 'Protection from Discrimination' (Spratt, 2013). Nor does the section on Protection from Discrimination (s 15) extend to discrimination on grounds of sex and gender (Farran, 2015). The exclusion of sex as grounds for protection makes it 'theoretically legal' to discriminate against women, insofar as 'laws which discriminate against women cannot be held to be unconstitutional' (Crook et al., 2016, p. 77). There is also currently no recognition in the *Constitution* of de facto or same sex relationships. Addressing these gaps in constitutional protections would represent a significant step in enhancing national access to sexual and reproductive health.

2.2.2. The legal system

The legal system in Kiribati is based on the Common Law system inherited from the United Kingdom. However, courts are also required to take into account customary law in specified criminal and civil matters. There are three tiers of justice: the Magistrates' Court, the High Court and the Court of Appeal. The final court of appeal is the Privy Council in England, reflecting the colonial history of Kiribati. The High Court has jurisdiction in serious civil and criminal cases and appeals from decisions made by the High Court are heard in the Court of Appeal. The President of Kiribati appoints the Chief Justice, who presides over the Court of Appeal. In the outer islands, the Magistrates' Courts deal with common cases.

The Magistrates' Court is responsible for civil and criminal cases. The court includes three lay people well versed in Kiribati culture, land tenure and customary laws, who are appointed by the President on the advice of the Chief Justice and are recognised as community elders (*unimane*). Their expertise in customary laws allows them to deal with matters of 'divorce, adoption, care of children, paternity, inheritance, land and criminal offences' (Uakeia, 2016, p. 126) as magistrates.

The judicial system in Kiribati has been described as complex and is also challenged by shortages of qualified local lawyers and judges, necessitating reliance on the recruitment of judges from overseas (Uakeia, 2016, p. 127).

2.2.3. Relevant international commitments and conventions

The SDGs were set in 2015 by the United Nations General Assembly, with Kiribati adopting the 2030 Development Agenda at this time. This global agenda includes the nomination of specific targets relevant to SRHR and GBV, that all member states have committed to. Targets under the SDGs that are specifically relevant to this review are shown in the table below.

Table 2: Relevant SDG targets and indicators

SDG targets	Aligned indicators
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio (MMR) (note Kiribati has a national target based on number of deaths rather than MMR) 3.1.2 Proportion of births attended by skilled health personnel
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations
3.7 By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (10-14 years, 15-19 years) per 1,000 women in that age group
5.2 Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3 Eliminate all harmful practices, such as child early and forced marriage and female genital mutilation	5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care information and education

This report will support Kiribati to report against SDG indicator 5.6.2 in particular.

Kiribati acceded to CEDAW in 2004, with no reservations. The Government of Kiribati notes that because of the strong patriarchal traditions and clearly demarcated gender roles in traditional Kiribati culture, this accession was historically significant, which was both 'applauded as a landmark decision for I-Kiribati women and for Kiribati as a 'young nation' as well as drawing strong negative reactions from some sectors of the

public' (Government of Kiribati, 2019b, para 15). Kiribati has not ratified the CEDAW Optional Protocol which sets up a mechanism for individuals to submit complaints to the Committee on the Elimination of All Forms of Discrimination against Women. It has also not ratified the International Labour Organization's recent Violence and Harassment Convention.

However, Kiribati has demonstrated its commitment to preserving the human rights and opportunities of I-Kiribati girls through accession to the CRC in 1995, and the Optional Protocol to the CRC on the sale of children, child prostitution and child pornography (in 2015). Kiribati acceded to the CRPD in 2013.

The right to health is generally viewed as an economic, social and cultural right, contained within the International Covenant on Economic, Social and Cultural Rights (Article 12). Kiribati is not a signatory to this international covenant. However, Kiribati does have health-related obligations under CEDAW. These include the obligation to take all appropriate measures to 'eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning' and to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (Article 12). CEDAW also requires states to guarantee women equal rights in deciding 'freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights' (article 16(e)). The CRPD also outlines the right for persons with disabilities to access the same health care as other persons, including sexual and reproductive health (Article 25). While not legally binding, Kiribati is also party to a number of international declarations of commitment relevant to sexual and reproductive health, including the 1994 ICPD Programme of Action and the subsequent Nairobi Statement agreed at ICPD25, and several international declarations on HIV and AIDS facilitated by the United Nations.

In addition to these international obligations and commitments, Kiribati has committed to a number of regional agreements to promote sexual and reproductive health in the Pacific. These include the regional Moana Declaration (2013) that recognizes the crucial role parliamentarians play in advocating for the implementation of the ICPD Programme of Action. The Moana Declaration saw Pacific countries commit to the integration of sexual and reproductive health into national development strategies, health plans and budgets. Kiribati has also endorsed the Pacific Youth Development Framework 2014-2023 (The Pacific Community, 2015), the Pacific Sexual Health and Well-being Shared Agenda 2015-2019 (The Pacific Community, 2014), and the 2015 KAILA! Pacific Voice for Action on Agenda 2030: Strengthening Climate Change Resilience through women's, children's and adolescent health. The KAILA! Declaration outlines governments' commitment that sexual and reproductive health and rights be an integral part of national development strategies, national plans and public budgets, and affirms the centrality of advancing gender equality for sustainable development. Kiribati has also been an active participant in regional decision making and advocacy forums relevant to the promotion of SRHR and elimination of violence against women including the Forum Economic Ministers Meetings, Pacific Women Leaders Meetings, Pacific Heads of Health Meetings, the Micronesian Women's Conference, and the Pacific Women's Network Against Violence Against Women. Kiribati is also a party to regional agreements relevant to the prevention of GBV, including the Revised Pacific Platform for Action on the Advancement of Women and Gender Equality (2005-2015), and the Pacific Leaders Gender Equality Declaration of 2012.

Table 3: Relevant international human rights conventions

International Instrument	Ratification or commitment
Convention on the Rights of the Child See in particular Article 13 (Right to seek, receive and impart information), Article 19 (Right to be protected from all forms of violence and abuse), Article 24 (Right to health and health care), Article 34 (Right to be protected from sexual exploitation and abuse)	1995
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	2015
Convention on the Elimination of All forms of Discrimination Against Women See in particular Article 12 (Elimination of discrimination in access to health care services including family planning), Article 13 (2.b Elimination of discrimination in access to health care facilities including family planning for rural women), Article 16 (Elimination of discrimination in marriage, including in relation to family planning and elimination of child marriage); and CEDAW Committee General Recommendations No.19 and No.35 on gender-based violence against women	2004
Convention of the Rights of Persons with Disabilities See in particular Article 16 (Freedom from exploitation, violence and abuse), Article 21 (Right to information), Article 23 (Right to marriage, parenthood, family planning and retention of fertility), Article 25 (Right to health and health care, including specific SRH)	2013

(Source: UN Human Rights Treaty Body Database, 2020)

Table 4: Relevant regional commitments and agreements

Regional commitments	Year
Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2009-2015	2008
Revised Pacific Platform for Action on the Advancement of Women and Gender Equality (2005-2015)	2012
Pacific Leaders Gender Equality Declaration (2012)	2012
The Moana Declaration	2013
Pacific Sexual Health and Well-being Shared Agenda 2015-2019	2014
Pacific Youth Development Framework 2014-2023	2015
KAILA! Declaration (Pacific Voice for Action on Agenda 2030, Strengthening Climate Change Resilience through women's, children's and adolescent health)	2015

2.3. The health system and context

Kiribati faces particular and substantial challenges in relation to health and health care. It is one of the most geographically disparate countries in the world, with its 33 atolls spread across approximately 3.5 million square kilometres of ocean. Delivery of health services to such a scattered population is both challenging and expensive. Kiribati has high levels of poverty, and in South Tarawa where over half of the population lives, substantial overcrowding. While health is a stated priority for the Government of Kiribati, the country is one of only three Pacific Islands countries that did not achieve any of the health Millennium Development Goals (WHO, 2017). Kiribati has high rates of neonatal, infant and under-5 mortalities, and also has a high maternal mortality ratio with 90 maternal deaths per 100,000 births (noting the limitations of using MMR as an indicator in small populations) (WHO, 2017). Population growth is increasing the pressure on already strained health services.

The Ministry of Health and Medical Services is responsible for provision of healthcare services, and the development, implementation and monitoring of health policy (including in relation to SRH). Kiribati has a publicly funded health system with free medical services and medicines. There are four levels of facilities – the Tungaru Central Hospital (which is the central referral hospital in the country, based in South Tarawa); three other referral hospitals (in Betio, Kirimati Island and Tabiteuea North (Southern Kiribati Hospital)); 21 island health centres; and 106 village health clinics/dispensaries (Government of Kiribati, 2018). The population uses both biomedical and traditional health systems, although there is no mechanism for formal coordination between the two systems.

In its *20-Year Vision 2016-2036* (Government of Kiribati, 2016a), the Government of Kiribati clearly identified the need to implement measures to ensure an accessible and affordable quality healthcare system and made commitments to strengthen the capacity of health facilities by 100 per cent, and the doctor patient ratio to 1:1000, by 2036 (Government of Kiribati, 2016a, p. 34). The *Ministry of Health and Medical Services Strategic Plan 2016-2019* focuses on improving population health and health equity through improving the quality and responsiveness of health services, through effective and efficient use of existing resources. It outlines six strategic objectives, several of which are particularly relevant to SRH and GBV. The strategic objectives of the plan are to:

1. Strengthen initiatives to reduce the prevalence of risk factors for NCDs, and to reduce morbidity, disability and mortality from NCDs
2. Increase access to and use of high-quality, comprehensive family planning services, particularly for vulnerable populations, including women whose health and wellbeing will be at risk if they become pregnant
3. Improve maternal, new-born and child health
4. Prevent the introduction and spread of communicable diseases, strengthen existing control programmes and ensure Kiribati is prepared for any future outbreaks
5. Address gaps in health services delivery and strengthen the pillars of the health system, and
6. Improve access to high-quality and appropriate healthcare services for victims of gender-based violence, and services that specifically address the needs of young people.

In support of the Ministry of Health and Medical Services Plan, the *Kiribati-WHO Country Cooperation Strategy 2018-2022* outlines strategies for improving the quality and accessibility of healthcare, including for I-Kiribati living in outer islands, and includes a specific focus on improving reproductive, maternal, newborn, child and adolescent health. Through its Field Office in Tarawa, UNFPA provides technical and programme support to the Ministry of Health and Medical Services, particularly in relation to addressing unmet need for family planning, and young people's sexual and reproductive health. UNFPA has supported the Ministry of Health and Medical Services in developing standard operating procedures for the management of GBV, and these are awaiting final review and endorsement. Development partners such as the Australian Government's Department of Foreign Affairs and Trade (DFAT), the New Zealand Ministry of Foreign Affairs and Trade (MFAT) and others provide a range of resources to support Ministry of Health and Medical Services in implementation of their strategic plan.

3 Summary of key findings

The following table summarises Kiribati's legislation and policies according to key SRHR and intersecting GBV domains. Legislation and policy are mapped against the domains according to corresponding indicators, as outlined in the methodology. The indicators are intended to identify the extent to which Kiribati's current national legislation and policies align with relevant international frameworks and commitments around universal access to SRHR and eliminating GBV. It should be noted that the GBV indicators included in this review are only those which intersect most closely with SRHR.

Table 5: Summary of findings from the desk review of legislation and policy relating to SRH and GBV

Domain	Sub-domain	Specific indicators	Status	Notes
Gender equality and non-discrimination		Constitutional guarantee of substantive equality between men and women	Partial	<p>The preamble to the <i>Constitution</i> notes that the principles of equality and justice will be upheld, but there is no specific reference to gender equality in the <i>Constitution</i>.</p> <p>Section 3 of the <i>Constitution</i> notes that every person in Kiribati is entitled to fundamental rights and freedoms whatever their sex. While there is a specific section of the <i>Constitution</i> that outlines protection from discrimination on the grounds of race (s 15), there are no specific protections from discrimination on the basis of sex or gender identity or expression.</p> <p>In addition to the <i>Constitution</i>, s 114 of the <i>Employment and Industrial Relations Code 2015</i> mandates that an employer pay men and women employees equal remuneration for work of equal value.</p>
		Does the <i>Constitution</i> contain an anti-discrimination clause on the grounds of sex, gender, marital status, sexual orientation or disability?	Partial	<p>Section 3 of the <i>Constitution</i> (1979) states that every person in Kiribati is entitled to fundamental rights and freedoms whatever his race, place of origin, political opinions, colour, creed or sex. However, the <i>Constitution</i> does not address discrimination on the basis of gender, marital status, sexual orientation or disability.</p> <p>While the <i>Constitution</i> does not address discrimination comprehensively, Section 107 of the <i>Employment and Industrial Relations Code 2015</i> mandates that an employer shall not discriminate on the basis of (amongst other attributes) sex, pregnancy, marital status, sexual orientation, family responsibilities, HIV/AIDS status or disability.</p>

Domain	Sub-domain	Specific indicators	Status	Notes
SRH general	National SRH strategy	National sexual and reproductive health policy (or strategy) ³	Partial	Three objectives of the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> are specifically related to SRH, but there is no standalone policy or strategy ⁴ . The overarching <i>Kiribati Development Plan 2016-2019</i> also lists strategies (in relation to family planning and maternal health) and key performance indicators relevant to SRH.
		Does it include allocation of resources (including budget) to achieve targets and indicators to measure implementation?	Partial	The <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> includes budget and other resources to achieve objectives 2, 3 and 4 (related to SRH), and indicators to measure implementation (noting that this is not a standalone SRH plan).
	Fertility	Population policy on fertility (raise, lower, maintain)	Yes	The Government of Kiribati's <i>20-Year Vision 2016-2036</i> includes reducing the total fertility rates as a longterm national priority, with a target fertility rate of 1.8 by 2036.
		Population policy on adolescent birth rate	Yes	An indicator in relation to Objective 2 of the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> is number of teenage pregnancies (baseline was 120 in 2014, target of 100 by 2019). A key performance indicator for the <i>Kiribati Development Plan 2016-2019</i> is a declining adolescent birth rate.
	Adolescent and youth SRHR	Legislated equal minimum age of 18 for marriage	Yes	The <i>Marriage (Amendment) Act 2002</i> outlines that the legal minimum age for marriage is 21 years, or 18 with parental/guardian permission.
		Law requires full and free consent of both parties to a marriage	Yes	The <i>Marriage Ordinance</i> requires that both parties enter into the contract of marriage freely and voluntarily.
		Legislated minimum age of consent to sexual activity	Partial	The <i>Kiribati Penal Code</i> states the minimum age for consensual sex in Kiribati is 15 years. However, there is no legislated minimum age at which a person can consent to same-sex sexual activity, with sex between men being specified as a criminal act in the <i>Penal Code</i> regardless of consent.

³ "Recognizing that countries are in different positions in terms of resources, capacity, and the policy and legal environment, the most realistic option is for countries to commit in principle to a comprehensive approach to SRHR by adopting the definition proposed by the Guttmacher – Lancet Commission" (UNFPA, 2019). The Guttmacher-Lancet commission provides an outline of a comprehensive SRH essential services package in line with the ICPD Program of Action and other key international frameworks (Starrs, et al., 2018). Refer to Annex 2. Official adoption of a defined package of SRHR health services is a clear commitment that helps to ensure accountability.

⁴ Please note that Kiribati has a draft RMNCAH Policy in August 2022 when this report is being published. The policy was not available at the time of policy and legislative review. Please note that Kiribati has a draft RMNCAH Policy in August 2022 when this report is being published. The policy was not available at the time of policy and legislative review.

Domain	Sub-domain	Specific indicators	Status	Notes
SRH general	Adolescent and youth SRHR	Legislated compulsory primary and secondary education for boys and girls	Yes	The <i>Education Act 2013</i> legislates the compulsory education period as beginning in the year a child reaches six years and 7 months and ends when they reach the age of 15 or complete Year 9 (whichever comes first).
		Legislated prohibition on expulsion from school due to pregnancy	Yes	Section 41 of the <i>Education Act 2013</i> prohibits the disciplining of a student because she is pregnant or a parent.
Sexual health	STIs, HIV and AIDS	Law(s) or regulation(s) that guarantee access to:		
		Voluntary counselling and testing (VCT)	Partial	There is no national HIV or STI legislation in Kiribati, and while the <i>Public Health Ordinance</i> is inclusive of 'venereal disease' it does not address HIV or STI testing and counselling. Rather, the national response to HIV and STIs has been guided by a series of Strategic Plans. These plans have contributed to availability of VCT and HIV treatment and care in a number of locations in Kiribati. While there is no legislative protection of personal information regarding HIV status in employment settings, Section 111 of the <i>Employment and Industrial Relations Code 2015</i> , specifies that an employer not require an employee to undergo HIV or STI testing.
		Treatment and care	Partial	
		Confidentiality	Partial	
		No legislative restrictions to the above based on age, sex, marital status, or thirdparty authorization	Yes	Whilst the most recent <i>HIV/STI Strategic Plan</i> sighted was from 2013-2016, it outlines availability of VCT, HIV treatment and care, and confidentiality as outlined above. No legislation restricts access to these. However, the <i>Immigration Ordinance</i> permits an immigration officer to require any person entering Kiribati to submit to a medical examination (s 5) and the terms of the Ordinance are sufficiently broad to enable mandatory HIV testing. Similarly, Section 21 of the <i>Prisons Ordinance</i> provides that every prisoner undergoes medical examination upon admission and discharge, and this could extend to mandatory HIV testing with no requirement of judicial consent. In contrast, Section 111 of the <i>Employment and Industrial Relations Code 2015</i> specifies that an employer not require an employee to undergo HIV or STI testing.
		Legal prohibition of discrimination based on HIV status	Partial	There is no constitutional protection against discrimination on the grounds of HIV status, or legislative protection of personal information regarding HIV status in employment and other settings. However, the <i>Employment and Industrial Relations Code 2015</i> s 107, specifically prevents an employer from discriminating directly or indirectly against any employee or applicant for employment on the grounds of HIV/AIDS status.

Domain	Sub-domain	Specific indicators	Status	Notes
Sexual health	HPV	Law(s) or regulation(s) mandating access to HPV Vaccine for adolescent girls?	Partial	Kiribati introduced a national HPV vaccination schedule in 2010 but coverage is low. Gardasil is not included on the <i>Kiribati Essential Drugs List 2009</i> (the most recent Essential Drugs List sighted for Kiribati).
Contraception and family planning	Contraception	Does any law(s) or regulation(s) guarantee access to contraceptive services?	Partial	Legislation in Kiribati does not guarantee access to contraceptives. However, policy does not restrict availability of contraception or family planning services on the basis of age or marital status.
Essential medicines include:				
		Female condoms?	Yes	Female condoms are included on the <i>Kiribati Essential Drugs List 2009</i> (item 18.3.4).
		Contraceptive implants?	Yes	The <i>Kiribati Essential Drugs List 2009</i> includes implantable levonorgestrel (Jadelle) (item 18.3.5), copper containing IUDs (item 18.3.3), and injectable hormonal contraceptive medroxy progesterone acetate (Depo) (item 18.3.2).
		Emergency contraception (levonorgestrel)?	Yes	The Kiribati Essential Drugs List 2009 includes the combined oral contraceptive pill Microgynon, which could be used for emergency contraception. The list also includes oral levonorgestrel (Microlut) (item 18.3.1), though this is not recommended for emergency contraception as it is a very low dose of levonorgestrel.
		Law(s) or regulation(s) that guarantee the provision of full, free and informed consent for contraceptive services (including sterilisation)?	No	Legislation does not specify that full, free and informed consent is required prior to sterilisation or provision of contraceptive services. There is no legislation that specifically addresses forced sterilisation, though this may be considered a crime under the <i>Penal Code</i> if seen as an offence endangering life and health (see, for example, Section 226, Cruelty to Children).
		Does any law(s) or regulation(s) guarantee access to emergency contraception?	Partial	Legislation does not guarantee access to emergency contraception; however policy does not restrict availability and levonorgestrel is included in the <i>Kiribati Essential Drugs List 2009</i> .

Domain	Sub-domain	Specific indicators	Status	Notes
Contraception and family planning	Contraception	No legislative restrictions on contraception or contraceptive services based on age, marital status or third-party authorisation (e.g. spousal, parental/guardian, medical)	Partial	There are no legislative restrictions, or policy positions, that restrict access to contraception on the basis of age, marital status or disability. There are no requirements for third-party authorisation. However, policy and legislation do not make reference to protections or requirements in relation to consent or authorisation in relation to women with disability (for example).
	Family planning	Policy on provision of family planning services	Yes	The <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> has a specific focus on family planning services, with Strategic Objective 2 being to 'Increase access to and use of highquality, comprehensive family planning services'.
		Through government sources?	Yes	The <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> specifically outlines strategies for increasing availability of contraceptives at government service delivery points. A key performance indicator of the <i>Kiribati Development Plan 2016-2019</i> is an increased number of contraceptive contacts at health facilities per 1000 population.
		Financial support for provision through non-government?	Partial	The <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> includes strategic action 2.4 which is to strengthen partnership with the Kiribati Family Health Association, faithbased organisations, youth groups and other non-government organisations to expand family planning services and increase involvement of men, and this strategic action has a very small budget line attached (DB \$20,000 and RC \$10,000). However, it is unclear whether this financial support is to government service, to support their partnership building, or to non-government services to support service delivery.
Comprehensive sexuality education and information	CSE law	Legislated mandatory integration of comprehensive sexuality education into national school curriculum	Partial	The <i>Education Act 2013</i> mandates that schools must adhere to the national educational framework, which is the National Curriculum and Assessment Framework (NCAF), however it does not specifically mandate integration of comprehensive sexuality education (CSE) into the national school curriculum. The NCAF does not specifically require CSE.
	CSE curriculum	Minimum requirements for the curriculum to cover:		National Curriculum and Assessment Framework (n.d.). <i>*As this document is undated it is unclear whether the version retrieved is the most recent.</i>
		Relationships?	Yes	Health education in the NCAF includes a focus on 'building healthy relationships in such contexts as family, peer, friendships, sexual relationships, sport, community or work team'.

Domain	Sub-domain	Specific indicators	Status	Notes
Comprehensive sexuality education and information	CSE curriculum	Understanding gender?	No	Gender is not a focus of the NCAF.
		Violence and safety?	Partial	Health education in the NCAF includes a focus on 'understanding the challenges, risks and safety issues of behaviours that have an impact on personal and community health such as violence, substance abuse, sexual behaviours and safety in general'. Violence that is gender-based or against women is not specifically mentioned.
		Sexuality and sexual behaviour?	Partial	While health education in the NCAF includes a focus on 'building healthy relationships', including specific mention of sexual relationships, the Framework does not mention sexuality or sexual behaviour as a specific focus. The <i>National Youth Policy 2011-2015</i> notes that communication strategies to 'promote healthy sexual and reproductive behaviour' should involve delivery of messages through the school curricula. It is understood that a more recent youth policy (2018-2022) refers to family life education but was unsighted during this review.
		Sexual reproductive health?	Partial	While health education in the NCAF includes a focus on 'understanding the challenges, risks and safety issues of behaviours that impact on personal and community health such as sexual behaviours' there is no other reference to SRH in the Framework. The <i>National Youth Policy 2011-2015</i> notes that communication strategies to 'promote healthy sexual and reproductive behaviour' should involve delivery of messages through the school curricula.
		Human body and development?	Partial	The NCAF makes reference to Health Education including 'learning about the social, biological and physical environments in which people... grow and develop', however there is not specific reference to puberty or human development and its relationship with SRH.

Domain	Sub-domain	Specific indicators	Status	Notes
Maternal health	Maternity care	Does any law(s) or regulation(s) guarantee access to maternity care? Specifically:		While the right to life is protected under the <i>Constitution</i> , there are no specific provisions enshrining the right to health or health care generally or in relation to maternal and newborn care specifically.
		Comprehensive prenatal care	No	While there is no legislative guarantee of access to maternity care, it should be noted that maternal health is a priority in policy, with the third strategic objective of the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> being to 'improve maternal, newborn and child health' with the strategy outlining a number of strategic actions to be taken to improve the quality of, and access to, maternity care. Key performance indicators for the <i>Kiribati Development Plan 2016-2019</i> include maintaining the number of maternal deaths at zero or as close to that as possible; and increasing the proportion of births attended by skilled health personnel.
		Delivery by skilled birth attendants		
		Emergency obstetric care		
		Post-natal and newborn care		
		No legislative restrictions based on:		While there are no legal provisions that guarantee access to maternity care, there are also no legislative restrictions on who can access maternity care in either law or policy.
		(a) age	Yes	
		(b) marital status		
		(c) third-party authorization (e.g. spousal, parental/guardian, medical)		
	Abortion	Legal ground on which abortion is permitted?		Abortion is illegal under Sections 150-152 of the <i>Penal Code</i> . Sections 214-215 and Section 227 of the Code allow for abortions to be performed to save the life of a pregnant woman. The Code does not provide for any other circumstances in which abortion is permitted.
		To save a woman's life	Yes	
		To preserve a woman's physical health	No	
		To preserve a woman's mental health	No	
		In case of rape	No	
		In cases of fetal impairment	No	

Domain	Sub-domain	Specific indicators	Status	Notes
Maternal health	Abortion	If abortion is legal on some or all grounds, no restrictions based on:		<p>The only grounds on which abortion is permitted is to save the life of a pregnant woman, with Section 227 of the <i>Penal Code</i> noting that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation... upon any unborn child for the preservation of the mother's life.</p> <p>There is no mention of restrictions or exemptions based on parental or judicial consent, or husband's consent.</p> <p>Women can be criminally charged for illegal abortion under Section 151 of the <i>Penal Code</i>; and is liable to imprisonment for life. A person who performs an abortion is liable to imprisonment for 10 years under Section 150 of the Code.</p> <p>A 2015 SRH Needs Assessment report produced by the Ministry of Health and Medical Services noted that some health facilities provided services for prevention of unsafe abortion and management of post-abortion care services, but this is not mandated in law or policy.</p>
		Medical professional authorization	No	
		Parental or judicial consent for minors	No	
		Husband's consent for married women	No	
		Women cannot be criminally charged for illegal abortion	No	
		Guaranteed access to post-abortion care is mandated in policy or legislation, irrespective of legal status of abortion	No	
		National list of Essential Medicines includes:		
Lifesaving commodities		Oxytocin	Yes	Included under item 22.1
		Misoprostol	Yes	Included under item 22.1
		Magnesium Sulfate	Yes	Included under item 5
		Injectable antibiotics	Yes	Included under items 6.2.1 and 6.2.2
		Antenatal corticosteroids	Yes	Dexamethasone included under item 18.1
		Chlorhexidine	Yes	Included under item 15
		Resuscitation devices for newborns	No	Not included in the <i>Essential Drugs List 2009</i>
		Amoxicillin	Yes	Included under item 6.2.1

Domain	Sub-domain	Specific indicators	Status	Notes
Maternal health	Lifesaving commodities	Oral rehydration salts	Yes	Included under item 17.6 and 25.1
		Zinc	Yes	Included under item 17.6
	Family/ work balance	Legislated maternity leave	Yes	Section 95 of the <i>Employment and Industrial Relations Code 2015</i> mandates 12 weeks paid maternity leave for all pregnant workers, paid at not less than 25 per cent of full pay, and that women be appointed to the same or equivalent position they held prior to taking maternity leave. Maternity leave in the public sector is 12 weeks with full pay, though women can avail of this only twice during their employment with government.
		Legislated paternity leave	No	There is no provision for paternity leave in Kiribati legislation.
Gender-based violence	National action plan or strategy on violence against women	Does legislation guarantee provision of childcare by the employer or state?	No	There is no provision for childcare in Kiribati legislation.
		National action plan or strategy on gender-based violence? ⁵	Yes	The <i>National Approach to Eliminating Sexual and Gender-Based Violence (SGBV) in Kiribati: Policy and Strategic Action Plan 2011-2021</i> is the overarching strategy and action plan on gender-based violence.
		Does it include allocation of resources (including budget) to achieve targets?	No	The plan notes the need for resources, but these are not specifically detailed or allocated in the document.
		Does it include benchmarks, indicators to measure implementation of legislation?	Partial	While the plan outlines desired performance outputs, and includes as an overarching priority the development of a monitoring and evaluation framework, specific benchmarks and indicators are not included.
		Does it establish multisectoral referral mechanisms?	Yes	Key strategic area 4 of the Strategic Action Plan outlines a range of actions to improve access to preventive, protective health and multi-sectoral support services for women and their families who experience violence; and outlines the establishment of SafeNet (a formal referral network of service providers). This led to the development of the Kiribati Standard Operating Procedures for Gender-Based Violence Response, launched by the Ministry of Women, Youth, Sport and Social Affairs in 2018.

5 In line with Essential Services Package for women girls subject to violence <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>

Domain	Sub-domain	Specific indicators	Status	Notes
Gender-based violence	National action plan or strategy on violence against women	Does it establish mechanisms for collection of GBV data, including administrative and case management data?	Partial	While the national plan does not specifically establish mechanisms for the collection of GBV data, Section 44 of the <i>Te Rau N Te Mwennga Act 2014</i> requires that the ministry responsible for women's affairs compile annual statistics on protection orders, court proceedings, sentences, referrals and effectiveness of prevention and response interventions.
	Criminalisation and civil legislation	Are there specific domestic violence offences in criminal legislation?	Yes	Section 2 of the <i>Te Rau N Te Mwennga Act 2014</i> includes a comprehensive definition of domestic violence and states that 'In enacting this Act, the Maneaba ni Maungatabu recognises a) that domestic violence, in all its forms, is unacceptable behaviour and is a crime'. Section 33 of the <i>Te Rau N Te Mwennga Act 2014</i> outlines offences and penalties that may be incurred by a person who commits domestic violence, breaches a protection order and does not comply with a Policy Safety Order, noting in Section 34 that they may also be prosecuted under any other criminal laws if the acts of domestic violence constitute a criminal offence under those provisions (such as acts outlined in the <i>Penal Code</i> which constitute assault, reckless and negligent acts, grievous harm, attempt to murder etc). However, the <i>Penal Code</i> does not include specific domestic violence offences.
	Criminalisation of sexual violence		Partial	Sections 128-139 of the <i>Penal Code</i> criminalise, and outline punishments for, rape, attempted rape, abduction with the intent of rape, indecent assault, procuration and defilement. However, it should be noted that the definition of rape only refers to 'sexual intercourse' without further explanation or description of the breadth of acts that could be considered sexual violence (Section 161 of the <i>Penal Code</i> defines sexual intercourse in relation to proof of penetration). Sexual violence against men is addressed in Sections 153-155 of the <i>Penal Code</i> , however these sections also criminalise consensual sex between men. While the <i>Penal Code</i> does not characterise rape or sexual assault in this way, Section 4(2)(a) of the <i>Te Rau N Te Mwennga Act 2014</i> defines sexual abuse as including any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of a person and defines sexual assault in a way that includes a broad range of acts of sexual contact. However, the <i>Te Rau N Te Mwennga Act 2014</i> is focused on sexual violence in the broader context of domestic violence and not on non-partner sexual violence.

Domain	Sub-domain	Specific indicators	Status	Notes
Gender-based violence	Criminalisation and civil legislation	Comprehensive definition of domestic violence in legislation, including physical, sexual, psychological and economic violence	Yes	<p>Section 2 of the <i>Te Rau N Te Mwenga Act 2014</i> states that 'In enacting this Act, the Maneaba ni Maungatabu recognises d) that domestic violence extends beyond physical, sexual, psychological and economic violence and may involve the exploitation of power imbalances and/or patterns of abuse over many years'</p> <p>Section 4 of the <i>Te Rau N Te Mwenga Act 2014</i> notes that an act or omission or conduct shall constitute domestic violence if it a) harms, injures or endangers the health, safety, life, limb or well-being, whether mental or physical of the complainant or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse, and economic abuse. Section 4(b) of the Act also notes that this extends to demand for property. The Act includes a range of inclusions of what would be considered physical, sexual, verbal, emotional, psychological and economic abuse.</p>
		Domestic violence legislation covers marital relationships	Yes	In defining the types of relationship covered under the Act, Section 5 of the <i>Te Rau N Te Mwenga Act 2014</i> includes relationships between the complainant and the respondent when a) they are or were married to each other, whether in accordance to law, custom or religion.
		Domestic violence legislation covers non-marital relationships	Yes	In defining the types of relationship covered under the Act, Section 5 of the <i>Te Rau N Te Mwenga Act 2014</i> includes relationships between the complainant and the respondent when b) they live or lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other.
		Domestic violence legislation covers same sex relationships	Yes	<p>While same sex relationships are not specifically mentioned in Section 5 of the <i>Te Rau N Te Mwenga Act 2014</i> (where the meaning of 'domestic relationship' is specified), the definition of domestic relationship is framed in gender neutral terms and many of the examples included apply to same sex relationships:</p> <ul style="list-style-type: none"> (b) they live or lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other (c) they are parents of a child or are persons who have or had parental responsibility for that child (e) they are or were in an engagement, courtship or customary relationship, including an actual or perceived intimate or sexual relationship of any duration (f) they share or recently shared the same residence <p>However, it should be noted that Sections 153-155 of the <i>Penal Code</i> criminalise consensual sex between men which may limit the ability of men in same sex relationships to access protection under the law.</p>

Domain	Sub-domain	Specific indicators	Status	Notes
Gender-based violence	Criminalisation and civil legislation	Domestic violence legislation covers non-cohabiting relationships	Yes	In defining the types of relationship covered under the Act, Section 5 of the <i>Te Rau N Te Mwenaga Act 2014</i> includes relationships between the complainant and the respondent when (e) they are or were in an engagement, courtship or customary relationship, including an actual or perceived intimate or sexual relationship of any duration.
		Domestic violence legislation covers family relationships	Yes	In defining the types of relationship covered under the Act, Section 5 of the <i>Te Rau N Te Mwenaga Act 2014</i> includes relationships between the complainant and the respondent when (d) they are family members related by legal or customary adoption and (g) they are wholly or partially dependent upon ongoing care in the same household.
		Domestic violence legislation covers members of household	Yes	In defining the types of relationship covered under the Act, Section 5 of the <i>Te Rau N Te Mwenaga Act 2014</i> includes relationships between the complainant and the respondent when (f) they share or recently shared the same residence and (g) they are wholly or partially dependent upon ongoing care in the same household.
		Broad definition of sexual assault including rape, characterised as a crime against the right to personal security and physical, sexual and psychological integrity?	Partial	While the <i>Penal Code</i> does not characterise rape or sexual assault in this way, Section 4 (2a) of the <i>Te Rau N Te Mwenaga Act 2014</i> defines sexual abuse as including any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of a person. Section 112 of the <i>Employment and Industrial Relations Code 2015</i> prohibits sexual harassment of employees or prospective employees, and notes that employers must take all reasonable steps to prevent sexual harassment.
		Sexual assault within a relationship specifically criminalised (e.g. "no marriage or relationship constitute a defense to a charge of sexual assault under the legislation")?	No	While rape is a crime, spousal rape is not explicitly included in the definition of rape (see Section 128 of the <i>Penal Code</i> for the definition of rape).

Domain	Sub-domain	Specific indicators	Status	Notes
Gender-based violence	Criminalisation and civil legislation	In relation to sexual assault, defence of consent is defined as 'unequivocal and voluntary agreement' explicitly including a non-exhaustive list of circumstances which cannot constitute consent	No	Consent is not defined. While section 128 of the <i>Penal Code</i> outlines some circumstances that cannot constitute consent (such as where there is force, threats, intimidation, fear of bodily harm, false representations, personating a husband), Section 133 notes that consent of a girl under 15 years is no defence to charges of indecent assault, Section 134 notes that consent of a girl under 13 is no defence to charges of defilement, and Section 135 notes sexual intercourse/attempts to have sexual intercourse with a woman or girl with intellectual disability ('an idiot or imbecile') is unlawful, a number of other relevant circumstances are not listed. Reasonable belief that a girl under 18 years was above 18 years can be used as defence against charges of abduction of a girl under 18 years with the intent to have sexual intercourse (s 132). The <i>Te Rau N Te Mwenaga Act 2014</i> does not define consent.
		Prohibitions on the use of corroboration, prior sexual conduct and proof of resistance in sexual offence proceedings	No	These prohibitions are not outlined in legislation.
	Health sector response to GBV	Legislation guarantees issuance and monitoring of eviction, protection, restraining or emergency barring orders against alleged perpetrators, including adequate sanctions for non-compliance	Yes	Sections 11-21 of the <i>Te Rau N Te Mwenaga Act 2014</i> outline who can apply for a protection order (including who can apply for a protection order on behalf of another, such as a family member, police officer, community worker or health care provider); the form of application to a court for a protection order; the power of the court to make protection orders; the types of protection orders that can be made; the conditions of a protection order (including in relation to child custody and access); and variations or cancellation of a protection order. Sections 26-30 outline the duty of police to act, including in relation to breaches of a protection order. Section 33 notes that someone who has committed domestic violence, breached a protection order and failed to comply with a Police Safety Order has committed an offence, punishable by up to a maximum of six months' imprisonment or a fine up to \$250. Penalties escalate for repeated offences, and an offender may also be prosecuted for criminal acts under the <i>Penal Code</i> .
		Are there clinical guidelines/ SoP for identification and management of cases of GBV, including sexual assault and domestic violence, for use in the health sector?	Yes	One of the six strategic objectives of the <i>Ministry of Health and Medical Services Ministry Strategic Plan 2016/2019</i> is to 'improve access to highquality and appropriate health care services for victims of genderbased violence, and services that specifically address the needs of youth', indicating the high priority placed on health care for people who have experienced GBV. One of the strategic actions outlined in the plan is to implement Standard Operating Procedure of Eliminating Sexual and Gender-Based Violence Policy.

Domain	Sub-domain	Specific indicators	Status	Notes
Gender-based violence	Health sector response to GBV	Does legislation or policy guarantee access to healthcare and reproductive health care (incl. emergency contraception and post exposure prophylaxis against HIV) for victim/survivors of GBV?	Yes	Section 32(3) of the <i>Te Rau N Te Mwenga Act 2014</i> clarifies that a health care professional must examine the complainant adhering to professional standards or confidential treatment and advise the victim of support options available and refer to counselling where available.
		No restrictions on the above based on marital status, residency, age or other factors?	Yes	No such restrictions are outlined, though the Act notes limited service availability in the outer islands.
SRH and GBV in key populations (cross-cutting)	Legislative protection	No additional legislation that restricts access to SRH or GBV response services, or otherwise undermines SRH and protection from GBV, for:		
		Adolescents and youth	Partial	While no additional legislation specifically restricts access to SRH or GBV services or undermines SRH and protection from GBV for youth and adolescents, there is limited consideration specifically of young people in relevant legislation.
		People with disabilities	Partial	While no additional legislation specifically restricts access to SRH or GBV services or undermines SRH and protection from GBV for people with disabilities, there is limited consideration specifically of people with disabilities in relevant legislation.
		LGBTIQ people	No	Sections 153-155 of the <i>Penal Code</i> criminalise consensual sex between men which may limit the ability of men in same sex relationships to access SRH services and information, and protection from GBV. Section 107 of the <i>Employment and Industrial Relations Code 2015</i> mandates that an employer shall not discriminate on the basis of (amongst other attributes) sexual orientation. However, the law is largely silent on the status of same sex relationships between women and on the rights of and protections owed to IKiribati people who may identify as members of the LGBTIQ community.
		Sex workers	Partial	Prostitution is not criminalised in Kiribati, but soliciting in a public place, and gains from prostitution, procuring women and children to engage in prostitution, and running brothels are under the <i>Penal Code</i> . Trafficking is also criminalised under the <i>Measures to Combat Terrorism and Transnational Organised Crime Act 2005</i> . Otherwise, sex workers are not specifically considered in health or GBV related legislation.

Domain	Sub-domain	Specific indicators	Status	Notes
SRH and GBV in key populations (cross-cutting)	Special provisions	Special provisions in legislation or policy to improve access to SRH and ensure protection from GBV for:		
		Adolescents and youth	Yes	One of the six strategic objectives of the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> is to 'improve access to highquality and appropriate health care services for victims of genderbased violence, and services that specifically address the needs of youth', indicating the high priority placed on health care for youth and adolescents. Strategic actions outlined in the plan include to finalise and implement national operational guidelines for youth-friendly health services (YFHS); to improve planning of and expand access to YFHS; and to strengthen coordination of YFHS with national youth stakeholders. The <i>Children, Young People and Family Welfare Act 2013</i> contains specific provisions to protect young people from domestic violence, which may include gender-based violence.
	People with disabilities	Partial	Kiribati is a signatory to the Convention on the Rights of Persons with Disabilities (CRPD), which obligates state parties to take measures to protect people with disabilities from violence, including GBV, and to ensure realization of sexual and reproductive health, including through access to services and information. A key focus of the <i>National Disability Policy and Action Plan (2018-2021)</i> is to ensure all Kiribati legislation complies with, and supports the intent of, the CRPD. A key activity under the plan is to develop a National Disability Inclusion Act, but this has yet to be passed into legislation. Additional key focus areas of the National Disability Plan are to improve access to quality health care, rehabilitation services and assistive technologies, with the policy specifically noting the need to ensure SRH and GBV programs are accessible to people with disabilities; and to address the particular disadvantage experienced by women and girls with disabilities. Relevant activities included in the plan include the disaggregation of all Ministry of Health and Medical Services data; and including people with disabilities in SRH and GBV programs, however no budget has been allocated to ensure activities are implemented. However, there is no mention of people with disabilities in the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> in relation to SRH or GBV, or in the <i>National Approach to Eliminating Sexual and Genderbased Violence in Kiribati Policy and National Action Plan 2011-2021</i> .	

Domain	Sub-domain	Specific indicators	Status	Notes
SRH and GBV in key populations (cross-cutting)	Special provisions	LGBTIQ people	No	People who identify as being members of the LGBTIQ community are rarely considered in policy, with issues relating to sexual orientation, gender identity and expression largely invisible in Kiribati policy measures relating to SRH and GBV including in the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> and the <i>National Approach to Eliminating Sexual and Genderbased Violence in Kiribati Policy and National Action Plan 2011-2021</i> .
		Sex workers	No	While there is occasional mention of sex work and sex workers in policy documents, including of <i>ainen matawa</i> (women – often young women – who board foreign fishing vessels and engage in sex with seafarers in exchange for money and goods), specific provisions to increase sex workers' access to SRH or protection from GBV have not been identified in current policies or legislation. This group is not mentioned in either the <i>Ministry of Health and Medical Services Strategic Plan 2016-2019</i> or the <i>National Approach to Eliminating Sexual and Genderbased Violence in Kiribati Policy and National Action Plan 2011-2021</i> .
Plural legal systems		No constitutional/statutory/customary/traditional/ religious laws contradictory to any of the above	Yes	The plural legal system in Kiribati ranks the <i>Constitution</i> , statutes and the received laws (the latter with some exceptions, particularly in relation to land and marine practices) supreme over customary law. Therefore, any customary rule or law that may undermine sexual and reproductive health or protection from violence is void if in conflict with the <i>Constitution</i> or statutes.
Humanitarian and disaster	Provisions for SRH in disaster legislation and national plans	Are there provisions in relevant health or disaster policy and legislation to require that the MISP for sexual and reproductive health objectives and related indicators are assessed, resourced and delivered?	Partial	While the MISP is not explicitly required through policy or legislation, the Government of Kiribati (2019c, par 1) made a public policy commitment to integrate the MISP in disaster management plans and response efforts at the Nairobi ICPD25 conference: 'By 2022, we will have integrated the Minimum Initial Service Package (MISP) in disaster management plans and response efforts'. Existing commitments, partnerships, policy and legislation provide an enabling environment, with the <i>Kiribati Joint Implementation Plan for Climate Change and Disaster Risk Management 2019-2028</i> being gender responsive, and having as its fifth strategy 'Strengthening health-service delivery to address climate change impacts'. However, the Joint Implementation Plan does not specifically include or refer to SRH. The <i>Kiribati COVID-19 Development Response Plan</i> , developed through a partnership between the Governments of Australia and Kiribati, notes that Australia will work with the Government of Kiribati and local organisations to deliver essential sexual and reproductive health services in the context of COVID-19 disruptions (p.2).

Domain	Sub-domain	Specific indicators	Status	Notes
Humanitarian and disaster	Provisions for GBV in disaster legislation and national policy and plans	<p>Are there provisions to respond to VAW/GBV in emergencies in legislation, policy and plans?</p> <p>Are there specific provisions in policy and legislation to require alignment with the Minimum Standards for Prevention and Response to GBVIE?</p>	Partial	<p>The <i>Joint Implementation Plan for Climate Change and Disaster Risk Management 2019-2028</i> is gender responsive and under result area 5.4, lists the number of family health clinics trained in women's mental health, climate change and GBV as a performance indicator. Under result area 7.2, the plan seeks to ensure communications programs include key gender-responsive messages to encourage attitudinal and behaviour change amongst men to discourage GBV and amongst women to take on leadership roles.</p> <p>The <i>Strategic Roadmap for Emergency Management in Kiribati 2020–2024</i> includes as a key result area the mainstreaming of protection (mitigation of GBV, gender mainstreaming and focused support for people living with a disability and the elderly), and a cross-cutting strategy for the roadmap as being increased capability, including the capacity of the social sector to evaluate GBV in emergencies programming and coordination, and to ensure mitigation of the risks of GBV particularly for vulnerable populations.</p> <p>The <i>Kiribati COVID-19 Development Response Plan</i> acknowledges that the pandemic has been associated with increased levels of GBV globally, and includes a focus on strengthening responses to GBV to mitigate the impact of COVID-19, with key results for the plan to include examples of improved services for women and girl survivors of violence (p.5).</p> <p>While there are not specific provisions in policy and legislation in Kiribati to require alignment with the Minimum Standards for Prevention and Response to GBVIE, the overall policy environment provides an enabling environment for this alignment with key policies recognising the intersection between emergencies and GBV, and the need to strengthen prevention and response in emergency contexts.</p>

4 Sexual and reproductive health in law and policy

This section of the report outlines national policy documents, highlighting their relevance to SRHR. Policies and legislation are then explored further in relation to the key domains of SRH that are the focus of this review. As noted earlier, there is substantial overlap between issues relevant to SRHR and to GBV, though the current policy landscape specifically relevant to GBV will be the focus of Section 5 of this report.

4.1. Background

The *2015 Sexual and Reproductive Health Rights Needs Assessment* for Kiribati (hereafter the SRHR Needs Assessment), commissioned by the Ministry of Health and Medical Services, noted that:

'The rising population, combined with the remoteness of many of Kiribati's coral atolls, provides an on-going challenge for the Ministry of Health and Medical Services to provide universal access to sexual and reproductive health services. This spread of the rural population across 33 widely scattered islands poses high risks for unintended pregnancies, unsafe abortions, complications during pregnancy and delivery, especially for teenage girls, as well as the transmission of sexually transmitted infections (STIs) and HIV' (p. 8).

The fertility rate in Kiribati has steadily declined over recent decades, though it remains above replacement level with the *Kiribati Social Development Indicator Survey 2018-2019* (KSDIS) finding the national fertility rate to be 3.3 (ranging from a rate of 4.1 in the Northern Gilbert island group to 3.0 in the Central Gilbert group) (Kiribati National Statistics Office, 2019). Fertility is highest among women with pre-primary or no education, and among those in the lowest wealth quintile. There is considerable variability in the adolescent birth rate, with the KSDIS reporting a national average of 51 in every 1,000 girls aged 15 to 19 years having had a live birth in the three years preceding the survey. However, the rate in the Central Gilbert island group was found to be 37 compared to 133 in the Line/Phoenix islands. The adolescent birth rate was highest among women with pre-primary or no education (Kiribati National Statistics Office, 2019).

The *20-Year Vision for Kiribati 2016-2036* outlines the intention to reduce the fertility rate to 1.8 by 2036, suggesting that an improved healthcare system that is acceptable and accessible will contribute to this (Government of Kiribati, 2016a, p.34). The SRHR Needs Assessment notes that key issues for the Kiribati health sector include a number of challenges specifically relevant to SRH, including high maternal morbidity and mortality, the incidence and burden of communicable diseases including STIs and HIV/AIDS, and gaps in health services delivery (Ministry of Health and Medical Services, 2015b, p.8). The KSDIS found that only 6 per cent of women aged 15-49 years currently in a union were using a modern contraceptive method with another 27 per cent of women reporting using traditional methods (Kiribati National Statistics Office, 2019). About 17 per cent of women aged 15 to 49 years reported unmet need for family planning, and this need was higher among young women aged 15 to 19 years (at 30 per cent).

While the SRHR Needs Assessment acknowledged significant service delivery challenges, including resourcing and under-staffing, it also identified outdated policies and guidelines and noted 'a need to continue

to work to strengthen legislation, policy and political and social commitment to gender equality and equity at all levels...to strengthen SRHR' (Ministry of Health and Medical Services, 2015b, p39).

4.2. Domestic legislation and policy

A number of laws in Kiribati are relevant to the delivery of SRH services and the realisation of SRHR by I-Kiribati, in general. These include, in particular, the *Penal Code*, the *Marriage Ordinance*, the *Native Divorce Ordinance*, and the *Marriage (Amendment) Act 2002*; the *Medical Services Act 1996* and the *Public Health Ordinance*; and the *Te Rau N Te Mwenga Act 2014*. Legislation will be discussed where relevant under thematic headings below. However, national policies and plans are more specifically related to SRHR and are therefore outlined in greater detail in this section of the report.

Nationally, SRH services and activities are guided by policies and plans to increase SRH outcomes for I-Kiribati and improve access to services and quality service delivery. Key policies, and the lead ministry responsible for implementation, are highlighted in Table 6 below.

Health and the healthcare system are outlined as priorities in the Government's *20-Year Vision 2016-2036*, with reducing the total fertility rate specifically mentioned as a long-term national priority with the target of a fertility rate of 1.8 by 2036 a nominated performance indicator for the healthcare system.

Of the other national plans relevant to SRH, the *Kiribati Development Plan (2016-2019)* and the *Ministry of Health and Medical Services Strategic Plan (2016-2019)*, could be said to be the broadest and most high level and are discussed in detail below. Under these plans, strategic health objectives relating specifically to SRH include increasing access to and use of highquality, comprehensive family planning services, particularly for vulnerable populations; and improving maternal, newborn and child health. Both plans also speak to the need to improve access to highquality and appropriate health care services for victims of gender-based violence, for violence prevention, and for SRH and GBV services that specifically address the needs of youth, as will be discussed further in Section 5.

Table 6: Key policies relating to SRHR

Lead ministry/entity	Title of policy
Ministry of Finance and Economic Development	Kiribati 20-Year Vision 2016-2036
	Kiribati Development Plan 2016-2019
	Ministry of Health and Medical Services Strategic Plan 2016-2019
	Essential Drugs List 2009
Ministry of Health and Medical Services	National HIV Policy 2018 and the related guidelines: <ul style="list-style-type: none"> • National guideline on the use of antiretroviral drugs for treating and preventing HIV infection • National HIV testing services guideline • National guideline on prevention of mother to child transmission of HIV, syphilis, and hepatitis B and C • National STI diagnosis, management and treatment guideline

Lead ministry/entity	Title of policy
Ministry for Women, Youth, Sport and Social Affairs	National Youth Policy 2011-2015 (it is understood that there is a National Youth Policy 2018-2022, but this was unsighted during this review)
	National Disability Policy and Action Plan 2018-2021
	National Policy on Gender Equality and Women's Development 2019-2022
	National Approach to Eliminating Sexual and Genderbased Violence in Kiribati: Policy and National Action Plan 2011-2021
Ministry of Education	Education Sector Strategic Plan 2016-2019 (reviewed ed. June 2017)
	WASH in Schools Policy
Population Strategy National Taskforce	Kiribati Population Policy 2014-2034 and the Kiribati Population Policy Implementation Strategy

4.2.1. Kiribati Development Plan 2016-2019

The third goal of the overarching development plan for Kiribati is focused on health. The plan lists a large number of strategies for achieving this goal, with those specifically relevant to SRH listed below the goal here.

Goal 3: Improve population health and health equity through continuous improvement in the quality and responsiveness of health services, and by making the most effective and efficient use of available resources.

Strategies specifically relevant to SRH include:

- Increase access to and use of highquality, comprehensive family planning services, particularly for women
- Improve maternal, new-born and child health through care procedures during pregnancy, delivery and the immediate postpartum period and for the new-born; improve the skills and capacity of maternal care attendants; and improve maternal and child health facilities and equipment.

A number of other strategies listed in relation to Goal 3, such as to improve the effectiveness and efficiency of health service delivery; to improve the quality and appropriateness of health care services for victims of genderbased violence, and to develop services that specifically meet the needs of youth, will also contribute to improvements in SRH.

Key performance indicators for this goal in the national development plan include:

- Declining adolescent birth rate for 10-14 years, 15-19 years per 1000 girls in that age group
- Increased contraceptive contacts (all forms) as seen at health facilities per 1000 population
- Maintaining the number of maternal deaths at zero or as close to zero as possible
- Increasing proportion of births attended by skilled health personnel
- Maintaining at least 80 per cent availability of essential medicines and commodities at primary health care facilities.

Other indicators, such as the proportion of health workers to population, the number of outpatient consultations, and proportion of the population accessing Family Health Centre services, are also relevant to SRH.

The Kiribati Voluntary National Review and Kiribati Development Plan Mid-Term Review does not specifically address national performance in areas relevant to SRHR (Government of Kiribati, 2018).

4.2.2. Ministry of Health and Medical Services Strategic Plan 2016-2019

This plan has six strategic objectives. The objectives specifically related to SRH are outlined below, along with the strategic actions focused on SRH that are listed under each of these objectives:

Objective 2: Increase access to and use of highquality, comprehensive family planning services, particularly for vulnerable populations including women whose health and wellbeing will be at risk if they become pregnant.

- 2.1 Improve skills, quality of services and access to family planning drugs and commodities for rural and urban islands.
- 2.2 Reinvigorate national Reproductive Health committee to proactively monitor & evaluate the data input towards Family Planning services
- 2.3 Engage with development partners around support for initial implementation of the RH strategy, and initiate work to identify a sustainable funding mechanism.
- 2.4 Strengthen partnership with Kiribati Family Health Association (KFHA), faith-based organisations, youth groups and other non-government organisations to expand Family Planning services and increase involvement of men.
- 2.5 Engage with other ministries departments to coordinate and integrate resources and approaches to managing population growth to benefit the aspirations of all sectors.

Relevant indicators related to this objective include:

- Fertility rate
- Service delivery points (SDPs) offer at least three contraceptive methods
- Contraceptive prevalence rate (1549 year-olds)
- Service Delivery Points reporting stock-outs of family planning drugs and commodities in the last 12 months
- Number of teenage pregnancies
- Number of communities visited for family planning awareness.

Objective 3: Improve maternal, new-born and child health

- 3.1 Improve the quality of services and care procedures during pregnancy, delivery and the immediate postpartum and for the newborn
- 3.2 Improve the skills and capacity of maternal care attendants
- 3.3 Improve maternal and child health facilities and equipment
- 3.4 Collect quality health information and data and use to improve maternal, newborn and child (MNC) health care practice
- 3.5 Strengthen community-based and outreach maternal and child health services
- 3.6 Develop and implement set of guidelines for MNCH (treatment and referral)
- 3.7 Development of mother and baby friendly settings – workplace, institutions
- 3.8 Scale up MNC programmes through inter-sectoral policies and legislations.

Relevant indicators related to this objective include:

- Proportion of births attended by skilled health personnel
- Maternal mortality ratio
- Antenatal care coverage
- Percentage of anaemia in pregnant women.

Objective 4: Prevent the introduction and spread of communicable diseases through strengthening existing control programmes and ensure Kiribati is prepared for any future outbreaks

- 4.4 Revise the National HIV and STI Strategic Plan 2012-2015 with a focus on reversing the spread of STIs through improving prevention, increased testing capacity, and improved treatment services.

Indicators related to this objective include:

- Number of tests conducted for STIs and percentage of positive cases
- Comprehensive correct knowledge of HIV/AIDS by gender (1524 year olds).

It should also be noted that two other objectives of the Ministry of Health and Medical Services Strategic Plan are highly relevant to creating an enabling environment for SRH – that is Objective 5 (address gaps in health service delivery and strengthen the pillars of the health system) and Objective 6 (improve access to highquality and appropriate health care services for victims of genderbased violence and services that specifically address the needs of youth). The latter is discussed further in Section 5 of this report.

4.2.3. Other national policies and plans relevant to SRHR

The *Population Policy 2014-2034* highlights the impact of population growth on social and economic problems faced by the I-Kiribati people. In this policy, the government outlines the central role of faithbased organisations and non-government organisations in working with government to address both current and future population goals (which are not explicitly outlined in the policy).

The *National HIV Policy* was revised in 2018, with a number of related guidelines produced. However, these guidelines were unsighted at the time of writing. A Ministry of Health and Medical Services SRHR Needs Assessment (2015) refers to a SRH and HIV Linkages policy as being in draft form, but it is unclear whether this draft was completed or whether this was superseded by the 2016-2019 Ministry of Health and Medical Services Strategic Plan, which has a considerable focus on SRH. The previous National HIV and STI strategic plan noted that creation of an enabling environment for HIV and STI prevention in Kiribati would require reform of legislation relating to abortion, consensual sex between men, and sex work. These reforms have not occurred at this time.

The *National Youth Policy 2011-2015* has a substantive focus on SRH, with the third policy objective being ‘to promote healthy lifestyles amongst youth with special focus on the dangers of alcohol and substance abuse, unintended pregnancy, STIs, HIV & AIDS, and other social problems’. Strategies listed in the policies include to provide ‘access to improved and youth-friendly health services including sexual and reproductive health and counselling services for both young men and young women, in both rural and urban areas, as well as to young people in positions of greater risk and vulnerability. Young men and women should be involved in the process of development and implementation’ and to develop ‘communication strategies with the involvement of both young men and young women to ...promote healthy sexual and reproductive behaviour’. It is understood that there is a National Youth Policy 2018-2022, but this was not sighted during this review.

The *National Disability Policy and Action Plan 2018-2021* aims to ensure that all Kiribati legislation complies with the CRPD. The CRPD has considerable focus on ensuring that people with disabilities have access to SRH services and information on an equal basis with other members of the community. The National Disability Policy Area 9 aims to ‘improve access to quality health care, rehabilitation services and assistive technologies’ for people with disabilities in Kiribati. Under this policy area, the need for accessible SRH programs is mentioned and a specific activity under the Action Plan (9.6) is to ‘include people with disabilities in health promotion programmes including those related to sexual and reproductive health and eliminating gender-based violence’.

The *Education Sector Strategic Plan 2016-2019* (reviewed ed. June 2017) does not have a specific focus on SRHR, though it does emphasise the importance of healthy school settings. The plan also notes that an inclusive education implementation plan should include a focus on eliminating sexual and genderbased violence. The Kiribati primary school curriculum includes modules on 'health education' and 'moral education' under the Healthy Living Syllabus, to be delivered to students each year of primary school from Year 3. These modules focus on healthy behaviours and respectful relationships. The secondary school curriculum was unsighted during this review, though stakeholders report that a curriculum for Years 1-9 has been developed. It should be noted that both primary and secondary enrolment rates are relatively low in Kiribati, with poor retention of boys in particular. Junior secondary school (years 7-9) is the last stage of education for the majority of young people in Kiribati (Coffey International, 2016). With support from UNICEF, a national WASH in Schools Policy was endorsed by the Ministry of Education at the end of 2015, which saw the Ministry commit to enhancing education around menstrual hygiene management as part of the curriculum and out-of-school activities, and to improving the environment for girls in schools.

The *Kiribati Essential Drugs List* (revised March 2009). The list includes drugs relevant to maternal health including Oxytocin, Misoprostol, Ergometrine, Magnesium Sulphate, Chlorhexidine, Amoxycillin, injectable antibiotics, corticosteroids, and drugs and commodities relevant to sexual health including antiretroviral medicines, antifungal medicines, antiherpes medicines, male and female condoms, diaphragms, oral hormonal contraceptives, injectable hormonal contraceptives, copper IUDs, and implantable contraceptives. Vaccines included on this 2009 list do not include the HPV vaccine, though this was reportedly added to the national schedule in 2010.

While practice guidelines, rather than national policy, the *Kiribati National Evidence Based Family Planning Guidelines: Towards a healthy family 2015* are an important inclusion in this desk review, given their specific relevance. These guidelines were developed to assist health workers in the provision of family planning and counselling services. They cover client counselling and choice; client assessment; and a range of contraceptive methods – oral contraceptives, progesterone only injectables, hormonal implants, intrauterine contraceptive devices, barrier methods, surgical sterilisation (male and female), traditional family planning methods. They also provide guidance to clinicians on the collection of family planning data and monitoring of their service.

A number of other policies and plans are cross referenced in these documents, and several older, out-of-date plans and policies were identified during this desk review. In some instances, it was not possible to locate the most recent versions of relevant national policies and plans.

4.3. Intersection of sexual health issues with policy and legislation

4.3.1. Contraception and family planning

Given the very specific issues with overcrowding and population growth that Kiribati faces, strengthening family planning is an identified national priority, as outlined in the Government's 20 Year Vision 2016-2036 and the *Kiribati Development Plan (2016-2019)*. The *National Evidence Based Family Planning Guidelines* describe access to family planning services as a 'fundamental and principal human right' (p.7).

Contraceptive methods available and used in Kiribati include the modern methods of combined oral contraceptive pills (Microgynon), hormonal implant (Jadelle), progesterone only injectable (Depo Provera), copper intrauterine device, and male and female surgical sterilisation. However, the modern methods contraceptive prevalence rate in Kiribati is low. The KSDIS found that only 6 per cent of women aged 15-49 years currently in a union were using a modern contraceptive method with another 27 per cent of women reporting using traditional methods such as fertility awarenessbased methods (Kiribati National Statistics Office, 2019). The KSDIS found that demand for family planning was satisfied with modern methods among 53.6 per cent of married/in-union women.

Legislation in Kiribati does not guarantee access to contraceptive services; essential medicines such as emergency contraception, contraceptive implants and female condoms; or provision of full, free and informed consent for contraceptive services. However, policy in Kiribati does not restrict availability of contraception and family planning services on the basis of age or marital status. Parental consent for provision of contraceptives to under 18s is not mandatory in Kiribati (Ministry of Health and Medical Services, 2015b; 2015c). However, in Kiribati those with the highest unmet need for family planning are 15 to 19 years old, with unmarried adolescents having slightly more than double the unmet need for family planning than their married counterparts (Kiribati National Statistics Office, 2019).

The national family planning guidelines highlight that contraception should be available to all couples, women and men, including young women and young men, with restriction of eligibility only on medical grounds (Ministry of Health and Medical Services, 2015c). They also outline a range of suggested family planning methods that should be discussed with clients at all facilities, and made available – noting that lower level health facilities do not have staff trained to provide all contraceptive options. The SRHR Needs Assessment found that non-government organisations played a key role in implementing government policy to increase awareness of and access to contraception and family planning, particularly the Kiribati Family Health Association and the Kiribati Red Cross (Ministry of Health and Medical Services, 2015b). The SRHR Needs Assessment also recommended that research be conducted on the underlying factors associated with the unmet need for family planning and contraceptive services (Ministry of Health and Medical Services, 2015b, p.40). Given findings from the KSDIS, research to identify actionable strategies to address the unmet need for family planning among young people (particularly unmarried young people) is especially urgent.

Of particular relevance to this review, the *2010 Kiribati Family Health and Support Study* found that women experiencing domestic violence were less likely to be currently using family planning than women who had not experienced partner violence (Secretariat of the Pacific Community, 2010). Women who had experienced partner violence were more likely to report that their partner did not know they were using family planning, and that their partners had tried to stop them using family planning, than women with no experience of violence. There was a statistical association between women experiencing partner violence and their last pregnancy being unintended or unplanned. Women who had experienced violence were likely to have more children than non-abused women, and significantly more likely to have had more than five children than

women who had not experienced violence. This intersection between domestic violence and barriers to family planning is reflected in the Ministry of Health and Medical Services Strategic Plan, which has a focus on both SRHR and GBV. The *National Action Plan on Eliminating Sexual and Gender-based Violence* mentions the need to train reproductive health workers (and that support will be sought from the Pacific Human Resources for Health Alliance) but does not provide any further detail about responses at the intersection of SRHR and GBV.

4.3.2. HIV and STIs

The incidence of HIV in Kiribati is among the highest in the Pacific, though overall numbers are low with 22 people currently estimated to be living with HIV in the country (Ministry of Health and Medical Services, 2017).

HIV testing is routinely required for visa applicants, seafarers before each overseas contract, and for all new Kiribati Marine Training Centre entrants, i.e. is mandatory (Ministry of Health and Medical Services, 2017). While there is no constitutional or legislative protection of personal information regarding HIV status in employment and other settings (HIV and HR Legislative Compliance Review, 2009, p.12), in 2008 the *Employment Ordinance* was revised to prevent HIV-based discrimination in the workplace. The current *Employment and Industrial Relations Code 2015*, Section 107, specifically prevents an employer discriminating directly or indirectly, against any employee or applicant for employment on the grounds of HIV or AIDS status. This is particularly important in Kiribati where a significant proportion of infections has been among a specific workforce (seafarers) and their family members. The Code also prevents employers from enforcing HIV or STI testing of employees (s 111). There is no overarching law prohibiting discrimination on the basis of sexual orientation or gender identity, an important consideration in ensuring that people of all sexual orientation and gender identity and expression can access health services and information. However, the *Employment and Industrial Relations Code 2015* in Section 107(b) prevents employers discriminating against employees or applicants for employment on the basis of sexual orientation.

While there is no national HIV or STI legislation in Kiribati, the national response to HIV has been guided by a series of HIV and STI Strategic Plans. The most recent plan sighted during this desk review (2013-2016) focuses on five priority areas:

- Prevention of HIV and other STIs, prevention of parent-to-child transmission, safe blood supply, and assurance of universal precautions
- Community leadership and an enabling environment to reduce stigma and discrimination
- Diagnosis, treatment and support of people living with HIV
- Quality diagnosis, management and control of STIs
- Strengthening management and coordination of the national response.

The national response to HIV is coordinated by government ministries, civil society and non-government organisations, faithbased organisations, the private sector and maritime and seafarer trade unions (Ministry of Health and Medical Services, 2017). The HIV Program Unit within the Ministry of Health and Medical Services runs HIV/STI prevention programmes that target men who have sex with men, sex workers and young people in particular. There are five HIV testing sites in Kiribati. Because HIV and STI data are currently not disaggregated for gender or age, there is insufficient information to report against specific indicators and targets (Ministry of Health and Medical Services, 2017).

STI data in Kiribati are incomplete and difficult to interpret. Data where diagnosis is based on testing are sometimes combined with data where diagnosis is based on symptoms. Data are not always disaggregated by different types of STI. It is likely that health facility data significantly underestimate the national prevalence of different STIs (Ministry of Health and Medical Services, 2017).

4.3.3. HPV and cervical cancer

The priorities of the 2015 Pacific Forum Secretariat meeting, under the Framework for Pacific Regionalism, highlighted the substantial burden that cervical cancer places on women and girls in the Pacific region. In 2005, cervical cancer was reported to be the most common type of cancer in Kiribati (Government of Kiribati, 2005). Kiribati started a cervical cancer screening programme in 1999 with support from Australian cytology services. Screening facilities have also been established on the outer islands. Barriers to screening include inadequate knowledge of the screening procedure and reluctance to participate because of fear and embarrassment (Coulter, 2017). Kiribati officially introduced a national HPV vaccination schedule in 2010 but the coverage rates are low. Gardasil (the vaccine) is not included in the Kiribati Essential Drugs List (with 2009 being the most recent version of this list sighted).

The Ministry of Health and Medical Services Strategic Plan includes 'Number of cervical smears, HPV tests and percentage of cases confirmed by cytology and rapid test' as an indicator in relation to outcome 1 (reducing NCD prevalence), with the mid-term review of the Kiribati Development Plan suggesting a substantial increase in the number of tests conducted between 2015 and 2018. There is no indicator related to HPV vaccination.

4.3.4. Sexual health education

The *National Youth Policy 2011-2015* makes little mention of supporting or increasing sexual education in school curricula, but does note that communication strategies to 'promote healthy sexual and reproductive behaviour' should involve the 'delivery of messages through the school curricula, extra-curricular activities of advisory/support services in schools, as well as through community-based and non-government organisations' (Government of Kiribati, 2011, p.24). It is understood that there is a more recent National Youth Policy 2018-2022, which includes promotion of family life education, though this document was unsighted during this review.

A 2013 review of HIV, sexuality and reproductive health education in the Pacific found that SRH and HIV were integrated into the primary school curriculum in Kiribati with the support of the DFAT funded Kiribati Education Improvement Project (UNICEF, 2013). A syllabus of Family Life Education had been developed for secondary schools, but it is unclear as to the status of this curriculum at this time. This review found that Kiribati was 'furthest behind of the four countries studied' in relation to sexual health and sexuality education (UNICEF, 2013, p.29) in part because of the poor attendance of I-Kiribati adolescents at school. The undated National Curriculum and Assessment Framework (n.d.) retrieved during this review includes a focus on 'building healthy relationships in such contexts as family, peer, friendships, sexual relationships, sport, community or work team'. It states that it focuses on understanding the challenges, risks and safety issues of sexual behaviours, but does not mention sexuality, puberty, human development or sexual health specifically.

The recommendations of the SRHR Needs Assessment do not make any reference to sexual health education in the school curriculum, however it does mention reviewing 'SRH curriculum and individual training packages so as to maximise training opportunities for health workers and also to ensure a standardised approach to providing current best practice SRH and HIV information in Kiribati' (Ministry of Health and Medical Services, 2015b, p.40). The UNICEF (2013) review found limited collaboration and communication between the Ministry of Education and the Ministry of Health and Medical Services with regard to sexual health education, and limited capacity of teachers to deliver sexual health material, suggesting an important area for strengthened coordination. The Ministry of Health and Medical Services Strategic Plan (2016-2019) includes strategic actions to expand access to youth-friendly health services (YFHS), and to finalise and implement national guidelines for YFHS. At the time of writing these guidelines had not yet been finalised, and it is therefore unclear whether and how they address sexual health education.

Findings of the KSDIS highlight the importance of sexual health education, with only 24 per cent of young men aged 15-24 years and 37 per cent of young women in the same age group reporting accurate HIV knowledge. The majority of young people also report discriminatory attitudes towards people living with HIV (Kiribati National Statistics Office, 2019).

4.3.5. Menstrual hygiene management

A 2017 study of menstrual hygiene management in Kiribati found that: girls lack knowledge about menstruation and reproductive health; poor water and sanitation contributes to girls being unable to manage their menstruation in Kiribati schools; it is often taboo for men and boys to talk about menstruation or interact with menstruating women and girls; behavioural restrictions can have harmful outcomes for girls; girls have difficulty managing menstrual pain; and school leaders lack knowledge about menstrual health and hygiene (Ministry of Education and UNICEF, 2018). The Ministry of Education has acknowledged the importance of supporting menstrual hygiene management in schools to promote inclusive education, and has committed to the improving standards through the WASH in Schools Policy, however this policy has not been sighted at the time of writing.

4.4. Intersection of maternal and reproductive health issues with policy and legislation

As in other countries with small populations, the maternal mortality ratio in Kiribati is highly susceptible to change based on a small variation in the number of actual deaths. The SRHR Needs Assessment conducted in 2015 recommended that Kiribati establish 'realistic and achievable national maternal mortality targets, using actual number of deaths to monitor and report progress' (Ministry of Health and Medical Services, 2015b, p.40). The most recent Ministry of Health and Medical Services Strategic Plan (2016-2019) has a target of less than two maternal deaths per year (Ministry of Health and Medical Services, 2015a).

4.4.1. Antenatal and maternal health care

Antenatal care (ANC) attendance is high for all I-Kiribati women, with the KSDIS finding that 89 per cent of women aged 15 to 49 years with a live birth in the two years prior to the 2018-2019 study were attended during their last pregnancy at least once by skilled health personnel, and 67 per cent of women were attended at least four times by any provider. Fewer than half (47 per cent) of women attend their first antenatal care visit before their fourth month of pregnancy however (Kiribati National Statistics Office, 2019). Maternal health care at the time of delivery is also high, with 92 per cent of births attended by skilled health personnel, and with 86 per cent of births occurring in a health facility (Kiribati National Statistics Office, 2019). However, the *Kiribati Development Plan (2016-2019)* highlights that the quality of care provided by maternal care attendants, particularly in the outer islands, and the quality of maternal and child health facilities and equipment needs to be improved. There is alignment between these two plans in their focus on strategic actions to improve the quality of care provided, and to increase the availability of highquality facilities and equipment. However, these plans do not provide clear guidance as to what skills and capacities a birth attendant should have, or what constitutes an acceptable quality of care or facility.

The SRHR Needs Assessment (Ministry of Health and Medical Services, 2015b) recommended that:

- Women be encouraged to attend their first ANC visits in the first trimester
- Assess the quality of services provided by ANC clinics
- Assess the quality of Emergency Obstetric Care programmes, especially in the outer islands.

It is unclear what actions have been taken in response to these recommendations.

4.4.2. Parental leave

The *Employment and Industrial Relations Code 2015* states that a pregnant employee is entitled to maternity leave for a period of 12 consecutive weeks, at least 6 weeks of which are to be taken immediately after childbirth. This maternity leave is available to all pregnant workers in Kiribati, including those in the private sector, government employment and working for non-government organisations. Section 95(3) of the Code notes that employers shall pay the employee an amount for the period of maternity leave of not less than 25 of what she would have earned had she been at work. Section 95(4) of the Code mandates that a woman who returns to her employment after maternity leave shall be appointed to the same or equivalent position she held prior to taking maternity leave. Maternity leave in the public service is 12 weeks with full pay, though women can use this only twice during their employment with government. There is no provision for paternity leave in current legislation.

Section 86 of the *Employment and Industrial Relations Code 2015* requires employers, whether the Government or in the private sector, to provide women employees paid nursing breaks of half an hour for every four hours worked, from the time the employee returns to work after childbirth up until the child is aged 12 months.

4.4.3. Abortion

Abortion is illegal in Kiribati, under Sections 150 – 152 of the *Penal Code*. Procuring an abortion for another person carries a 10-year imprisonment term and a woman found guilty of procuring her own abortion faces life imprisonment.

The *Penal Code* allows abortions to be performed to save the life of a pregnant woman.

According to the 2015 Kiribati Sexual and Reproductive Health Rights Needs Assessment report, nine of the 15 health facilities assessed provided services for 'prevention of unsafe abortion and management of post abortion care services' (Ministry of Health and Medical Services, 2015b, p. 30). There were no records of presentation for services. The nine health facilities are located in the two main urban areas. The report suggests that 'there is anecdotal evidence of unsafe abortions and little is known of post-abortion care for those cases' (Ministry of Health and Medical Services, 2015b, p. 5).

5 Gender-based violence in law and policy

This section of the report introduces the issue of GBV in Kiribati and its intersection with SRH and then reviews key policies and legislation relevant to this intersection between SRH and GBV. This should not be seen as an all-encompassing review of policy and legislation relevant to GBV, as the report does not consider in-depth issues such as access to justice, juvenile justice, sentencing and policing.

5.1. Background

Rates of physical, sexual and psychological violence against women in Kiribati are reported to be among the highest in the world (Forster, 2011). The groundbreaking *2010 Kiribati Family Health and Support Study* found that 68 per cent of ever-partnered Kiribati women aged 15-49 years reported having experienced at least one act of physical or sexual violence by an intimate partner across the course of their life (Secretariat of the Pacific Community, 2010). This research 'shocked the nation and resulted in a strong political call and whole of government and nation commitment to eliminate violence against women and girls' (Government of Kiribati, 2019b, p.5/33) including through the establishment of a dedicated Ministry for Women, Youth, Sport and Social Affairs in 2013. Since this original prevalence survey, the *Kiribati Social Development Indicator Survey 2018-2019* (KSDIS) found similarly high levels of violence, with 67 per cent of ever-partnered women reporting having experienced physical or sexual violence in their lifetime, and 53 per cent reporting experiencing violence in the last 12 months (Kiribati National Statistics Office, 2019).

The KSDIS found just under 79 per cent of ever-partnered women aged 15-49 years had experienced at least one form of controlling behaviour by an intimate partner, suggesting that controlling behaviour is a normalised part of women's experience of intimate relationships in Kiribati (Kiribati National Statistics Office, 2019). The KSDIS also found that 70 per cent of women and 59 per cent of men aged 15 to 49 years justified intimate partner violence against women for reasons such as a woman going out without telling her partner, a woman arguing with her partner or refusing him sex, or burning food (Kiribati National Statistics Office, 2019).

In addition to intimate partner violence, both the KSDIS and the Family Health and Support Study found 10 per cent of women reported experiencing sexual violence from someone other than an intimate partner at some time in their lives, with the most commonly mentioned perpetrators being male acquaintances (family friends, work colleagues etc.) or strangers. The Family Health and Support Study reported 19 per cent of women aged 15-49 reported having been sexually abused before the age of 15 years; and 20 per cent of women who had ever had sex reported that their first sexual experience was either coerced or forced. The KSDIS found that 55 per cent of women who had experienced physical or sexual violence had never told anyone and had never sought help.

Recent findings published as baseline data from the *South Tarawa Healthy Living Study: An impact evaluation of the strengthening peaceful villages violence prevention intervention in Kiribati*, conducted by The Equality Institute (2020), found that 57 per cent of men in South Tarawa reported perpetration of physical and/or sexual abuse against a wife or female partner in the previous year.

These data reinforce that preventing and responding to GBV (that is violence that is enacted on the basis of gender, most commonly men's violence against women) is an urgent priority for Kiribati, with current policy and legislation reflecting this need.

While there are a limited number of formal services supporting women and girls experiencing violence in Kiribati, SafeNet coordinates service delivery and case management throughout the country. The Kiribati Women and Children Support Centre opened in February 2018 and provides free confidential counselling for women and children, legal information, case management, community awareness and other services. The Centre also works closely with health services, providing referral and support as needed as well as training health workers. While the Centre is the sole provider of specialist-trained GBV service providers in Kiribati, there is also a shelter run by Our Lady of the Sacred Heart Crisis Centre, which is the social welfare division of the Ministry of Women, Youth, Sport and Social Affairs.

5.2. Domestic legislation relevant to GBV

The Constitution of Kiribati guarantees the protection of fundamental rights and freedoms of the individual, which includes the right to live in safety and with the protection of the law:

Whereas every person in Kiribati is entitled to the fundamental rights and freedoms of the individual, that is to say, the right, whatever his race, place of origin, political opinions, colour, creed or sex, but subject to respect for the rights and freedoms of others and for the public interest, to each and all of the following, namely (a) life, liberty, security of the person and the protection of the law.

In addition, Section 7 of the Constitution notes that no person shall be subjected to torture or to inhuman or degrading punishment or other treatment.

A range of laws are relevant to the intersection of GBV and SRHR in Kiribati, with those specifically considered during this review shown in Table 7 and discussed below.

Table 7: Legislation relevant to the intersection of GBV and SRHR in Kiribati

Relevant domestic legislation
<i>Penal Code 1977 and amendments</i>
<i>Evidence Act 2003</i>
<i>Measures to Combat Terrorism and Transnational Organised Crime Act 2005</i>
<i>Children, Young People and Family Welfare Act 2013</i>
<i>Education Act 2013</i>
<i>Te Rau N Te Mweenga Act 2014</i>

5.2.1. Penal Code 1977 and Amendments

Sections 128-139 of the *Penal Code* criminalise, and outline punishments for, rape, attempted rape, abduction with the intent of rape, indecent assault, procuration and defilement. However, it should be noted that the definition of rape only refers to 'sexual intercourse' without further explanation or description of the breadth of acts that could be considered sexual violence (sexual intercourse is defined in Section 161 of the Code, and is deemed complete upon proof of penetration). The definition of rape is as a crime committed against women or girls. Sexual violence against men is addressed in Sections 153-155 of the *Penal Code*, however these sections also criminalise consensual sex between men. Rape is a crime with a maximum penalty of life in prison, but sentences are typically much shorter (U.S. Department of State, 2018). Spousal or marital rape is not specifically addressed in the Code, with no express direction that the rape provisions apply to non-consensual sexual acts within relationships. The UN Handbook for Legislation on Violence Against Women recommends that rape within relationships such as marriage should expressly be criminalised in legislation, noting that the provisions should apply irrespective of the nature of the relationship between the perpetrator and the complainant and that marriage or other relationship is not a defence (UN Women, 2010).

The *Penal Code* does not make prostitution a criminal offence, but it does make it an offence for anyone to procure or attempt to procure a woman or girl into prostitution, and sets out criminal offences related to being a male person living on the earnings of prostitution (s 145); being a woman controlling the prostitution of another woman (s 146); keeping or permitting the use of premises for a brothel (s 148).

No section of the Kiribati *Penal Code* specifically addresses trafficking, though abduction is illegal. Other acts that may involve GBV or harmful practices against women and girls, which are criminalised under the *Penal Code* 1977, include, but are not limited to, incest (s 56); offences relating to marriage (ss 162-164); traffic in obscene publications (s 66); murder and manslaughter (ss 192-202); offences connected with murder and suicide (ss 208-215); offences endangering life and health (ss 216-229); criminal recklessness and negligence (ss 230-236); common assaults (ss 237-240); and offences against liberty (ss 241-249).

It should be noted that provocation remains a defence under the *Penal Code*. Provocation is a doctrine that has historically been relied upon by male perpetrators of violence to limit their criminal responsibility for killing their partners. Section 198 of the Code states that when the person charged was provoked to lose his self-control, the question of whether the provocation was enough to make a reasonable man do as he did shall be determined by the court.

5.2.2. Evidence Act 2003

One of the first government initiatives post ratification of CEDAW was to remove the gender discriminatory corroboration rule in rape cases. Section 11 of the *Evidence Act 2003* abolished the requirement for corroboration or independent evidence, allowing the court to convict without corroboration. Sections 13 and 14 of the *Evidence Act 2003* give some protection to female and young witnesses in sexual offence cases to prevent wide questioning about matters outside the actual offending.

5.2.3. Measures to Combat Terrorism and Transnational Organised Crime Act 2005

Trafficking of women and girls is an internationally recognised form of GBV that, regardless of the purpose of trafficking (e.g. into sexual slavery, domestic servitude, or exploitative labour), severely undermines women and girls' sexual and reproductive rights. Part VIII of the *Measures to Combat Terrorism and Transnational Organised Crime Act 2005* focuses on trafficking in persons and people smuggling, clarifying that trafficking in adults or children is an offence, noting that it is not a defence that a trafficked person consented to the intended exploitation or the intended exploitation did not occur. The Act also criminalises people smuggling. Part VIII of the Act outlines protections for trafficked and smuggled persons.

5.2.4. Children, Young People and Family Welfare Act 2013

The primary objectives of the *Children, Young People and Family Welfare Act 2013* are focused on the support, care, development, protection and wellbeing of children and young people. Section 6(f) notes that custody arrangements should be made within the best interests of the child, prioritising their safety and wellbeing (that is, men will no longer have the default right to custody of children following the breakdown of a relationship). The Act outlines government duties to develop programmes to support I-Kiribati families to prevent violence against children and young people, including to remedy conditions that might place children and young people at risk (which would include settings of family violence). Provisions under the Act outline the circumstances when a child or young person might be removed to a place of safety to ensure their care and protection, when protection orders may be enacted, and when maintenance orders may be placed.

5.2.5. Education Act 2013

The *Education Act 2013* seeks to make available to every student in Kiribati an education to maximise their potential. Section 43 provides guidance in relation to disciplinary actions, noting national obligations under the CRC and CEDAW. The Act deems the use of corporal punishment as unacceptable under any circumstances.

5.2.6. Te Rau N Te Mweenga Act 2014

The *Te Rau N Te Mweenga Act 2014* (also known as the Family Peace Act) was developed after the 2010 Kiribati Family Health and Support Study found that more than two thirds of I-Kiribati women had experienced physical or sexual violence from their partner. The objectives of the Act are to ensure the safety and protection of all persons who experience or witness domestic violence; to provide them support, redress and recovery; to facilitate enforcement of Court Orders to stop domestic violence; and to enact provisions consistent with Kiribati's international commitments. The Act states that domestic violence, in all its forms, is a crime; and that domestic violence extends beyond physical, sexual, psychological and economic violence and may involve the exploitation of power imbalances and/or patterns of abuse over many years. Importantly, the Act, in defining the range of conduct that may constitute domestic violence, notes that a single act may amount to violence and that a number of acts that form part of a pattern of behaviour may amount to violence, even though they may appear to be minor or trivial when viewed in isolation.

The Act does not just cover domestic violence by a current or former intimate partner, but is inclusive of violence by other family members or household members. It stipulates a system of protection orders to prevent violence and maximise safety; decrees that ministries and departments shall introduce public awareness programmes to prevent violence (including training on the causes of violence in the family for government and other agencies, and inclusion of gender equality and GBV in the education curricula at all levels); outlines duties of police, healthcare workers and social service providers in relation to domestic violence.

While the *Penal Code* does not characterise rape or sexual assault in a broad and comprehensive way, Section 4 (2a) of the *Te Rau N Te Mweenga Act 2014* defines sexual abuse as including any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of a person and defines sexual assault in a way that includes a broad range of acts of sexual contact. However, the *Te Rau N Te Mweenga Act 2014* is focused on sexual violence in the broader context of domestic violence (inclusive of sexual, physical, psychological and economic violence) and not on non-partner sexual violence.

5.3. Domestic policy relevant to GBV

In addition to legislation, the national priority afforded GBV is evident in its inclusion in government plans at the highest level. Domestic violence is mentioned in the *Kiribati 20-Year Vision 2016-2036*, with reduction in the number of incidents of domestic violence listed as a key performance indicator. The need to address GBV is also emphasised in the *Kiribati Development Plan 2016-2019*, with domestic violence highlighted in relation to two goals (health and governance). The plan lists the proportion of cases dealt with by the Family Health Centre and other health facilities, and a reduction in the number of domestic violence incidents and reported as a key performance indicator. However, GBV is not given the same prominence in the new *Kiribati Development Plan 2020-2023*, despite the fact that more than half of I-Kiribati women reported having experienced violence in the last 12 months on the KSDIS.

Table 8: Key policies relating to the intersection of GBV and SRHR

Lead ministry	Title of policy
Ministry for Women, Youth, Sport and Social Affairs	National Approach to Eliminating Sexual and Gender-Based Violence (SGBV) in Kiribati: Policy and Strategic Action Plan 2011/2021
	and the
	Shared Implementation Plan to Eliminate SGBV in Kiribati (SHIP) 2014
	National Policy on Gender Equality and Women's Development 2019-2022
	Kiribati National Disability Policy and Action Plan 2018-2021
Ministry of Health and Medical Services	National Youth Policy Framework 2018-2022
	MHMS Ministry Strategic Plan 2016-2019

5.3.1. National Approach to Eliminating SGBV in Kiribati: Policy and Strategic Action Plan 2011-21

The National approach is based on these two key complementary documents – the National Policy to Eliminate Sexual and Gender-based Violence and the National Action Plan. The priority issues the national approach seeks to address include reducing the high rate of violence against women and girls; strengthening laws related to violence against women; increasing availability and strengthening capacity of support services throughout the country; challenging views and attitudes; strengthening data on violence against women; strengthening the health response; and developing a gender equality policy.

The goal of the National Policy is to eliminate gender-based violence. It seeks to do this through five priority policy commitments:

1. Develop national leadership and commitments to eliminate GBV
2. Strengthen legal frameworks, law enforcement and the justice system
3. Build institutional and community capacity
4. Strengthen and improve preventive, protective, social and support services
5. Eliminate and prevent GBV through civic engagement and advocacy.

The policy called for the establishment of an autonomous Division for Women in government. The Ministry of Women, Youth, and Social Affairs was subsequently established in 2013 (Ministry of Women, Youth,

Sport and Social Affairs since 2018). The policy also called for a National Task Force to assist with the implementation of the Action Plan, and in 2012 the Committee Against Violence Against Women was formed with representatives from government, civil society and faithbased organisations. In 2013, this changed to SafeNet. SafeNet supports service delivery and case management throughout the country.

The National Action Plan seeks to facilitate implementation of the National Policy by bringing together key government departments, civil society, the private sector and other stakeholders to ensure a cohesive and national approach to ending GBV in Kiribati. The Plan outlines outcomes and detailed actions in relation to each of the five policy commitments of the Policy.

The *Shared Implementation Plan to Eliminate SGBV in Kiribati (SHIP)* endorsed by government in November 2014 provides overarching guidance for a whole of government approach to eliminating sexual and gender-based violence in Kiribati.

The current policy framework supports an integrated multi-sector response and new guidance has been established building on a network of government ministries and non-government organisations, the SafeNet, which has been working together for the past six years.

5.3.2. National Policy on Gender Equality and Women's Development 2019-2022

This policy aims to ensure equal opportunities, human rights and access to services for men and women, boys and girls in Kiribati. The vision of the policy is that all Kiribati men and women reach their full potential and has a goal of doing so through the mainstreaming of gender in government policies, plans, budgets and programmes.

The policy is based around five priority areas: gender mainstreaming; women's economic empowerment; stronger, informed families; women's political participation and leadership; and eliminating sexual and gender-based violence. While elimination of GBV is a priority in this policy, it does not outline specific actions relevant to this priority, noting that these are already included in the National Action Plan and SHIP outlined above.

5.3.3. Ministry of Health and Medical Services Strategic Plan 2016-2019

This plan has six strategic objectives. One of these, Objective six, aims specifically to improve access to highquality and appropriate health care services for victims of gender-based violence, and services that specifically address the needs of youth. The strategic actions relevant to GBV listed under this objective include:

- 6.1 Ministry of Health and Medical Services to implement the standard operating procedure of eliminating sexual and genderbased violence policy in line with the national policy, taking into account constant reviews and updates
- 6.2 Improve health care facilities and systems or management, treatment and care of victims of GBV
- 6.3 Build the capability and capacity of the health workforce so that it is better able to meet the health care needs of victims of GBV
- 6.4 Strengthen GBV task force activities in terms of meetings, auditing of cases, awareness, data recording and improving service delivery points
- 6.5 Strengthen Ministry of Health and Medical Services GBV coordination with national GBV stakeholders.

Relevant indicators related to this objective include:

- Review of GBV standard operating procedures
- Healthy Family Clinic established
- Service delivery point staff to receive basic specialised training on the management and care of GBV victims

- GBV task force commitment
- Number of GBV cases treated with post-exposure prophylaxis and for STI and pregnancy prevention.

To achieve this objective, the Ministry of Health and Medical Services has established a sexual and gender-based violence unit and set up a Family Health Clinic in 2017 to provide medical services for women and children who have experienced domestic violence.

The Ministry of Women, Youth, Sport and Social Affairs Strategic Plan is referred to in a number of documents reviewed for this report, however was unsighted at the time of writing.

The *Kiribati National Disability Policy and Action Plan 2018-2021* outlines ten priority areas for action, including to address the particular disadvantage experienced by women and girls with disabilities. The policy notes the high rate of violence against women and girls with disabilities globally (and as found in the Pacific, see Spratt, 2013), and calls for violence and health related information and programming to be inclusive of and accessible to women and girls with disabilities. A key performance indicator for this plan is that the challenges for, and needs of women with disabilities are reflected in mainstream policies including the national policy to eliminate GBV. At this point in time the National Approach to Eliminating SGBV in Kiribati: Policy and Strategic Action Plan 2011-2021 does not mention disability.

None of the policies reviewed for this report consider GBV against, or the need for specific violence prevention and response services for, people of diverse sexual orientations or gender identity and expression, or who identify as LGBTIQ I-Kiribati.

6 Law and policy in relation to key populations

6.1. Adolescents and youth

The minimum age for consensual sex in Kiribati is 15 years. Sexual relations with a girl younger than 13 years carries a maximum penalty of life imprisonment, and sexual relations with a girl aged 13 or 14 carries a maximum penalty of five years in prison. The victim's consent is not a permissible defence under either provision; however, in the latter case, reasonable belief the victim was 15 or older is a permissible defence (U.S. Department of State, 2018). However, 17 per cent of young men and four per cent of young women aged 15 to 24 report having had sex before the age of 15 years (Kiribati National Statistics Office, 2019). Incest is illegal in Kiribati. Consensual sex between men is a designated criminal act in the Penal Code, meaning there is no age at which a young man can legally consent to sex with another man. Sex between women is invisible in legislation and policy in Kiribati.

The *Marriage (Amendment) Act 2002* outlines that the legal minimum age for marriage is 21 years, or 18 with the permission of a parent or guardian. Nonetheless, the KSDIS found that in rural areas four per cent of women aged 20 to 24 years were married or in first union before the age of 15, and 24 per cent were married before the age of 18 (as compared to 2 per cent at 15 and 14 per cent at 18 in urban areas) (Kiribati National Statistics Office, 2019). Women in the lowest wealth quintile are three times more likely to be married before age 18 than women in the highest wealth quintile. Bigamy is illegal in Kiribati.

Section 41 of the *Education Act 2013* prohibits the disciplining of a student because she is pregnant or a parent, with the act noting that Kiribati is obliged to ensure that female and male students are to be treated equally and the practice of expelling students who become pregnant is inconsistent with this obligation. However, most schools will not accept girls as students once they are engaged, married or pregnant, an informal policy which discriminates against girls. The combined reports submitted by Kiribati to the CEDAW committee noted that 'when a girl became pregnant she would be immediately expelled from school. The baby's father could still attend school' (Government of Kiribati, 2019b, p.18/33).

While the production and importation of pornography is illegal, and Kiribati has acceded to the *Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography*, the *Penal Code* has no specific provision concerning child pornography (U.S. Department of State, 2018).

The most recent *National Youth Policy sighted* (2011-2015) prioritises sexual and reproductive health as a priority issue for young people in Kiribati. The policy identifies young people with disabilities and 'specific groups of young people at greater risk and vulnerability', including young women who sell sex and young people from single-parent families. The Kiribati Family Health Association Youth Work Plan describes strategies to increase young people's access to SRH information and services and includes specific strategies for engagement with young women involved in sex work.

6.2. People with disabilities

There are no overall legal protections for people with disabilities (U.S. Department of State, 2018). The law prohibits discrimination in employment against people with disabilities but does not define disability. As is the case globally, people with disabilities in Kiribati are often wrongly assumed to be asexual and do not receive adequate sexual health information or health care (Spratt, 2013). People with disabilities are at greater risk of poor reproductive health because of poor access to services and information. While women with disabilities access antenatal care and the hospital system for deliveries, they have limited access to information on contraception, sexual health, breast self-examination and cervical pap smears (Spratt, 2013). Many health professionals are unable to assist women with disabilities because they lack knowledge about the issues they face, and often have prejudicial attitudes (Spratt, 2013).

While the *Kiribati National Disability Policy and Action Plan 2018-2021* recommends improving the accessibility of physical spaces, including health services, and information for people with disabilities (p. 11) it is unclear to what extent progress in this area is inclusive of SRH services and information. A report of the Independent Review of the Kiribati Disability Inclusive Development Programme notes however that there has been consideration of accessibility at the Family Health Clinic (DFAT, 2017). Local disabled people's organisation Te Toa Matoa (TTM) has a strategic plan for the period 2016-2020 that includes a focus on mainstreaming disability in SRH programmes, and the National Policy and Action Plan makes explicit the need to include people with disabilities in health promotion programmes 'related to sexual and reproductive health' (p. 36). The *National Youth Policy 2011-2015* notes that young people with disability receive less SRH information and education. However, there are no specific strategies or actions for disability inclusive SRH programming in the *Ministry of Health and Medical Services Strategic Plan 2016-2019*.

6.3. LGBTIQ communities

Consensual sexual conduct between men is illegal in Kiribati, with Section 153 of the Penal Code outlawing buggery and Section 155 specifying the illegality of indecent practices between males. Offences under this section of the Penal Code carry penalties of between five and 14 years' imprisonment, however there have been no reports of prosecutions under these provisions for many years (U.S. Department of State, 2018).

In 2018, the Ministry of Health and Medical Services established a partnership with a local LGBTIQ community group – Boutokaan, Inaomataia ao Mauriia Binabinaine Association (BIMBA) – to increase its visibility and provide opportunities for leadership in the HIV response in Kiribati. This includes a drop-in centre on Ministry of Health and Medical Services premises in Tarawa. This is a strategic response, as research suggests that many men who have sex with men often do not use condoms, have experienced forced sex and feel shame about their sexual identity. However, the study also suggested high levels of HIV and STI knowledge among men who have sex with men (Worth et al., 2016). There is little information available about the SRH needs or experiences of lesbian or transgender women in Kiribati.

6.4. Sex workers

Sex work is legal in Kiribati (U.S. Department of State, 2018). However, Section 16 of the Kiribati Penal Code makes it an offence for anyone to procure or attempt to procure a girl or woman into prostitution. Sex work is most often associated with the presence of foreign vessels fishing in Kiribati's economic zone, which generate income critical to Kiribati's economy. Research has found that I-Kiribati women engage in transactional sex and sex work in an effort to escape the effects of poverty, unemployment, abuse and exploitation (McMillan & Worth, 2019) and that their numbers are increasing. In contrast to the short-term

arrangements generally associated with sex work, women may engage in transactional sexual relationships with foreign fishing crew members for up to three months and many also have sex with local partners.

The Ministry of Health and Medical Services Global AIDS Monitoring report (MHMS, 2017) suggests that the HIV Programme Unit within the Ministry of Health and Medical Services prioritises outreach work with sex workers under the national HIV strategic plan, though the most recent version of this strategic plan has not been sighted. A regional research study found that sex workers in Kiribati were at serious risk of sexual violence, with 64 per cent having been sexually assaulted in the previous 12 months (Worth et al., 2016), highlighting the need to address both sex workers' SRH and right to live free from violence.

There is no specific consideration in policy of the sexual and reproductive health needs and rights of sex workers who may also identify as being LGBTIQ I-Kiribati.

7 Humanitarian and disaster contexts

The disaster context for Kiribati is framed by the impact of climate change including ongoing drought, king tides, and rising sea levels resulting in saltwater inundation with impacts on staples include coconut, fish stock and supplies of fresh water. The low-lying dispersed islands means that many people in Kiribati are exposed to these impacts on a daily basis. Kiribati is also vulnerable to tsunamis. Even in the absence of rapid onset natural disasters, climate-change related events can be regarded as an increasing and urgent emergency, that contributes to the existing challenges of overcrowding on South Tarawa.

The geographical and social context of Kiribati, and South Tarawa in particular, means that the I-Kiribati community faces specific risks associated with catastrophic global events such as the COVID-19 pandemic and the associated economic and social impacts.

7.1. International frameworks, commitments and guidelines

Kiribati is a signatory to a number of international treaties and agreements specific to climate change and disaster, and often plays a leading role advocating for accelerated international policy and legislative responses to climate change in particular. International agreements to which Kiribati is party include the *Paris Agreement*, which Kiribati ratified in April 2016, and the *Sendai Framework for Disaster Risk Reduction*.

Recognising that SRH needs are often overlooked in crisis situations, with potentially life-threatening consequences, the international Inter-Agency Working Group for Reproductive Health in Crisis (IAWG) developed the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations* (IAWG, 2020). The MISP is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. UNFPA, in partnership with stakeholders, supports the implementation of the, ensuring that all affected populations have access to lifesaving SRH services. The key aims of the MISP are to ensure that there is no unmet need for family planning, no preventable maternal deaths and no GBV or harmful practices, even during humanitarian crises.

The six objectives of the MISP are to:

1. Ensure the health sector/cluster identifies an organisation to lead implementation of the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Planning for comprehensive services and their integration into existing services.

The recommended services are evidence-based interventions geared to be implemented at the onset of humanitarian crises. Following the acute emergency response and the implementation of the MISP objectives, a transition into comprehensive, integrated and ongoing SRH services is vital. The SPRINT Initiative of the International Planned Parenthood Federation (IPPF) supports countries across the Pacific to

deliver the MISP SPRINT program, working through member associations such as the Kiribati Family Health Association. However, delivery of the MISP is not as yet addressed in domestic legislation in Kiribati.

Two documents produced by the Inter-Agency Standing Committee (a forum of UN and non-UN humanitarian partners, aiming to strengthen humanitarian assistance) provide the foundational guidance on preventing and responding to GBV in emergencies (GBViE): the *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC, 2015) and the *Minimum Standards for Gender-Based Violence in Emergencies Programming* (IASC, 2020). The latter document outlines GBViE standards, a comprehensive set of 16 standards developed by UNFPA and providing practical guidance on how to prevent and respond to gender-based violence in emergencies and facilitate access to multi-sector services (IASC, 2020). The GBViE standards also build on the *Essential Services Package for Women and Girls Subject to Violence* (UN Women, 2015). It is important to note that the Minimum Standards for SRH and GBViE are interrelated and inter-dependent. Both sets of standards should be explicitly incorporated into relevant disaster, gender, national development plans and health policy as a basis for preparedness, response and recovery.

7.2. Regional agreements and networks

Kiribati is party to a number of disaster-related regional commitments. These include:

- The Framework for Resilient Development in the Pacific: An Integrated Approach to Address Climate Change and Disaster Risk Management 2017–2030 (Pacific Community et al., 2016)
- The Boe Declaration on Regional Security and related action plan (Pacific Islands Forum Secretariat, 2018)
- Framework for Pacific Regionalism endorsed by the Pacific Islands Forum (2014)
- Suva Declaration on Climate Change adopted in 2015 by the Pacific Islands Forum
- The Pacific Platform for Disaster Risk Management (Pacific Community, 2016)
- The Small Islands Developing States Accelerated Modalities of Action (SAMOA Pathway) (2014)
- KAILA! Pacific Voice for Action on Agenda 2030: Strengthening Climate Change Resilience through Reproductive, Maternal, New-born, Child and Adolescent Health (2015).

Whilst gender equality is a stated goal of several of these agreements, the only SRH specific agreement is the *KAILA Strengthening Climate Change Resilience through Reproductive, Maternal, Newborn, Child and Adolescent Health* (2015). Other regional climate and disaster agreements do not appear to have specific provisions or guidance regarding sexual and reproductive health or gender-based violence in emergencies, however there are references to addressing gender equality and inequalities especially with vulnerable groups.

There are two additional key plans that have been developed in response to the COVID-19 pandemic by UN agencies in partnership with development partners, the Pacific Community, and in the case of the Humanitarian Response Plan, the Red Cross, non-government organisations and faith- and community-based organisations. These plans are inclusive of Kiribati, and are the *COVID-19 Pacific Health Sector Support Plan* (2020) developed by the Pacific Joint Incident Management Team (coordinated by WHO) and the *Pacific Humanitarian Team COVID-19 Humanitarian Response Plan* (Pacific Humanitarian Team, 2020).

It should be noted that UNFPA's Regional Prepositioning Initiative has established hubs in Australia and Fiji that can quickly provide SRH-related supplies to, and support prevention and response to GBV, in countries such as Kiribati in case of humanitarian crisis. This may include provision of dignity kits, establishing women friendly spaces or capacity building.

7.3. Domestic policy and legislation

While the MISP is not explicitly required through national policy or legislation, the Government of Kiribati made a public policy commitment to integrate the MISP in disaster management plans and response efforts at the Nairobi ICPD25 conference: “By 2022, we will have integrated the Minimum Initial Service Package (MISP) in disaster management plans and response efforts” (Government of Kiribati, 2019c, par 1).

Existing commitments, partnerships, policy and legislation provide an enabling environment to do this. The *Kiribati Joint Implementation Plan for Climate Change and Disaster Risk Management 2019-2028* is gender responsive, and has as its fifth strategy ‘Strengthening health-service delivery to address climate change impacts’. The plan does not specifically refer to SRH, but under result area 5.4 it lists the number of family health clinics trained in women’s mental health, climate change and GBV as a performance indicator. These clinics provide integrated family planning/SRHR and GBV services, and so expanding this indicator to include training in SRHiE and GBViE would be an effective way to strengthen inclusion of SRH and GBV in the plan. Under result area 7.2, the plan seeks to ensure communications programs include key gender-responsive messages to encourage attitudinal and behaviour change amongst men to discourage GBV and amongst women to take on leadership roles.

The *Kiribati COVID-19 Development Response Plan*, developed through partnership between the governments of Australia and Kiribati, notes that the Australia will work with the Government of Kiribati and local organisations to deliver essential sexual and reproductive health services in the context of COVID-19 disruptions (Government of Kiribati and Government of Australia, 2020, p.2). This plan also acknowledges that the pandemic has been associated with increased levels of GBV globally, and includes a focus on strengthening responses to GBV to mitigate the impact of COVID-19, with key results for the plan to include examples of improved services for women and girl survivors of violence (p.5).

The *Strategic Roadmap for Emergency Management in Kiribati 2020–2024* includes as a key result area the mainstreaming of protection (mitigation of GBV, gender mainstreaming and focused support for people living with a disability and the elderly), and a cross cutting strategy for the roadmap as being increased capability, including the capacity of the social sector to evaluate GBV in emergencies programming and coordination, and to ensure mitigation of the risks of GBV particularly for vulnerable populations.

While there are not specific provisions in policy and legislation in Kiribati to require alignment with the *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies*, the overall policy environment provides an enabling environment for this alignment with key policies recognising the intersection between emergencies and GBV, and the need to strengthen prevention and response in emergency contexts.

8 Conclusions and recommendations

This desk review suggests that Kiribati has made substantial progress towards creating a legislative and policy environment that protects women and girls from GBV, and good progress towards an environment that is enabling of universal access to SRH. While the effectiveness and quality of implementation of policy and legislation in Kiribati was beyond the scope of this review, it is recognised that Kiribati faces unique challenges in the delivery of services (including those related to SRHR and GBV). These include the geographical remoteness of much of the population, and the small population limiting the human resources and capacity available for implementation of law and policy. Ensuring accountability for the implementation of current policy and legislation would make a substantial contribution to an enabling environment in relation to SRHR and GBV in Kiribati. Accountability could be strengthened by:

- ensuring monitoring and evaluation systems are robust and responsive
- ensuring regular reporting against national and international commitments
- supporting research into barriers to implementation and the identification of solutions

In addition, this preliminary desk review suggests specific actions that could be undertaken to strengthen policy and legislation in Kiribati.

8.1. General recommendations

- There is a need for Kiribati to review and repeal legislation that is contradictory to the country's international human rights obligations under international conventions such as the CRC, CEDAW, and the CRPD. Any legislative reform should be approached in a comprehensive and integrated manner involving consultation with civil society and key population groups, including gender impact assessment to understand possible unintended consequences.
- Strengthen mechanisms for data collection to support monitoring and evaluation of policy and legislative implementation to ensure annual targets are met and allow evidence-based reform (e.g. ensuring that health management and information systems collect data on GBV and SRH, ensuring interoperability of administrative data systems and collection of GBV service data).
- Revitalise efforts to revise the *Constitution* to guarantee protection from discrimination on the basis of gender, gender identity and expression, and sexual orientation.

8.2. SRHR recommendations

- Draw on national family planning guidelines to strengthen indicators in relation to SRHR in future Ministry of Health and Medical Services Strategic Plans. This could include incorporation of specific targets for availability of each of the different contraceptive methods at all service delivery points.
- Consider reform of legislation to ensure access to contraception in all government run service delivery points.
- Support research to better understand the low contraceptive prevalence rate in Kiribati, with a particular focus on adolescents and young women, to inform policy and practice (if, for example, service provider knowledge and attitudes about provision of contraception to unmarried young people is a clear barrier to access, then specific training should be conducted for service providers).
- Given findings from the Kiribati Family Health and Support Study that found women experiencing GBV were less likely to be using family planning, more likely to report their last pregnancy was unintended and more likely to have more children than women who had not experienced partner violence, there is a need to strengthen policy responses at the intersection of SRHR and GBV. This could include policy in relation to bi-directional referral pathways between violence response services and health services, and service provider training.
- Review primary and junior secondary school curricula to ensure that comprehensive sexuality education content is based on contemporary best practice.
- The Ministry of Health and Medical Services and Ministry of Women, Youth, Sport and Social Affairs to work with the Ministry of Education to monitor enforcement of legislation to prevent disciplining or exclusion of pregnant students, to support young mothers to return to school, and to develop indicators relevant to menstrual hygiene management for inclusion in Ministry of Education policy.
- Revise the current indicator in the Ministry of Health and Medical Services Strategic Plan relevant to cervical smears and HPV testing to incorporate coverage of HPV vaccination.
- Strengthen collection, collation and analysis of STI data across the country to inform policy and practice.
- Incorporate provision for post-abortion care into health policy and practice guidelines, basing this on research into the prevalence, contexts and impact of unsafe abortion in Kiribati.
- Consider reform of legislation that currently criminalises some sexual activity between consenting adults, and ensure legislation addresses discrimination on the basis of sexual behaviour, sexual orientation, gender identity and expression.
- Develop strategies to ensure access to comprehensive SRHR services and information for all LGBTIQ I-Kiribati.
- Consider reform of legislation to provide access to paternity leave, complimentary to maternity leave, for personnel in government positions.
- Work with WHO to clarify the minimum standard of capacities required for a birth attendant to be assessed as 'skilled', and monitor and report against efforts to improve the quality of services provided by ANC clinics and through emergency obstetric care.

- Consider revision of future Ministry of Health and Medical Services strategic plans to incorporate actions to ensure SRHR services and information are inclusive of people with disabilities.

8.3. GBV recommendations

- Consider reform of legislation to prohibit discrimination on the grounds of sex, sexual behaviour, sexual orientation, gender identity, HIV status, and disability.
- Consider revision of legislation that defines rape as an act only committed against women and girls to incorporate sexual violence against men and boys. Consider revisions to the Penal Code to incorporate a comprehensive definition of rape, including marital rape, and all forms of sexual violence.
- Given the very high rate of violence against women and girls who sell sex, there is a need to generate evidence about their experiences that can identify strategies to prevent GBV, improve their access to SRHR, and to assess whether there is a need to strengthen protection legislation in Kiribati. There is also a need to generate evidence about the experiences of men and transgender I-Kiribati who sell sex.
- Ensure that the next Policy and Action Plan on GBV includes specific actions to reduce violence against women and girls with all forms of disabilities, including the disability that can be a consequence of violence.
- Ensure that the next Policy and Action Plan on GBV, and future Ministry of Health and Medical Services Strategic Plans, address the need for specific violence prevention and response services for LGBTIQ I-Kiribati.

8.4. Humanitarian and disaster recommendations

- Ensure that the public commitment to the MISP for SRH is realised and that the MISP is embedded in disaster risk management and response policy and plans. Current efforts to strengthen the governance and coordination of disaster risk management and response in Kiribati through a cluster system represents an important opportunity to prioritise the MISP within a health cluster.
- Ensure the MISP is also situated in broader Ministry of Health and Medical Services policy in ways that strengthen health systems as part of SRHiE preparedness and readiness. Given the long-term and escalating impact of climate change in Kiribati, adopting the MISP as an ongoing minimum standard may be appropriate.
- Ensure that current efforts to strengthen the governance and coordination of disaster risk management and response in Kiribati is inclusive of a protection cluster, and that a GBViE working group is prioritised within such a cluster.
- Ensure GBViE standards are embedded in policy and legislative frameworks, and that any protection cluster develop guidance relevant to preventing and responding to GBV for government and non-government agencies.
- Ensure that the roles and responsibilities outlined under the governance mechanisms currently under development include SRH and GBV.

- Consider revising the *Joint Implementation Plan for Climate Change and Disaster Risk Management* 2019-2028 to include expand the indicator for 5.4 to include the number of family health clinics trained in SRHiE and GBViE, and to incorporate the MISp and GBV minimum standards.
- Include measures to prevent sexual exploitation, abuse and harassment in emergency contexts, including of and by workers in the response.

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Annex 1: Desk review search terms

Kiribati

AND "fertility"	OR "SRH"	OR "Gender-based violence"
OR "Maternal mortality"	OR "Reproductive health"	OR "Violence against women"
OR "Matern* health"	OR "Sexual health"	OR "Domestic violence"
OR "Matern* leave"	OR "Contracept*"	OR "Intimate partner violence"
OR "Patern* leave"	OR "Abortion"	OR "Family violence"
OR "Pregnancy"	OR "Family planning"	OR "Trafficking"
OR "Childbirth"	OR "Sex* education"	OR "Sex work"
OR "Skilled birth attendan*"	OR "Sex* curriculum"	OR "Early marriage"
OR "Life-saving commodit*"	OR "Family Life education"	OR "Forced marriage"
OR "Life-saving medicine*"	OR "AIDS"	OR "Child marriage"
OR "HPV"	OR "HIV"	OR "Female genital mutilation"
OR "Discrimination"	OR "Gender"	OR "Female genital cutting"
OR "Plural legal system"	OR "Disability"	

Annex 2: Integrated sexual and reproductive health and rights

Guttmacher-Lancet Commission Integrated sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health.

The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;
- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth, and postnatal care;
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections; and
- prevention, detection, and treatment of reproductive cancers.

Source: Starrs, et al. (2018). Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. The Lancet Commissions. 391(10140) 2642-2692.

