PASSION FOR RIGHTS

Ten years of fighting for sexual and reproductive health

ICPD – the foundation for the Millennium Development Goals

PASSION FOR RIGHTS – Ten years of fighting for sexual and reproductive health RFSU

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RFSU

The Swedish Association for Sexuality Education (RFSU) is a politically and religiously independent non-governmental organisation, promoting an unprejudiced, tolerant and open approach to sexuality and personal relationships. We are striving for an open, equal society, where people are not sexually exploited or discriminated against, but instead where sexuality is a source of pleasure and joy.

RFSU comprises experts, individual members, local associations and member organisations. It also runs a clinic focusing on sexual medicine, sexual counselling/psychotherapy and supervision. RFSU is a member of the International Planned Parenthood Federation (IPPF).

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Double standards – a threat to the ICPD

Ten years have passed since the Programme of Action (PoA) for sexual and reproductive health was adopted by 179 countries at the International Conference on Population and Development (IPCD) in 1994. At this halfway point in 2004, there is a simultaneous sense of optimism and resignation. This publication brings up different perspectives of what was said in the Cairo Conference and the political debate of today, ten years after. It also gives concrete examples of how the situation for women's, men's and adolescents' sexual and reproductive rights appear. There is greater awareness of the issues at stake, and many countries have drawn up policy documents. A considerable number of admirable projects have also been implemented at grassroots level. But the gap between ideals and concrete action is still too wide.

One of the most problematic issues is the one about abortion. Most countries still have closely regulated abortion legislation, with severe sanctions imposed on those who break the law. In certain areas in African countries, 50 per cent of deaths in connection with pregnancy are the result of unsafe and illegal abortions. The abortion issue clearly involves double moral standards. There is a heavy burden of guilt, which is usually confined to the woman concerned. The right to abortion is vociferously opposed by the Catholic Church. The repressive global "Gag Rule" imposed by the United States gives the USA, the Vatican and other opponents of abortion enormous scope for silencing efforts by non-governmental organisations (NGOs) to work on a broad front to provide information about pregnancy, contraception, HIV/AIDS and the use of condoms.

Progressive governments (both donor and recipient nations), and civil society, activists and others working for human rights must develop strategies for dealing with this ongoing sabotage of sexual and reproductive health and rights (SRHR).

HIV/AIDS has inevitably created awareness of the links between sexuality, a lack of rights and equality and inadequate access to information and condoms. But there has been insufficient focus on the lack of rights of young people. The attitudes of national leaders in countries where religion has a considerable influence are often the same – "let sleeping dogs lie", "girls should wait", "refrain from sex until you are married", and "sexuality education and condom information lead to promiscuity".

But such attitudes get us nowhere. The need of sexuality education for young people is becoming increasingly urgent. But adults must first come to terms with their

double standards, and their apparent need to exert control over young people by means of restrictions or even physical compulsion.

The alternative is meeting young people's needs in the form of youth clinics (so-called "Youth Friendly Services"), which offer understanding and expert advice, in addition to providing youths with access to contraceptives, condoms, tests and safe abortions. The different situations facing young men and young women must be paid great attention. Give young men an opportunity to think about the gender stereotypes that permeate the views and expectations imposed by society on boys/men and girls/women, and help them to break these patterns. The powers, attitudes and behaviours of men in relation to women are currently a major factor in unwanted pregnancies and the spread of HIV/AIDS, and are often based on compulsion and accompanied by physical force. Men's desire for change must be encouraged in this context, and taken seriously.

Let young people become genuine resources that can push these issues in a long-term perspective. Adults often claim that they want to let young people participate, but peer educators (youth-information officers) are often reduced to picturesque alibis – confined to performances on the dance floor at international conferences. Young people must be allowed to influence policy documents and reports. Thousands of young people are currently playing an active part in SRHR and HIV/AIDS projects. We must ensure that they receive further training and become active participants in NGOs, and occupy other key strategic positions in society.

Many of the goals expressed in the PoA are based on international human rights conventions. This means that the countries that have ratified the conventions have promised to introduce corresponding legislation at national level. They have also undertaken to live up to morally binding international declarations, such as the PoA of the ICPD. Organisations working for sexual and reproductive rights in all parts of the world must follow this up by insisting that governments comply with internationally binding conventions, and that they implement the PoA. Donor countries must explicitly require that partner-country strategies for reducing poverty and achieving the Millennium Development Goals clearly indicate the ways in which they are trying to meet the ICPD and PoA objectives.

But it is not realistic to expect poor countries to manage this without continued long-term assistance from more affluent countries. Donor countries must devote a much higher proportion of their development-assistance funds to SRHR initiatives. Also, these governments have considerable responsibility for ensuring that people in poor countries are not afflicted by or killed by HIV/AIDS, and that women do not die in childbirth or as a result of improperly performed abortions.

One key prerequisite in efforts to implement the PoA is that we successfully influence senior officials in government ministries and public authorities. Giving governments' factual arguments indicating why investment in SRHR offers long-term economic benefits for society as a whole is a specific task. Initiatives taken by civil society are invaluable in this setting. NGOs have relevant experience and a desire for change. Their know-how about issues and policy development is a resource that must be respected and utilised.

Ann Svensén
Director of External Relations, RFSU

ICPD changed the world

The International Conference on Population and Development (ICPD), held in Cairo in 1994, changed the world's perspective on population issues for ever. The individual's right to sexual and reproductive health came into focus. But has the world become a better place since then?

"Yes, Cairo introduced a human-rights dimension into the population debate that significantly shifted the focus away from government demographic targets and toward individual freedom of reproductive choice," says Steven Sinding, Director General of the International Planned Parenthood Federation (IPPF).

Almost ten years have passed since 179 countries adopted the Programme of Action (PoA) in Cairo. 243 recommendations were made, with the individual's sexuality and reproduction at the centre of the programme. For 20 years – from 1994 onwards – the participating countries promised to improve people's sexual and reproductive health and rights (SRHR). Accordingly, the countries committed themselves to working for increased equality, and to creating access to reproductive health-care services, sexuality education, contraception, education for girls, and so on.[1] Earlier debates and conferences in the population arena had addressed issues on the basis of demographic targets. Terms like "population explosion" and "over-population" came to reinforce an already dismal scenario in the eyes of the general public. Also, some countries attempted to control their population growth by specifying how many children a family should have.

To meet quotas, some countries offered rewards for achievement or imposed punishments for non-achievement. For example, in order to implement the one-child policy instigated by China in 1979, regulations were imposed (1983-84). Women were to be compelled to undergo an abortion if their pregnancy was not approved, and all couples who had more than two

1 Singh Jyoti Shankar, *Creating a New Consensus on Population*, London, Earthscan Publication Ltd, 1998.

Straight ahead for the Cairo agenda? Ninety per cent of the countries are striving to achieve the goals. But double morality is still getting in the way.

children were to be compulsorily sterilised.[2] India implemented large-scale sterilisation campaigns during the 1970s, which were strongly criticised by women's organisations and others.[3] By contrast, in Communist countries like Romania, there was a desire to increase nativity. Right up into the 1980s, married women in Romania were obliged to provide the state with at least five children.[4]

With the ICPD came the paradigm shift that many activists at grass-roots level had longed for. They had seen how a lack of knowledge and rights took their toll on people's, and especially women's, reproductive lives.

2 Graham Maureen M, Ulla Larsen and Xiping Xu, *Son Preference in Anhui Province, China,* published in International Family Planning Perspective, Volume 24, No. 2, June 1998.
http://www.guttmacher.org/pubs/journals/2407298.html

3 Visaria Leela, Shireen Jejeebhoy and Tom Merric, *From Family Planning to Reproductive Health: Challenges Facing India*, published in *International Family Planning Perspective,* Volume 25, Supplement, January 1999.
http://www.guttmacher.org/pubs/journals/25s4499.html

4 Furubrant Kerstin, *Befolkningstillväxten saktar av*, Epok, Utrikespolitiska institutet.
http://www.ui.se/epok/

Preparatory work prior to the Conference confirmed that the time was right for a new perspective. ICPD was the global conference that radically changed conceptions among the thousands of people responsible for national population programmes. Population issues could no longer be treated from a top-down perspective with pre-set goals, but had to be regarded in light of the individual's needs and rights.

Sometimes, ideas find their right place in time. This must have been the case prior to the ICPD. The signals coming from the grass-roots and organisations from every corner of the world allied with the demands of many experts for a new focus. Many had come to realise that the threat to the world was not population increase, but rather the over-consumption and mismanagement of the world's assets – the benefits of which accrued to just a handful of rich people, primarily in the North.

Media interest in the Conference also contributed to the paradigm shift. The media tend to be attracted by classic conflicts; for example, the Vatican's opposition to abortion could be set against women's need to determine over their own reproduction. The abortion discussion at Cairo was reported extensively in the media. When Dr. Nafis Sadik, then Director General of the UN's Population Fund (UNFPA) met Pope John Paul II on 5 April 1994, the Reuter's news agency reported that: "Speaking to some 50,000 people in St. Peter's Square at his weekly general audience, the Pope frequently raised his voice as he spoke in passionate defence of the rights of the family. 'We cannot accept the systematic death of the unborn,' he said. ´Every family must know how to resist the false sirens of the culture of death".[5] When the main proceedings opened in Cairo, more than 4,000 journalists were present. This was a record in a UN context. Indeed, the number of journalists was slightly higher than that of the official delegations.

Sweden's work at the ICPD was led by Lars-Olof Edström, ambassador and principal secretary of Sweden's National Committee at the Conference.

"There was a recognition that something big, something new, was on the go. A lot of the key work took place during preliminary meetings, where the text formulations were negotiated. This was also where the paradigm shift took place, and where a majority of countries came to agreement that women's life conditions were central with regard to population issues."

During earlier conferences, perspectives had been narrower. Discussions had centred on the concept of family planning – an old-fashioned idea that it was difficult for recent Swedish governments to accommodate. The view was that the formulation excluded anyone who had sex without planning a family, and also all family constellations except that of the nuclear family. Even during the mid-20th century, SRHR had become a prioritised area in Sweden; in 1952 it became permissible to sell condoms, and in 1955 sexuality education was introduced as a compulsory subject in school.

"Prior to Cairo, Sweden and the other Nordic countries decided to adopt an overall perspective on sexual and reproductive rights – for both young people and

5 Singh Jyoti Shankar, *Creating a New Consensus on Population*, 1998.

women. We wanted to get away from the concept of family planning. We had expected strong opposition, even that we would be isolated in taking this line. But it proved that we were in the mainstream. Also, the USA did not act as we expected. Under President Bill Clinton, it adopted a similar line to that of the Swedish, which proved extremely important. Rapidly, a strong majority view was formed – that of abandoning old perspectives on family planning, and taking a broader approach," says Lars-Olof Edström.

The opponents of this perspective were not unexpected: the Vatican, some conservative Muslim states, and a number of Latin American countries. Several of the Latin American countries that had reservations against some of the terms of the PoA of 1994 have later affiliated themselves to the Cairo agenda. On the other hand, the USA has totally changed position, and – since George W. Bush became president in 2001 – has attached itself to some of the most conservative states at international conferences.

The Secretary General of the Swedish Association for Sexuality Education (RFSU), Katarina Lindahl, was a member of the Swedish delegation as an expert representing non-governmental organisations (NGOs). Before the ICPD she wrote a report on the development of sexual-political rights in Sweden.[6]

"In Cairo the USA was very much the driving force, and important for its success. But equally important in my view were all the NGOs who jointly made their voices heard," she says.

Even at one of the preparatory expert meetings – called "Population and Women", held in Botswana in 1992 – several radical demands were laid down. These included a desire to focus on young people, and an insistence that women who wanted an abortion should have access to knowledge and safe medical procedures. The initial draft for the Conference only referred to abortion as a health risk for women. But after the preparatory meetings, there was a change in direction. Dr. Sadik proposed that abortion should be treated as a decisive health issue for women – a position that was supported by several countries, including Sweden and the USA, at the PrepCom II meeting.[7]

Also, the ICPD became a global governmental conference where non-governmental organisations were permitted to play a larger role. Throughout the 1980s, women's organisations were more active than ever before. Women's rights were in focus in the debate on human rights, and several governments accepted such organisations as partners. Prior to the ICPD, NGOs gathered together their positions in the form of common statements. Female predominance during the main conference proceedings and at the preparatory stage were manifested in daily meetings with human-rights groups and in so-called "women's caucuses", where various demands – such as for sexuality education – were raised.

"Abortion was one of the hardest issues for the countries to unite over. It was the strong women from the South who played the decisive role. It would never have been possible to get as far as we did if the issue of

6 Bygdeman Marc and Lindahl, Katarina, *Sexualupplysning och reproduktiv hälsa i Sverige under 1900-talet*, SOU 1994:37.
7 Singh Jyoti Shankar, *Creating a New Consensus on Population*, London, 1998.

abortion had been pursued solely by rich women from the North," says Katarina Lindahl.

Fred Sai was Chair of the Main Committee at the ICPD. He remembers that the toughest issues on which to reach agreement were those concerned with reproductive health, especially the issue of safe abortion:

"The Vatican and its group held that there was no such thing as safe abortion, since the foetus always died in any abortion. Of course the majority refused to accept the personhood of the foetus. A small group of countries, probably just six, did not want any mention of the word 'abortion' at all. They even refused to accept the phrase 'reproductive health'. To them this meant abortion," says Fred Sai.

Fred Sai's greatest disappointment with the Cairo Conference concerned how the Vatican was able, according to UN rules, to stall preliminary meetings, and even the final Conference itself, through assertion of its ideological position.

"In the end, this gave us too little time to discuss and agree on important strategies for implementation and funding of the Programme of Action," says Fred Sai.

In his view, too much scope is given for philosophical, theological and ethical discussions in the abortion debate.

"At the ICPD we tried to make abortion into a public-health issue, as well as one of human rights," he says.

In the PoA, the countries finally agreed that abortions should be safe wherever they are not against the law.

"In this way, states against abortion could return home without needing to accept it in their own countries," says Katarina Lindahl.

The ICPD document is morally binding on the countries that have signed it. As in most UN documents that are not legally binding treaties, the ICPD document contains stipulations that implementation should be effected with respect for each country's cultural and religious context. This might be interpreted as giving countries an excuse to avoid striving to attain controversial goals. Or, it may be the only way for the UN to reach consensus on difficult issues. But, according to Fred Sai, this is not how it should be interpreted:

"They are not meant to be a cop-out. They are meant for the refining of strategies and for the phasing of implementation programmes. For example, if a culture does not treat boys and girls as equals today, the implementation of the ICPD should recognise this, but plan activities making for a change in the culture, as well as gradually introducing the ICPD activities. This would minimise confrontation or outright rejection."

The Cairo Conference also saw the unveiling of the so-called "conspiracy of silence" concerning genital mutilation and other harmful "traditional" practices. But here there is still much left to do. In Sweden, for example, there has been much debate recently about so-called "honour killings", since several young women have been murdered or injured by their male relatives because they did not live according to the norms of their father or family.

"To take the cultural-relativistic position is to say that Cairo meant nothing at all. If we did not believe in the universal values, there would be no need to have any statement out of any conference," says Steven Sinding.

Many issues were controversial at the ICPD. From a Swedish perspective there was disappointment on how the international community handled the final statement concerning the rights of young people:

"The problems of young people are referred to far

too weakly in the Programme of Action. With regard to sexuality education, there was extensive opposition even among countries that otherwise supported a paradigm shift," says Lars Olof-Edström.

The final document contained a statement that young people have the right to information to protect their sexual and reproductive health. But, as it is written, the section concerned affirms respect for cultural differences in this respect. The rights and responsibilities of parents are also emphasised. A five-year follow-up of the Cairo Conference took place in 1999, under the name ICPD+5. The goals of the PoA were confirmed, and new strategies for handling the needs of young people were introduced. Further, goals were "extended" in relation to the link between maternal mortality, morbidity and their connection and unsafe abortion, and the impact of HIV/AIDS on women and the young, as well as the importance of prevention.

Nevertheless, ten years after Cairo – there was no renegotiation of the ICPD. There are a number of reasons. First, the PoA from 1994 extended over 20 years, and international conferences cost a lot to conduct. Second, the PoA is regarded as still current, and renegotiation would be regarded as a squandering of resources that might better be employed elsewhere. Third, the political opposition has become more intense through the election of George W. Bush as President of the USA.

There is a general fear that opponents of SRHR might be successful in discarding the resolutions made in Cairo. At several international conferences, the USA has obstructed or blocked negotiations with this in mind, but without any great success. The current opposition to SRHR is strident and intense. For example, the USA has imposed bans on American development assistance and aid organisations that advocate or offer abortion (the so-called "Gag Rule"). There is intense lobbying against reproductive and sexual rights at local, regional and national levels (see the chapter on *The opposition – how they work*).

Steven Sinding believes that there is a serious risk of a world-wide backlash against SRHR:

"I see growing signs around me. Within the EU there is strong pressure from reactionary or conservative groups to force the European Commission to stop funding organisations like UNFPA or the IPPF. In parliaments throughout Europe, such as in the UK, these questions keep coming up. There is also strong pressure placed upon developing countries, like Kenya, to cut back on government investments in the SRHR arena. The Vatican and conservative groups in the USA are putting massive amounts of money into an organised campaign to re-write the Cairo agenda," he says.

Thoraya Obaid, the Secretary General of UNFPA, is somewhat more optimistic. She describes it as a conservative wind blowing across the world, backed by handful of fringe groups, hostile to the Cairo mandate.

"They are not winning. UNFPA has just completed its latest countries review survey. It shows that governments have increasingly started to introduce policies, laws and programmes in accordance with the Cairo agenda – against female genital mutilation, against violence against women, and all the rest of it. At our regional meetings to commemorate ICPD ten years on, there is strong support for the ICPD. The opposition has not succeeded in getting countries to stop financing UNFPA; on the contrary, we have enormous support. Our greatest challenge is to maintain the ICPD consensus, and also to obtain resources for further

investments in SRHR. We have to extend the rights of women and young people throughout the world – so that they obtain information, knowledge and access to reproductive health-care services," she says.

Financial support for UNFPA has also increased in recent years. Currently, the organisation's total donor contribution lies at around USD 373 m, in contrast with a figure of USD 277 m for 1998.[8]

Nevertheless, there remains concern that conservative forces will succeed in their attempt to reduce financial allocations to UNFPA and the IPPF.

"We have lost all funding from the USA after the Bush administration came to power, and also from some other countries. The same thing happened during the Reagan years of the 1980s when the IPPF received significantly lower funding allocations from several donors. At that time, many other countries compensated for the deficit, but it has not happened this time. The reason is that many donor countries are strongly influenced by conservative forces. Nevertheless, I think that we will see a change following the Papal succession from John Paul II. With a less active Vatican, less pressure will be exerted on governments in Catholic countries. The Vatican does not need to change its perspectives on abortion and contraception; it is enough for it to focus on other issues. This is what I believe will happen," says Steven Sinding.

The overall development assistance amount devoted to population issues has increased, but it is very hard to ascertain how much goes to sexual and reproductive health.

Fred Sai is also concerned about the opposition, but believes – in the long term – that it will not be possible to reverse the trend towards the extension of sexual and reproductive rights throughout the world.

"The North can contribute with the advocacy of reproductive rights. But I don't think it should be done by a shrill confrontational approach. Quiet diplomacy and programmes showing the benefits to the individual and the countries themselves are likely to be more successful," he says.

Steven Sinding also believes that specific countries must themselves drive the demands for change forwards. But it is still important for them to obtain explicit support from other countries and organisations. In his view, people's rights to sexual and reproductive health will triumph in the end:

"The long-term trend is very much for legislation on abortion on public-health grounds," says Sinding.

Fred Sai adds:

"Anyone demanding legal restriction of abortion is simply discriminating against the poorer and weaker women of society, as has been demonstrated everywhere."

At many international meetings, Katarina Lindahl has seen how an aggressive USA administration has attempted to both attract and threaten smaller countries to introduce reservations against SRHR. But the outcome has been quite the opposite, since countries have come together to manifest their conviction of the validity of the Cairo agenda.

8 UNFPA, Annual Reports 1998-2002.
http://www.unfpa.org/about/report/index.htm

Financial resource flows for population activities from donor countries, the UN, NGOs, commercial banks, and development banks (by year).[10]

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
USD (current)	1,306	1,033	1,310	1,637	2,034	2,044	1,960	2,133	2,231	2,579	2,521
USD (at 1993 prices)	1,386	1,064	1,310	1,596	1,929	1,883	1,765	1,891	1,935	2,163	2,057

In March 2004, Katarina Lindahl took part in the preparatory UN meeting for the Economic Commission for Latin America and the Caribbean (ECLAC). Several Latin American countries had expressed reservations against the PoA in 1994, but now the tone was quite different. Indeed, the meeting was described as a victory for SRHR. 37 countries attended, and the USA was the only country not to support the declaration that emerged.

"It was wonderful to see how these countries are now defending women's and young people's rights against those who are attempting to 'turn the clock back'. Cairo has played a decisive role in terms of attitudes, and has had an impact on the current state of affairs. People are aware that Cairo offers a path to development," says Katarina Lindahl.

At the Cairo Conference most countries came to agreement that population and development issues are closely inter-related, and that equality – as reflected, for example, in women's right to control their own sexuality – is a precondition for pursuing successful policies in this arena.

Today, over 90 per cent of the countries have introduced policies or programmes, or adopted legislation in order to live up to these goals.[9] But people's right to determine their own sexuality and reproduction is a charged question that often has to give way to religious and cultural preconceptions. Women die because they are denied rights or lack knowledge of sexuality and reproduction. Many women die because they lack access to condoms or are exposed to brutal violence or sexual exploitation. Lack of adequate support to adults results in young people being infected by HIV/AIDS, since they do not know how to protect themselves. Lesbian, gay, bisexual and transgender persons (LGBT) are tortured, murdered and persecuted all over the world. And right now, more than 350 million women lack access to safe and efficient contraception.

Ylva Bergman

9 *Report of the Secretary-General on the review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the International Conference on Population and Development*, Commission on Population and Development, 37th Sess., 31, U.N. Doc E/CN.9/2004, 2004.

10 UNFPA, *Financial resource flows for population activities in 2001.*
http://www.nidi.nl/resflows/rf_download/GPAR2001/GPAR2001.pdf

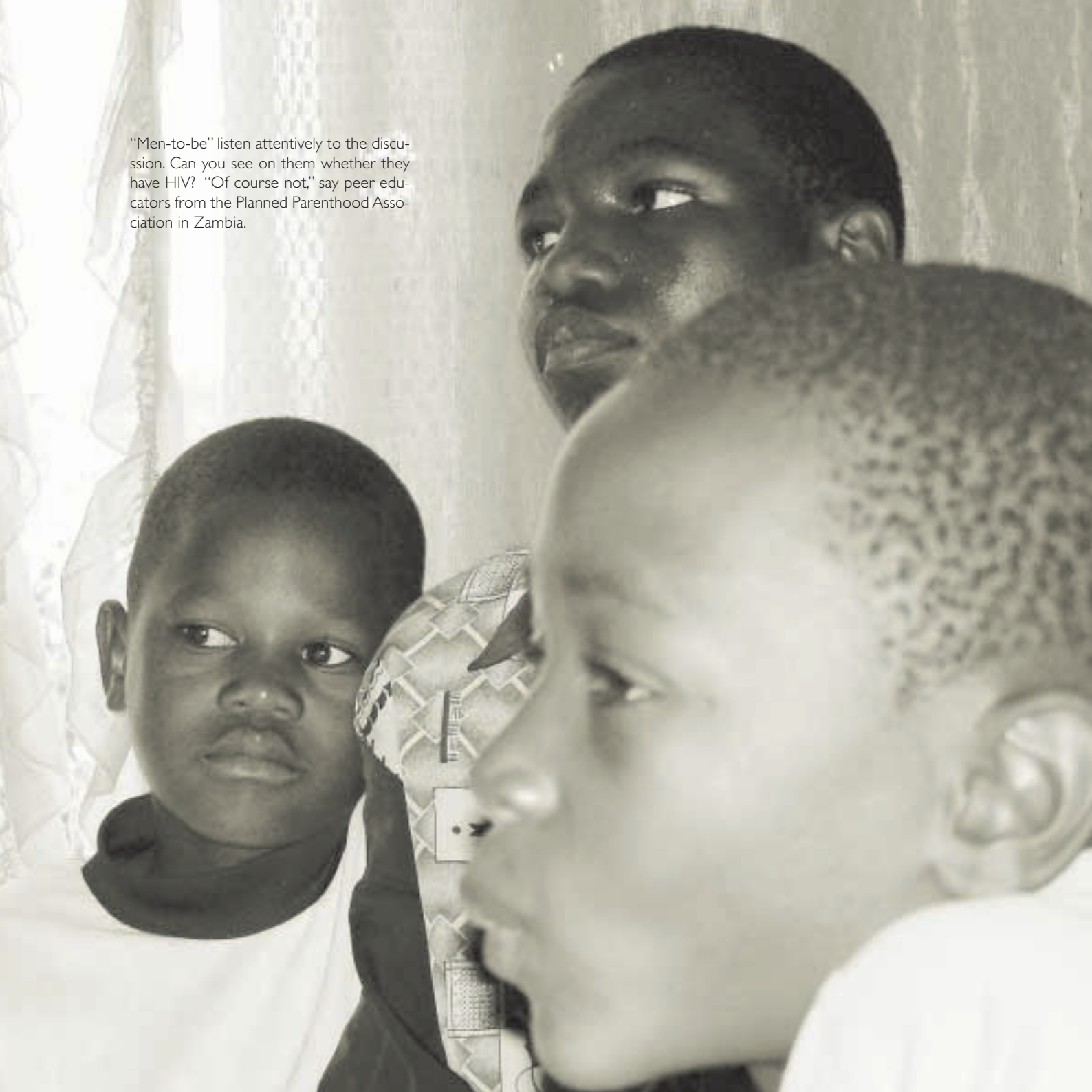
Key goals in the ICPD Programme of Action (PoA)

The ICPD Programme of Action (PoA) was the first international document explicitly to affirm the concept of reproductive rights. It provides a 20-year plan of action, which 179 countries agreed to. In July 1999 there was a five-year review. The outcome document, *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development* (ICPD+5)[1] reaffirmed the principles agreed to in 1994. Some objectives went even further and specific goals on HIV/AIDS prevention were added. Just before the new millennium, UN members reaffirmed their commitment to work toward sustainable development and the elimination of poverty. This came together under the Millennium Development Goals (MDGs), most of which are to be achieved by 2015. None of these MDGs explicitly mention sexual and reproductive health and rights (SRHR). It is undoubtedly so that SRHR is a foundation for achieving some of the goals, such as those pertain to gender equality, maternal mortality, HIV/AIDS and poverty reduction. The list below contains a selection of what RFSU has interpreted as some of the most important goals of the PoA. Under each heading several relevant paragraphs of objectives and actions from the PoA are presented, together with other relevant international documents such as ICPD+5, the MDGs and information from the Fourth World Conference on Women (FWCW).

The rights of adolescents

> Recognising the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide – in a manner consistent with the evolving capacities of the adolescent – appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict

1 *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development,* U.N. GAOR, 21st Special Sess., New York, United States, June 30-July 2, 1999, U.N. Doc. A/S-21/5/Add.1 (1999) [hereinafter ICPD+5 Key Actions Document].



"Men-to-be" listen attentively to the discussion. Can you see on them whether they have HIV? "Of course not," say peer educators from the Planned Parenthood Association in Zambia.

> the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, inter alia, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents (Paragraph 7.45, PoA).

This article provides adolescents with the right to sexuality education, contraception, and abortion. Recognising young people's rights to information, education and services to safeguard their sexual and reproductive health is ground-breaking. However, the paragraph is a compromise since it underlines respect for cultural values and religious beliefs, and restricts legal changes to where it is appropriate (see the chapter, *Controversial terms*). The PoA also restricts the rights of adolescents by recognising parental rights, obligations and responsibilities. However, the paragraph still provides for young people to receive reproductive health services without the consent of their parents by safeguarding their right to privacy and confidentiality. Health-clinic personnel must treat young people respectfully and be able to provide information empowering them to protect themselves against, for example, sexually transmitted infections (STIs) and unwanted pregnancy.

The rate of teenage pregnancy is lower in countries where young people have access to sexuality education and reproductive health services than in countries where they do not. An Allan Guttmacher Institute study compares teenage pregnancy in France, Sweden, the UK, Canada and the USA. The teenage pregnancy rate in the age group 15-19 in France and Sweden is 20 and 25 women per 1,000 respectively. This figure was twice as high in the UK, and four times as high in the USA (84 per 1,000). These discrepancies cannot be explained only by different levels of sexual activity, since the countries in question show approximately the same figures on that indicator. The explanation is rather that young women in the USA use contraception less than in the other countries.[2] Young people need access to information and counselling to be able to use contraceptives correctly and thereby reduce teenage pregnancies.
PoA: 6.11, 6.15, 7:41-48,
Millennium Development Goals 3, 4, 5 and 6

Access to information and reproductive health services

> The objectives are … to ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning are accessible, affordable, acceptable and convenient to all users (Paragraph 7.5 (a), PoA).

2 Darroch Jacqueline E. et. al., *Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use,* The Alan Guttmacher Institute, Family Planning Perspectives, Volume 33, Number 6, November/December 2001.

> All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015 (Paragraph 7.6, PoA).
>
> All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population… and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law (Paragraph 7.16, PoA).

Access to *services* means a complete range of reproductive health-care services, including pregnancy-related care, prevention and treatment of sexually transmitted infections (STIs), access to contraceptives, and safe abortion where it is legal.[3] Governments should ensure that women are included in the design and implementation of reproductive and sexual health programmes. It is also important that services are directed towards men, adolescents, migrants, and victims of sexual and physical violence.[4]

This is particularly important for young people who risk contracting diseases and having unwanted pregnancies because they do not know how to protect themselves. People with access to contraception, reproductive health services and quality maternity care can exercise control over their own sexuality, decide when and if they want to have children, how many and with whom, and can give birth in a safe setting. One of the objectives stipulated in ICPD+5 is that by 2005, 80 per cent of all babies should be delivered with the help of trained personnel. By 2015, this figure should reach 90 per cent. ICPD+5 also stipulates that the gap between contraceptive use and the need for family planning should be narrowed by 50 per cent by 2005, by 75 per cent by 2010, and by 100 per cent by 2015.

All this is necessary in order to achieve significant, measurable improvements in people's lives, including those set forth in the Millennium Development Goals.
PoA: 7.5, 7.6, 7.14-7.26
Millennium Development Goals: 1, 2, 4, 5 and 6

Access to safe abortion

> In no case should abortion be promoted as a method of family planning. All governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Any measures or changes related to abortion within the

3 *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, ¶¶ 7.6, 7.23(f); 7.31-7.33, 8.8, 8.17, 8.25 U.N. Doc. A/CONF.171/13, (1994) [hereinafter *ICPD Programme of Action].*

4 Ibid., ¶¶ 4.8, 4.9, 4.20, 7.7-7.9 and 7.11.

health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions (Paragraph 8.25, PoA).

This was the first time an international document of this standing pointed to unsafe abortions as a major contributor to maternal mortality. Every year, 20 million unsafe abortions are performed in the world, and one woman dies every minute from pregnancy-related causes. In some places, up to 50 per cent of maternal mortality is the result of unsafe abortion.[5] In total, an estimated 14 per cent of all maternal mortality in the world is due to unsafe abortion.[6] At the ICPD +5 conference, the text on abortion was expanded by adding that where abortions are legal, healthcare personnel should be trained and equipped to ensure that such abortion is safe and accessible.[7] Despite the fact that women are severely affected due to their lack of access to safe abortion, the issue of abortion is immensely controversial. At the Fourth World Conference on Women in Beijing in 1995, countries around the world agreed to *consider* reviewing laws which punish women for having illegal abortions.[8]

One of the Millennium Development Goals is to reduce maternal mortality by two-thirds by 2015.

PoA: 8.25
ICPD+5: 63(iii)
Millennium Development Goal: 5
FWCW: 106(k)

Men's responsibility

Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes (Principle 4, PoA).

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning … . Male responsibilities in the family must be included in the education of children from the earliest ages (Paragraph 4.27, PoA).

5 Oguttu Monica, Peter Odongo, *Midlevel Provider's Role in Abortion Care*, Kenya Country Report, A Paper for the Conference "Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care" South Africa, 2-6 December 2001.
6 UNFPA, *Fast Facts on Maternal Mortality and Morbidity*.
7 *ICPD+5 Key Actions Document*, supra note 1 ¶ 63(iii).
8 *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, ¶ 106(k), U.N. Doc. A/CONF.177/20 (1995) [hereinafter Beijing Declaration and Platform for Action].

For the first time in a major international context, the PoA explicitly stipulates that men must take responsibility for their own sexual behaviour, their fertility, transmission of STIs and the health and well-being of their partner and children. But men's responsibility includes a great deal more. Men's efforts to control women's sexuality, through acts of domestic violence, rape and female genital mutilation (FGM), impact on both women's sexual and reproductive health and their equal status within society. Gender equality is also part of men's responsibility and is a precondition for changing the lives of women and young people. Young men need to be targeted in sexuality education and educated about gender equality. They also need to have access to information and services, including access to male condoms. Shared responsibility between men and women is necessary to be able to achieve the MDGs (see chapter on *Political arguments*).
PoA: 4.24- 4.27, 4.29, 7.41, 8.22, 8.27,
Millennium Development Goals: 4 and 6

Violence against women

> Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights … (Principle 4, PoA).

The PoA recognises that gender-based sexual violence, and efforts to control women's sexuality, impact on both women's health and their equal status within society. Government's should stop harmful practices such as female genital mutilation (FGM). They should also promote respect for women and girls through educational programmes. Victims of sexual abuse and violence should be supported and be able to prosecute those responsible.[9] The PoA recognises that women who are raped and subjected to other forms of sexual violence have an increased risk of being infected with HIV or other STIs. Improving gender equality and eliminating violence against women is necessary for the empowerment of women, which is one of the MDGs.
PoA: Principle 4, Principle 9, Paragraphs 4.1, 4.4(e), 4.5, 4.9, 4.10, 4.21, 4.22, 4.23, 4.27, 7.6, 7.11, 7.34, 7.35, 7.38-7.40
Millennium Development Goals: 3, 4, 5 and 6

Reduce the spread and effects of HIV/AIDS

> The AIDS pandemic should be controlled through a multisectoral approach that pays sufficient attention to its socio-economic ramifications, including the heavy burden on health infrastructure and household income, its negative impact on the labour force and productivity, and the increasing number of orphaned children. Multisectoral national plans and strategies to deal with AIDS should be integrated into population and development strategies (Paragraph 8.30, PoA).

9 *ICPD Programme of Action*, supra note 3, ¶¶ 4.1, 4.4, 4.9, 4.13, 4.18, 4.19 and 4.22-4.23; *See also*,¶¶ 7.34-7.35 and 7.39-7.40.

This article calls upon all countries to make efforts to stop the spread of HIV/AIDS by providing information, counselling, condoms and drugs for the prevention and treatment of HIV/AIDS. The PoA also highlights the fact that women and girls are more vulnerable to STIs, including HIV/AIDS, and stresses the importance of meeting their needs. It also lays down the challenge to governments to eliminate discrimination on the grounds of HIV status and to safeguard the human rights of people who live with the virus. At ICPD +5, efforts to combat HIV were further emphasised. It was recognised that young people constitute a special target group who should have access to information, counselling and contraception.[10]

ICPD PoA calls for increased availability and affordability of condoms and drugs for the prevention and treatment of STIs.[11] Despite abstinence being promoted in many countries (see chapter on *Controversial terms*), humans are still sexually active and hence need comprehensive information and services on how to protect themselves.

Half of all new HIV infections occur in people aged 15 to 24 and a majority of them are girls.[12] WHO estimates that approximately 330 million new STIs occur every year, and about 111 million of these affect young people under the age of 25.[13] One of the goals of the ICPD +5 is by 2005, for 90 per cent of all young women and men between 15 and 24 years old to have access to information, education and services to develop the life skills required to reduce their vulnerability to HIV (rising to 95 per cent in 2010). The goal is to reduce the number of HIV infected young people by 25 per cent by the year 2010. This coincides with one of the MDGs.

PoA: 7.29, 7.31-7.33, 8.28-8.35,
Millennium Development Goals: 1, 2, 3, 4 and 6
ICPD+5: 67-72

A comprehensive definition of Sexual and Reproductive Health and Rights

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (PoA, Paragraph 7.2).
>
> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents (PoA, Paragraph 7.3).

For the first time, the international community agreed on a broad definition of reproductive health. The definition includes the important recognition that reproductive health is not just about health but it is also a

10 *ICPD+5 Key Actions Document*, supra note 1, ¶ 70.
11 *ICPD Programme of Action*, supra note 3, ¶ 8.35.
12 UNFPA, *State of the World Population*, 2003.
13 WHO Facts Sheet, *Young People and Sexually Transmitted Diseases*, 1997.

human rights issue which has already been recognised in international human rights documents, including legally binding treaties. The PoA recognised the right of individuals and couples to choose for themselves if, when and how often they want to have children. The definition also encompasses people's right to have access to "*reproductive health services*" (see also *Controversial terms*), including methods of fertility regulation where these are not against the law. This definition was reaffirmed at ICPD+5 where it was agreed that reproductive health cannot solely be measured in terms of how many people use contraception. Factors such as HIV/AIDS, STIs and maternal mortality, must also be considered.[14] At the Fourth World Conference on Women (FWCW) in 1995, 189 countries reaffirmed this broad definition of reproductive health and expanded on the issue of abortion by calling upon states to *consider* reviewing laws punishing women for undergoing illegal abortions.[15]

While the PoA does not recognise *sexual rights,* countries did agree to provide conditions for a safe sex life. However, in Bejing in 1995 the international community managed to recognise the existence of sexual rights without employing the exact term (see chapter on *Controversial terms*). A definition of reproductive health and rights can not be fully comprehensive if it excludes sexual rights. Sexual rights include the rights for women, youth and LGBT-persons to take decisions regarding their own sexuality (see sexual rights/orientation in chapter on *Controversial terms*).

PoA: Principle 8, Paragraphs 7.2, 7.3 7.5-7.9, 7.11, 7.23, 7.30-7.33, 7.36-7.38, 7.45-7.48, 8.8, 8.17, 8.22-8.27
Millennium Development Goals: 1, 2, 5, 6
ICPD+5: 3, 52
FWCW: 95, 106 (k)

RFSU and the Center for Reproductive Rights

14 *ICPD+5 Key Actions Document*, supra note 1 ¶ 52.
15 *Beijing Declaration and the Platform for Action*, supra note 8, ¶ 106(k).

The opposition – how they work

European and American opponents of abortion are becoming increasingly well-organised. In the USA they have direct access to political power through President Bush and there is ongoing and intense lobbying in the European Union (EU). Today, Portuguese women are being imprisoned for having abortions, Polish women are forced to give birth to unwanted children, and women from Slovakia are being forcibly sterilised. The Catholic Church will secure still greater influence, when the new member states enter the Union.

"I will do everything in my power to restrict abortions", said George W. Bush in The Dallas Morning News in 1994, thereby staking out his position on the abortion issue. The prominent position of abortion in American politics is partly a result of the financial power of the extreme Christian right-wing. A political career can be made by the candidate who promotes their issues.

On 20 January 2001, George W. Bush was sworn in as the new President of the USA. The route to the presidency was made easier by grants from the Christian Right. Since his accession to power, Bush has repaid the debt by zealously dismantling reproductive rights. Religious extremists have been placed in key positions in the administration. In December 2000, Bush announced that he would appoint John Ashcroft, a leading opponent of abortion, as Attorney General. As Governor of Missouri, Ashcroft declared the anniversary of the introduction of the Abortion Act in the USA should be made into a remembrance day for aborted foetuses. The former governor of Wisconsin, Tommy Thompson, was appointed Minister of Health.

These appointments had immediate results. The Center for Disease Control and Prevention (CDC)[1] had to change its website to support the Bush Administration's abstinence campaigns. "Programs that Work" was removed, which was a source of information for

1 The CDC is the leading American federal agency for the protection of health and safety.

educators on appropriate curricula for sexuality education, and on decreasing risks in the sexual behaviour of young people. Also, "Facts about Condoms and their Use in Preventing HIV Infection" disappeared from the web, and was only published after changes had been made to its content. The former fact sheet described how condoms were to be used and also discussed different types of condoms. In the new version, abstinence was advocated, and failures arising from the use of condoms were discussed. The Bush Administration considers that sex should be restricted to monogamous heterosexual relationships. National abstinence campaigns have a budget of USD 135 million. And, according to the Planned Parenthood Federation of America, pupils in at least 35 per cent of school districts receive no sexuality education.[2] Instead, they receive instruction in abstinence. Pupils are informed that sex outside marriage is dangerous and not accepted as a cultural norm. Nor do they receive information about contraception.[3] In the budget for 2005, the amounts allocated to the abstinence programme have been doubled.

The USA also lays down conditions for money channelled to aid recipients and programmes for HIV/AIDS. At the end of 2003, President Bush announced that the USA would contribute USD 15 billion for a crisis plan against HIV/AIDS. One third of all prevention funding must go to abstinence projects. [4]

American women obtained access to legal abortions in 1973 through a judgement in the Supreme Court (Roe vs. Wade). Since then, 355 federal laws have been introduced, making it more difficult for women to obtain abortions. Such laws have covered everything from requiring parental permission for an abortion to detailed regulation of how abortion clinics are built and designed. The restrictions mean that, in some American states, it is extremely difficult for women to get an abortion. A clear indication of the opposition's work on undermining the law on abortion is giving a

Since George W. Bush became US President, there has been a total reversal of policy on sexual issues. Now, it is abstinence and the fight against the right to abortion that is on the agenda.

2 Sjödahl, Silvia, *Mörkermakt*, Ottar, RFSU 2/2003.

3 Planned Parenthood Federation of America, *George W. Bush's War on Women: A Chronology*, 2003.

4 *Sexuality Information and Education Council of the United States*, Fact Sheet.

foetus the status of an individual. Foetuses have been entitled to care under the public health-care insurance scheme since March 2002.

The 1st of April 2004 President Bush signed a new law awarding rights to embryo/foetus. It is now a crime to harm or kill a foetus while attacking a woman.

The Supreme Court of the USA is the body that can declare a law to be in conflict with the Constitution and render it invalid; the judges have life-long tenure, and many are now old. If Bush is re-elected in 2004, he will in all probability appoint new representatives to the Supreme Court who are opponents of abortion. There is therefore a risk that women in the USA will be denied the right to abortion. Even now there is a direct threat, since Congress adopted a law in 2003 known as "partial-birth-abortion", which refers to a method for late abortions. The law is formulated in such a way that all late abortions are prohibited. The proposal, however, has not been approved by the federal courts and has thus not entered into force.

Immediately after Bush took up the Presidency, he reintroduced, exactly as anticipated, the Mexico City Policy, or the "Gag Rule" as it is also called. The Gag Rule means that American aid may not be disbursed to organisations providing information or advice concerning abortions. This applies irrespective of whether abortions are legal or not in the countries where the organisations are operating. Nor does it matter whether advice given on abortion is paid by means of other funds. The Gag Rule means that the organisations in question have to give up their freedom of speech, since they are not allowed to advocate safe abortion.

In practice, the Gag Rule has led to the closure of clinics. Fewer women have received advice on contraception and maternity care, and more have had to have an unsafe abortion. In December 2002, a regional population conference was held in Bangkok for Asia and Oceania. Representatives of the Bush administration tried by all possible means to water down the results of Cairo, stating that the USA supports life in all its innocence – from conception through to natural death.

Conservative, right-wing politicians and organisations in the USA and Europe are cooperating with religious institutions. The arguments they use are easily recognisable. The taking of power by the Christian Democrats and the right in the EU Parliament in 1999 was an indication of future power shifts in the many European countries where right-wing governments came to be formed. With this shift in power, a strong conservative and religious lobby emerged against reproductive rights in the EU. And the opposition continues to grow, even though it is still a minority group. Lobbying is undertaken not only by national movements, but also by other Catholic organisations, and by the Vatican, which has established an office in Brussels (Apostolica Nuncio). But the opposition is also collaborating with American opponents of abortion – as is evident from their methods and messages, where they use e-mail bombing and disseminate false information, or propose motions for changes to legislation, often direct copies of those in the USA.[5] The fact that

5 Chitalia, Salima *New Battleground, Same Old Story, Antichoice activists find their way to Brussels*, IPPF European Network, 2003.

religion is strong in the EU has left its imprint on work on its new constitution. At one point, the proposal was that the EU should be based on current Christian values, but this was later removed. What is left in the Convention proposal, however, is Article 51, where the EU is urged to hold a regular dialogue with the Church on decision processes. This may well mean that the Church will secure influence over individual rights. The Pope expressed his deep disappointment when he saw that a draft of the Constitution lacked any reference to God. Romani Prodi openly gave his support to the Pope's statement.

The Vatican is also an observer in the Council of Europe, the main aim of which is to scrutinise and provide information about human rights and democratic government in Europe. As an observer, the Vatican has no voting rights, but can make statements and negotiate with the other 45 member states.

When it was time to adopt new rules in 2002 for the EU's "Aid for Population Programmes and Policies in Developing Countries", a proposal was put forward to strengthen the PoA from the ICPD in Cairo. This meant giving all couples and individuals, among other things, the fundamental right and opportunity to fully protect their reproductive health, in particular with regard to unsafe abortions. The opposition protested, stating that this would mean that European taxes would go to financing abortions in developing countries. At the same time, support was mobilised to block the proposal for an increase in the 2003 aid budget for sexual and reproductive health. The opponents of abortion then mail bombed the representatives with false information, attacked the aid appropriation and criticised the umbrella organisation, namely the International Planned Parenthood Federation (IPPF) and Marie Stopes International.[6]

In 2002, the USA also froze payments of USD 34 million to the UN Population Fund (UNFPA), accusing it of sponsoring abortions in China, which was incorrect.

The European Commission then chose to show its support for UNFPA by increasing its support to EUR 32 million. Immediately, there were reactions from 47 members of the European Parliament hostile to abortion, who attacked UNFPA and IPPF, and criticised the Commission for supporting both organisations. The MEPs received support from two American anti-abortion organisations, the Population Research Institute and Human Life International, and also the ultra-conservative American senator, Chris Smith, who was invited by two British MEPs. The American guests visited the EU Parliament in November 2002, and provided information about UNFPA's alleged involvement in compulsory abortion in China.[7]

Just as in the USA, the opposition in France took up the question of the unborn child having legal status. One case has been taken to the European Court of Human Rights.[8] It concerned a woman who, as a result of a medical mistake, lost her unborn child. Now,

6 Chitalia, Salima *New Battleground, Same Old Story, Antichoice activists find their way to Brussels*, IPPF European Network, 2003.

7 Ibid.

8 La Cour européenne des droits de l'homme.

the prosecutor argues that the right to life shall exist for an unborn child, citing the Convention on Human Rights. There is much to indicate that she is supported by the French anti-abortion movement. The lawyer representing the woman is working for the opponents of abortion "Laissez-les vivre",[9] the Catholic family organisations and for the leader of the right-wing extremist party, Front National, Jean-Marie Le Pen.[10] In December 2003, the French parliament voted to add to the penal code a supplement concerning any negligence that leads to the loss of an unborn child. The proposal was put forward by the UMP representative, Garraud.[11] UMP stands for *Union pour un mouvement populaire,* and is a right-wing conservative grouping. A number of socialists have reacted by stating that this opens the way to challenge the right to abortion. The female lawyer, Gisele Halimi points out that it is a serious threat to the right of women to choose to give life.[12]

Prior to the enlargement of the EU, great care has been taken during negotiations to impose demands on human rights such as, for example, freedom of speech. But women's reproductive rights have been bypassed. The choice has been made to simply state that these rights come under national health legislation. This happened despite the fact that women's reproductive rights have been asserted in, among other things, the PoA of the ICPD in Cairo – an action plan that all EU countries made a moral commitment to follow. And, despite the fact that the Convention on Economic, Social and Cultural Rights (1966), which all EU countries have also adopted, lays down the right to health.[13] In the same way, countries have undertaken to support gender equality between men and women by signing the Women's Convention.[14]

These documents are legally binding for the States who have signed them. Nevertheless, Poland and Malta were granted what was called a "moral exemption", which guarantees that they can continue to withhold from women their reproductive rights and safe abortions. Malta also obtained an equally binding legal exemption which Ireland already had.

Henrik Norinder, university lecturer in EC law at Lund University, believes that there are no formal barriers for states to promote women's rights on the basis of human rights.[15]

Many of the people in current and future EU member

9 "Laissez-les vivre" is the French pro-life organisation.

10 Grosjean, Blandine *Les anti-IVG derrière la femme avortée malgré elle.*, Libération, 12 December 2003.

11 The proposal was taken up in the Senate in January 2004.

12 *French draft amendment on unborn children stokes abortion acrimony.* Associated Press. Yahoo news 28, November 2003.

13 *International Covenant on Economic, Social and Cultural Rights,* adopted Dec. 16, 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (entered into force Jan. 3, 1976), Art. 12.1

14 *Convention on the Elimination of All Forms of Discrimination against Women*, adopted Dec. 18, 1979, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981)., Art. 2(a), 3.

15 Bergman, Ylva, *Blindbockarnas sammanslagning*, Ottar, RFSU 1/2003.

states, who are denied their reproductive rights and legal abortions, had hoped that the other states in the EU would put pressure on other countries". So far this has been in vain. In Portugal, where abortions are forbidden, Duarte Vilar, General Secretary of Portugal's Family Planning Organisation, says that he wishes the abortion issue had been given political priority, and that governments within the EU had put pressure on Portugal in relation to it. During 2002 and 2003 midwives were prosecuted and sentenced for carrying out illegal abortions in Portugal. One midwife had already been in prison for four years before she was pardoned by the President.

Carina Hägg, a Swedish social-democratic member of parliament, asked Sweden's Minister for Foreign Affairs, Laila Freivalds, in December 2003, what action she was thinking of taking to put pressure on Portugal to liberalise its legislation on abortion. The Minister responded that the dialogue with Portugal on sexual and reproductive health and rights will continue, but that abortion remains a national concern.

In Poland, a country that also prohibits abortion, Wanda Nowicka, Secretary General of the Polish Federation for Family Planning, says that she is shocked over the development. She believes that a major reason why Polish women have become involved in EU membership was that they would get the same rights as other women in the EU. Piotr Kalbarczyk, the Secretary General of the Polish Family Planning Organisation, says that they are very angry that the EU member countries did not give the issue of abortion sufficient attention in the negotiations. Now they hope, alongside voluntary organisations from other countries, to be able to get the Polish government to change legislation on abortion after entry into the Union. Piotr Kalbarczyk also says that the Ministry of Education does not dare to make changes to the list of books for sexuality education, since they are frightened of the Catholic Church's reaction. But in the future, he hopes there will be solidarity from the other EU countries.

In Lithuania, the climate has become tougher under the new conservative government. According to Esmeralda Kuliesyte, Secretary General of Lithuania's Family Planning Organisation, the government is highly influenced by the Catholic Church. Sexuality education is not organised, but – when it is – it is largely based on the ideology of abstinence. Abortions are carried out frequently, and sexually transmitted infections are on the increase.

During 2003, the Swedish Association for Sexuality Education (RFSU) initiated a project with the Family Planning organisation in Lithuania to strengthen sexuality education in school. The Swedish International Development Cooperation Agency (Sida) is funding parts of the programme, together with the Government of Lithuania. The Catholic Church in Lithuania heard about the project, and – finding out it was partly financed by the Ministry of Education in Lithuania – reacted strongly. In a number of TV announcements, the Catholic Church spread false information about RFSU, for example, that RFSU was going to discuss condoms with seven-year-olds in Lithuanian schools. There was a reaction from the general public and the Ministry of Education withdrew its support, and also insisted on receiving a statement of support from the Ministry of Education and Science in Sweden in order to continue the project. After pressure from MPs in Lithuania, Sida, RFSU and others,

the Ministry understood that they had been misled by the Catholic Church.

In Sweden, the organisation "Ja till livet" (Yes to Life) no longer organises demonstrations, but the opponents of abortion and those who question sexuality education in Sweden are still active. This takes place more discreetly than 10 years ago, when they were standing in a central square in Stockholm (Sergelstorget), asserting that they were grateful for not having been aborted when they were foetuses. They have also started other activities, such as a telephone hotline for pregnant women called "livlinan" (Lifeline), where women are urged to complete their pregnancy. Organised opponents of abortion can also turn up in the media in the guise of an "ordinary person", who just wishes to raise a question about abortion, or through a letter to the local press.

Each year, problems related to abortion are raised in a number of motions to the Swedish Parliament. In the autumn of 2003, Mikael Oscarsson – Christian Democrat and former chairman of "Ja till livet" (Yes to Life) – drafted a motion that Sweden's National Board of Health and Welfare should be given the task of examining how knowledge about the relationship between abortion and breast cancer should be used for the benefit of women.

The alleged relationship, for which there is no scientific evidence, has been cabled out for a number of years by the international opposition. Mikael Oscarsson's party colleague, Tuve Skånberg, also wishes to review Swedish development assistance to UNFPA. He is concerned that Sweden is one of the largest donors to UNFPA. According to Tuve Skånberg, UNFPA extols China's single-child policy, with compulsory abortion and sterilisation. The argument is familiar from the Bush Administration and originates from Population Research Institute (PRI). The PRI was started by the Benedictine priest, Paul Marx, well-known for his anti-Semitic views. The Institute is a Department of Human Life International, one of the leading world-wide organisations working against the right to abortion and contraception.

In the Swedish Parliament, a group called the "Parliamentary Forum for Family and Human Values" has been established. Its aim is to promote the values that are rooted in Christian ethics and work for the inviolability of human life. In the spring of 1994, they invited the Chairman of the American "National Right to Life Committee" to lecture in the Parliament.

Both in the USA and Europe, conservative ideas are increasingly gaining ground. The opponents of abortions are strong, and reproductive rights are being questioned. Unfortunately, the opposition and the values of the religious right-wing more than occasionally gain ground in developing countries, and also impose a number of repressive conditions on the organisations working there. Bush and the Pope advocate abstinence and condemn the use of contraception, at the same time as millions of people suffer from HIV and die of AIDS. Even within the EU, midwives are being imprisoned for carrying out abortions, and women's reproductive rights have been completely set aside in the accession negotiations. Where then is the solidarity? It is time for a wake-up call and to start taking the opposition to reproductive rights seriously.

Johanna Nyström

Ten political arguments

Sexual and Reproductive Health and Rights (SRHR) are controversial and questioned from several angles. This chapter provides facts and background for political arguments in support of some of the most controversial SRHR issues, such as abortion. These are coupled to relevant legally binding treaties and morally binding international agreements. The arguments in support of safe abortion as a human right have been divided into three parts.

1. Women have the right to decide whether or not to bring a pregnancy to term

When a pregnancy is unwanted, it can take a heavy toll on a woman's physical and emotional well-being. A woman's right to physical integrity entitles her to decide whether or not she will carry a pregnancy to term. A woman's right to determine the number and spacing of her children requires governments to make abortion services legal, safe, and accessible to all women. Women should have access to all safe, effective means of controlling their family size, including abortion. In addition, there are a number of circumstances in which abortion may be a woman's only means of exercising her right to plan her family.

If a woman who has been raped is denied an abortion, she is also denied the right to decide over her body and her reproduction. For women who live in settings in which contraceptive services and education are unavailable, access to safe abortion services may be the only means of controlling family size. The woman concerned is the only relevant decision maker. She knows what her life is like, and she is able to judge if she will manage with an unplanned child. A woman's right to privacy, therefore, entitles her to decide whether or not to undergo an abortion without government interference. Only a pregnant woman knows whether she is ready

to have a child, and governments must play no role in influencing that decision.

• *International Convenant on Civil and Political Rights (ICCPR): arts. 9.1, 17*

• *Convention on the Elimination of All Forms of Discrimination Agains Women (CEDAW): art. 16.1*

• *Convention on the Rights of the Child (CRC): art.164*

• *International Conference on Population and Development (ICPD) Programme of Action (PoA): Principle 8 , ¶¶ 7.3, 7.17, 7.45*

• *Beijing Declaration and Platform of Action: ¶¶ 96, 106(f), 106(g), 107(e), 223*

2. Denying women access to abortion is a form of gender discrimination

It is discriminatory to force women to undergo unwanted pregnancies. It is also discriminatory that an act like abortion, which is only relevant to women, is criminalised. It prevents women from exercising their human rights, thus preventing them from being on an equal footing with men. Not being able to terminate a dangerous pregnancy also denies women healthcare that only women need, which is necessary for their right to health. Women are consequently exposed to health risks not faced by men.

The tendency to define women by their reproductive capacity remains common throughout the world. Laws that deny access to abortion, whatever their stated objectives, force women to stay in their traditional roles as nurturers and mothers. In general, women are the ones to suffer the physical, emotional and economic consequences of unwanted pregnancies. This makes it more difficult for women to participate in the areas of political, economic, social, cultural, and civil affairs.

The right to gender equality and the right to be free from gender discrimination is a fundamental human right, guaranteed in international treaties and documents.

• *Universial Decleration of Human Rights(UDHR): art. 2*

• *International Convenant on Economic, Social and Cultural Rights (ICESCR): art 2.2*

• *ICCPR: arts. 2.1, 26*

• *CEDAW: arts. 1, 3, 11.2*

• *ICPD PoA: ¶ 4.4*

• *Beijing Decleration and Platform for Action: ¶ 232(a)*

3. Unsafe abortion is a public health problem that kills women

Women dying as a result of an unsafe abortion make up a considerable proportion of maternal deaths. In some places this figure is as high as 50 per cent.[1] However, the link between unsafe abortion and maternal mortality needs to be emphasised more in international debate. In Latin America, 21 per cent of all maternal deaths are caused by unsafe abortions;[2] in Bolivia the rate is in the region of 25–30 per cent,[3] while in Kenya it is between 30 and 35 per cent of maternal deaths.

Unsafe abortions are performed in countries where women's access to safe abortion services are limited, forbidden or morally condemned. For example, in Romania, the number of deaths caused by unsafe abortions rose dramatically between 1975 and 1989, during which time abortion was banned. The last year in this period, the rate was as high as 142 women per 100,000. Just twelve months later, when most of the restrictions had been lifted, the figure had fallen by two-thirds.[4]

Out of a total of 200 million pregnancies occurring each year, an estimated 75 million are unwanted.[5] There will always be unwanted pregnancies and hence abortions regardless of whether it is legal or not. Where abortion is not legal, women have no choice but to seek abortions in secret and under conditions that are medically unsafe and life threatening. According to the World Health Organization (WHO), 78,000 women die every year as a result of unsafe abortion.[6] Countries that restrain women from accessing safe abortions violate women's rights to health and to life. Thus, governments should provide women with information and services, such as access to contraceptives that prevent unwanted pregnancies, and should guarantee the right to safe and legal abortion.

Ensuring women's access to safe abortion services may result in lower medical costs for governments. In some low- and middle-income countries, up to 50 per cent of hospital budgets are used to treat the complications of unsafe abortions. The treatment of abortion complications consumes a disproportionate share of resources, including hospital beds, blood supplies, antibiotics, pain control and other medications, operating theatres and services, anaesthesia, and medical specialists. Treatment of unsafe abortion complications

1 Oguttu Monica, Peter Odongo, *Midlevel Providers' Role in Abortion Care, Kenya Country Report.* A Paper for the Conference "Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care" South Africa, 2-6 December 2001.

2 AGI, *Sharing Responsibility: Women, Society and Abortion, Worldwide,* Special report, 1999. http://www.guttmacher.org/pubs/sharing.pdf.

3 UNFPA, *Proposed Projects and Proposals, Bolivia 1998-2002.*

4 AGI, *Sharing Responsibility: Women, Society and Abortion, Worldwide,* Special report, 1999.

5 UNFPA, *State of the World Population*, 1997.

6 WHO, *Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data 1995-2000. Third edition* (RHR). http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html

People will always fall in love, and have sexual desire. But, in many places, neither young people nor the unmarried have access to sexuality education.

may require a hospital stay of up to 15 days.[7]

Women who have abortions performed in developing countries[8] run 100 times the risk of death compared with women having abortions in developed countries. This is due to a much greater shortage of materials and financial resources. The stigma attached in many countries to abortions forces women to seek them underground, often at very high financial cost. This, together with stigma, leads poor women to have an abortion in the latter stages of pregnancy because it takes time to gather the necessary money. Abortions performed in the latter stages of pregnancy become increasingly dangerous.[9] Rich women can always pay for safe abortion even if it is illegal or access is poor. This makes unsafe abortion an injustice that mainly affects the poor.

Making women suffer from unwanted pregnancies is a major public health problem that affects the whole of society.

- *ICESCR: art. 12*
- *CEDAW: art. 12*
- *ICPD PoA: ¶ 8.25*
- *Beijing Deceleration and Platform for Action: ¶¶ 106(j)-106(k)*
- *Millennium Development Goal: 5*

4. Control of one's own body and fertility is a basic human right

Taking control of one's own sexual and reproductive health, including one's fertility, is a right guaranteed in many international treaties and agreements. For example, the ICPD Programme of Action commits governments to "[E]nsur[ing] that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities".[10] Women, men and adolescents must be able to take control of their own fertility and decide themselves how many children they wish to have, how often they want them and with whom. They must also be able to protect themselves from sexually transmitted infections (STIs). To be able to do this, they need access to information on sexual and reproductive health and contraceptives, including comprehensive sexuality education, which leads to increased use of contraceptives and reduces the spread of STIs. The use of contraceptives has increased in developing countries from around 10 per cent during the 1960s to almost 60 per cent today,

7 WHO, *Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data 1995-2000. Third edition* (RHR).

8 Excluding China.

9 AGI, *Sharing responsibility: Women, Society and Abortion, Worldwide,* Special Report, 1999.

10 *ICPD PoA, para. 7.36(b).*

and nine out of ten women who use contraception report using a modern method. Despite this, about 350 million couples around the world still do not have access to modern contraceptives.[11]

- *ICESCR: arts. 10, 12*
- *CEDAW: arts. 10(h), 12, 14.2(b)*
- *CRC: art. 24*
- *CERD: art. 5(e)(iv)*
- *ICPD: 7.2, 7.5, 8.25*
- *Beijing Decleration and Platform for Action: 89, 92, 94-97*

5. About one billion of the world's population are young people – they have the right to take control of their own bodies

Today, over a billion of the world's population are young people between 10 and 24 years old,[12] and in most parts of the world, people become sexually active during their adolescent years. Should adolescents become sexually active, consensually or not, sexuality education and services are necessary in order to avoid unwanted pregnancy or STIs and HIV/AIDS.

The right of young people to reproductive health education and services is recognised in international treaties and agreements, for example, the Convention on the Rights of the Child.[13] In many countries young people's rights are still a controversial issue, and parents are considered to be responsible for informing their children about sex and personal relationships. However, many parents around the world are unable or unwilling to provide this information to their children. In addition, these are issues some children would prefer not to talk to their parents about.

Those opposed to sexuality education and services for adolescents often state that it increases the sexual activity of young people. However, the WHO and UNAIDS surveys clearly indicate that there is no evidence for this. On the contrary, the studies show that young people protected themselves better, spoke to their parents more and were more tolerant towards others when they received accurate and appropriate information. Their self-confidence also increased when provided with such information, making it easier to make crucial decisions about their sexuality.[14] Swedish experiences indicate that access to contraceptives and

11 UNFPA Facts Sheet: *Meeting the Demand for Reproductive Health Essentials.* http://www.unfpa.org/issues/factsheets/essentials_demand.htm

12 UNFPA, *State of the World Population,* 2003.

13 *Convention on the Rights of the Child*, Article 24.

14 UNAIDS, *Impact of HIV/AIDS and sexual health education on sexual behaviour of young people: a review update,* 1997. www.unaids.org

sexuality education reduces teenage pregnancies and abortions. Sweden has increased the focus on sexuality education and reproductive health services since the 1970s, resulting in a reduction in both pregnancies and abortions among young women aged between 15 and 19. An example from a Swedish municipality shows that when the municipality subsidised contraceptives and disseminated more information, the number of abortions fell more than in the rest of the country.[15]

Governments should ensure that young people receive sexuality education in school and though other community settings. It should be accessible and non-judgemental. Information in community settings is especially important in developing countries where many primary school age children do not attend school and where primary education drop out rates are high.[16] Projects in Zambia and Tanzania have involved teenagers in teaching sexuality education to their peers. This has led to a rapid reduction in teenage pregnancy, a change in attitudes, less sexual harassment, and greater use of condoms.[17] It points to the importance of allowing young people to participate and influence decision-making.

- *CEDAW: Arts. 10(h), 12*
- *CRC: Art. 24*
- *ICPD PoA:¶¶ 7.20. 7.37 7.41-7.48*
- *Millennium Development Goal: 4*

6. No-one should contract HIV because they don't know how to protect themselves

About 40 million people currently have HIV/AIDS, and around one quarter of these are between 15 and 24 years old. Half of all persons newly infected with HIV are young people.[18] Many of them have no idea how to protect themselves against HIV/AIDS or other STIs. A study in Mozambique indicated that 74 per cent of girls and 62 per cent of boys in the 15-19 age group did not know how to protect themselves against HIV/AIDS.[19]

Young people are in many cases forced to be sexually

15 Swedish National Institute of Public Health, *Handlingsplan för prevention av oönskade graviditeter för perioden 2002-2007 (Action Plan for the Prevention of Unwanted Pregnancies 2002-2007).* http://www.fhi.se/pdf/aborter.pdf

16 UNFPA, *State of the World Population*, 2002. http://www.unfpa.org/swp/2002/pdf/english/swp2002eng.pdf

17 RFSU Young Men as Equal Partners, *YMEP*, 2003.

18 A UNICEF Fact Sheet, *Young People and HIV/AIDS.* http://www.unicef.org/publications/test.pdf

19 UNAIDS, *Fact sheet preventing HIV/AIDS among young people, 2000.* http://www.unaids.org

active, especially poor girls who, because of their poverty and/or status as AIDS orphans, have no choice. Under the constraints of poverty, sexuality becomes a negotiation tool that can provide food for the family, schoolbooks, or even a ride to school. In some cases, sexuality is the only thing children and teenagers have to negotiate with or sell, making them increasingly susceptible to HIV/AIDS and other STIs. Prevention initiatives, such as supplying sufficient information about sexuality (e.g. about condom use), must be developed and strengthened. In addition, it is crucial to address the gender inequalities and poverty dimensions that exacerbate the pandemic.

A country often mentioned as a success story when it comes to preventing the spread of HIV/AIDS is Uganda. The percentage of people living with HIV/AIDS went down from 15 per cent in 1991 to 5 per cent in 2001. The success of the 1990s is often attributed to the country's ABC initiative, which is an informational campaign promoting the equal importance of abstinence, being faithful to one's partner and condom use. In Uganda, the initiative has led to a higher use of condoms. For example, the proportion of women who had sex in the past four weeks and used a condom rose from zero in 1989 to eight per cent in 1995. The proportion of men in the same group rose from one to eleven per cent during the same time.[20]

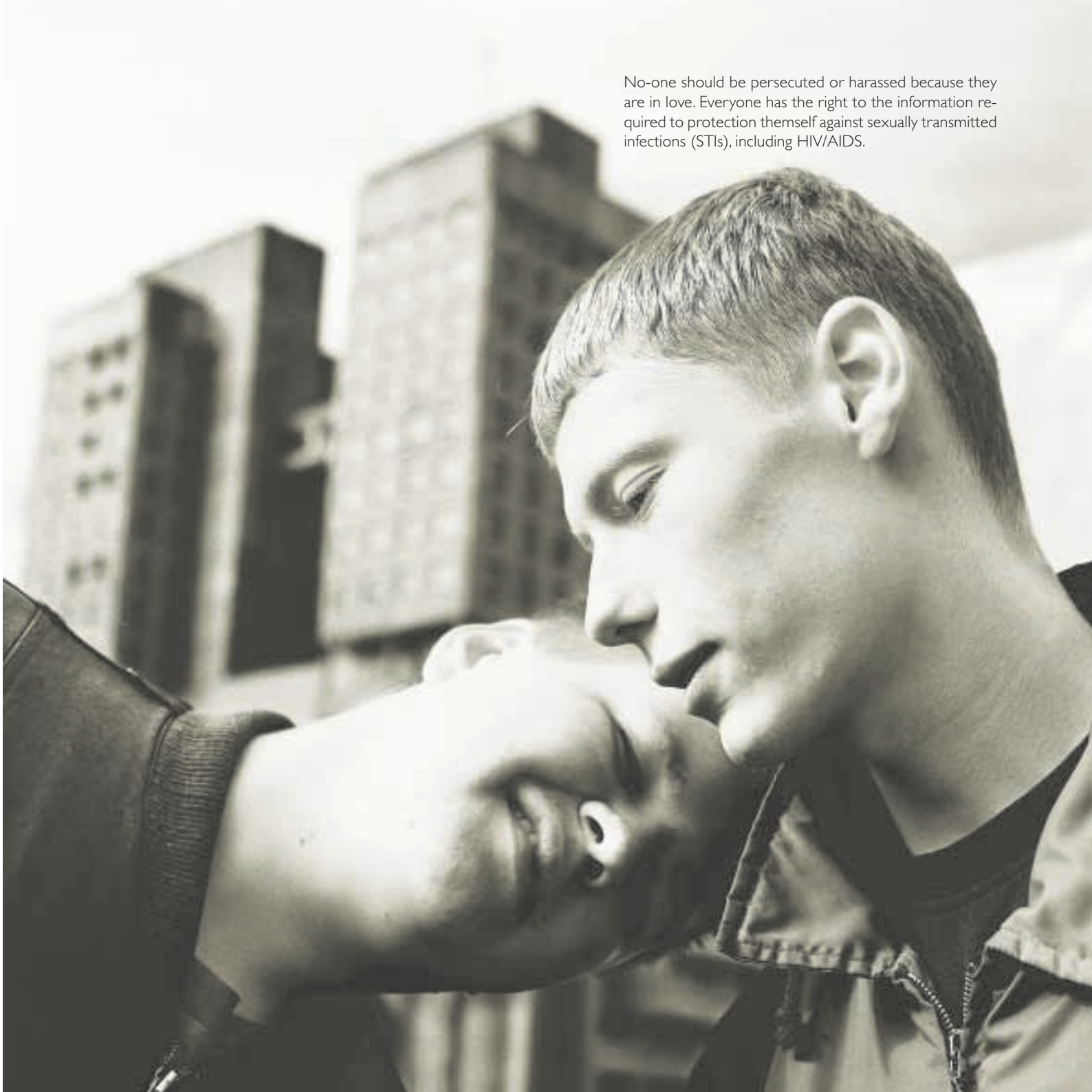
- *ICPD PoA: 7.3, 7. 38, 7.47, 7.2*
- *Millennium Development Goal: 6*

7. Sexual rights apply to everyone

Individuals should have the right to a satisfying and safe sex life as long as they do not harm anyone else. People should have the right to love and have sexual relations with whomever they choose, no matter what sex the other person is. Lesbian, gay, bisexual and transgender (LGBT) persons are persecuted and ridiculed in many countries in the world. A recent Swedish study shows that young LGBT persons in Sweden were living under great psychological stress, resulting in unusually high numbers of suicide attempts. The study also shows that LGBT persons are submitted to violence and stigma due to their sexual orientation.[21] The death penalty is still enforced in a number of countries under Sharia law for those accused of same-sex relations, and there are several reports of the death penalty having been implemented in both Afghanistan and Iran for this reason. Cases of police abuse of LGBT persons have been reported from a number of

20 AGI, *A, B and C in Uganda, 2003.* http://www.guttmacher.org/pubs/exs_abc03.pdf

21 Hanner Hans, *Psykisk hälsa och ohälsa hos ungdomar 16-24 år som attraheras av personer av sitt eget kön (Psychological health and ill-health of youths in the age 16-24 who are attracted to persons of the same sex.)*, Master's disseration, Department of Pychology, Stockholm University, 2002.



No-one should be persecuted or harassed because they are in love. Everyone has the right to the information required to protection themself against sexually transmitted infections (STIs), including HIV/AIDS.

countries all over the world, including India, Turkey, Argentina and Mexico.[22] It has also been reported that it is difficult for homosexuals to be granted asylum on the grounds of being persecuted due to their sexual orientation.

Women and adolescents must also have the right to enjoy their sexuality and to say yes or no to sex. They must have the right to marry whom they want at an appropriate age. Young women must have the right to demand that their male sexual partners use a condom during intercourse. This is often very difficult. If men don't want to wear a condom, girls are often powerless to do anything about it. Women's and men's sexuality is perceived differently. Women who recognise their own sexuality and lust are perceived as "bad women". Men who adopt the same behaviour are regarded as impressive and powerful. This is taken to the extreme in cultures where women accused of infidelity are stoned to death.

- *ICPD PoA: 7.2, 7.34*
- *Beijing Declaration and Platform for Action: 96*

8. Men have a responsibility for women's sexual health

Men's attitudes and their sexual behaviour are key factors in reducing unwanted pregnancies, the spread of STIs and HIV/AIDS, and in promoting the freedom of both men and women to have a satisfying and safe sexual life. Prioritising efforts to change the male gender role is therefore essential. Men should be given the opportunity to re-evaluate their values and actions. A change in male attitudes and behaviour could have a direct and positive impact on the sexual and reproductive health of both women and men.

A project in Zambia has led to boys changing their attitude from thinking it was "cool" to get a girl pregnant to seeing it as distinctly "uncool". Boys must learn about gender roles in order to understand how the life situations of girls and boys differ. If they do not understand this, they will fail as adults to see gender equality as an important goal and, as a result, women's sexual and reproductive lives will suffer.[23]

The current gender roles around the sexuality of women and men, however, are deeply rooted in most communities, making sexual equality difficult. For instance, the perception that girls should be virgins until they marry has supported harmful practices such as female genital mutilation (FGM). It also hinders girls and young women from access to sexuality education and sexual and reproductive health services because they are not considered appropriate. Also, girls who are married off at a young age lack basic knowledge of their bodies and are not yet biologically fully developed. When being forced into sexual activity they have no

22 International Gay and Lesbian Human Rights Commission, *Sexual minorities and the work of the United Nations Special Rapporteur on Torture,* 2001.

23 RFSU, *Young Men as Equal Partners, YMEP*, 2003.

means of protecting themselves and are more vulnerable to unwanted pregnancies and STIs.

Approximately 11.8 million young people aged between 15 and 24 live with HIV/AIDS. Girls/young women make up 62 per cent of this number.[24] The fact that older men have sex with young girls is a contributing factor. Young girls are attractive since they are assumed not to be HIV-positive. This age difference, coupled with older men often having a superior financial status, reduces the ability of girls to take control of their own sexual life. Girls are also particularly vulnerable to sexual abuse, often by a man in their neighbourhood. Men's attitudes and their sexual behaviour are therefore key factors in enhancing young girls and women's sexual health.

- *ICPD PoA 4.25, 7.28*
- *Millennium Development Goal: 3*

9. Sexual violence must be seen from a gender perspective

Economic and political power in the world lies in the hands of men. This makes women dependent on men, and women are therefore vulnerable to sexual abuse. Women and adolescents must not be forced into sexual activity whether for commercial purposes or in their homes. Women in prostitution, or who are victims of domestic violence, are often more susceptible to STIs, including HIV/AIDS, unwanted pregnancy and unsafe abortion.

Millions of women and young girls are currently being driven to sell their own bodies. A recent study shows that 500,000 Eastern European women may have been forced into commercial sex.[25] Prostitution carries major risks for physical and mental health and can even be life-threatening. The fact that young boys are sexually trafficked does not deflect from existing power structures which both uphold and propagate the superiority of men over women in the world.

Rape and other forms of gender-based violence, including domestic violence are unacceptable and must be forbidden by law. A recent report notes that women are not safe from domestic violence anywhere in the world. In Bangladesh, Colombia, India, Nigeria and Pakistan, every year thousands of women suffer from dowry-related deaths or are disfigured by acid thrown in their face by rejected suitors. In the United Kingdom 40 per cent of all female homicide victims are killed by their intimate partners.[26] Recently, many

24 UNFPA, *State of the World Population*, 2003.

25 UNFPA, *Trafficking in Human Misery.* http://www.unfpa.org/gender/trafficking.htm

26 UNIFEM, *Not a minute more, Ending Violence Against Women*, 2003. http://www.unifem.org/campaigns/november25/index.php

countries have passed laws and policies to prevent and punish trafficking and domestic violence. But many countries do not implement them and women and children are still not safe.

It is not acceptable that women are considered to consent to sex purely because men want it. Women must have the right to make all decisions about their sexuality, and the right to take pleasure from their own sexuality. Efforts to change men's attitudes must be prioritised. Projects with this aim have proven successful in reducing violence against girls.[27]

- *CEDAW, 5(a), 6*
- *CRC: 19,1, 34*
- *ICPD PoA: 4.23 7.35. 7.39*
- *Millennium Development Goal: 3*

10. Preventive measures are economically profitable

Preventive measures for sexual and reproductive health benefit the economy. Instead of ignoring the problems, communities that invest in preventive measures at an early juncture will promote not only growth but also the sexual and reproductive health of the population. Access to safe abortions and prevention of HIV/AIDS will lower the cost of healthcare. In the hardest hit African nations, 30 to 75 per cent of all hospital beds are occupied by AIDS patients. One out of ten infants are estimated to become orphans due to the AIDS pandemic.[28] Women who are healthy and have opportunities to enter paid employment will not only add income to their families but will also increase demand and supply in society at large. Violence against women and children are also a public health problem that costs society a lot of money. Access to reproductive health services is crucial to women's opportunities to support themselves and thereby to socio-economic growth.[29] If contraceptives were available to all the women of today that need but do not have access to them, 1.5 million lives would be saved.[30] (see the section above "*Abortion is a public health issue*")

RFSU and Center for Reproductive Rights

27 RFSU, Young Men as Equal Partners, YMEP, 2003.

28 PAI, Factsheet: Number 14, *How Reproductive Health Services works to reduce poverty,* 2000.

29 UNFPA, *State of the World Population*, 2002.

30 AGI/UNFPA, *Adding it all up*; *The benefits of Investing in sexual and Reproductive Health Care*, 2003. http://www.guttmacher.org/pubs/addingitup.html

Dare to be controversial

On many occasions since the UN's International Conference on Population and Development (ICPD) in Cairo in 1994, conservative forces have attempted to turn the clock back and change what 179 countries agreed upon. Many words and areas are regarded as controversial. What they all have in common is that they deal with giving individuals the right to determine over their own sexuality – regardless of gender or age. Members of the opposition often maintain ▶

that the fundamental values of society will be destroyed if the use of certain concepts is allowed. The values that should be maintained are often described as true and inviolable, and rooted in religious or cultural belonging. But working for people's sexual and reproductive health and rights (SRHR) involves placing the right of the individual above all these norms. Such norms, which are most commonly derived from patriarchal values, were created long ago – at a time when human rights and democracy were the province of men from a particular social class.

The Swedish Association for Sexuality Education (RFSU) has invited a number of writers to take up some of the most charged sexual-political issues of our time. These are matters of the right to abortion, the right to determine over one's own sexual disposition, and giving individuals the right to liberate themselves from repressive religious and cultural traditions. But they are also about young people having the right to sexual counselling and access to services and contraceptives without their parents' consent. Several of the texts are written from a rather privileged Swedish perspective, and go further than what ever was said at the ICPD ten years ago. Then, in several cases, countries affirmed reservations about words like *families, safe motherhood*, and *sexual behaviour/sexual rights*. It was thought that these could refer to an extended concept of the family (specifically one where the partners were of the same sex) or the right to abortion. Several countries also considered that these concepts were not compatible with their religious laws. These concepts are more thoroughly examined in the book *Breaking Through: A Guide to Sexual and Reproductive Health and Rights* (RFSU, 2004).

Abstinence didn't seem realistic

I met a guy of my own age, around 20, briefly in Zambia in the spring of 2002. He lives in a village outside Lusaka with his family and relatives. We talked about the weather, the drought, music, and – after a while – our partners. He had a girlfriend who lived on the other side of Lusaka. When we were discussing relationships, we got into sex and HIV. My new-found friend thought that the only thing he could do was to abstain from sex completely. He thought there was no other alternative, and what's more that abstinence was right. What was right about abstinence for him, I didn't understand; but from his voice it sounded as if it had something to do with his faith. We bade farewell, and on the plane home I made a wish that the rain would come in the winter.

Half a year later, I was back in the village. Little rain had come; there was water in the well, and somebody had fixed it with chlorine. My friend and I went for a walk and resumed our discussion about sex. He was no longer with his former girlfriend, and had a few questions – about sex, and about HIV and condoms. He told me that all this about abstinence didn't seem realistic, and he needed some answers.

I did what I could to explain to him what a condom was, how to use it properly, and shared my experience and gave a few tips. We talked a bit more about HIV, and after a while he told me that three of his four best friends had died of AIDS before they reached the age of 25. He told me that his sister also had HIV. He

thought that the village elder was lying when he said that people who had HIV only came from other villages. But we didn't have enough time to go further before I had to make my way back to Lusaka.

I try to keep in touch with my friend in the village, but it is not easy. The words don't flow easily on paper; a simple question such as "How are things going?" takes on a different dimension. The letters I sent have all disappeared in a poorly functioning postal-sorting system.

There are a billion people in the world aged between 15 and 24 years. We have the right to a sex life that is satisfying, safe, and enjoyable for both parties. We have the same questions about feelings, sex and our bodies. Our sexual and reproductive rights are not, however, respected in many countries, by many parents, and at many clinics. Young people get to hear that they should abstain from sex until they get married. Adults have the distorted idea that providing information about sex and prevention will make all the teenagers of the world promiscuous and irresponsible.

Prejudice of this kind is one of the factors leading to a situation where one out of every two people with HIV is aged between 15 and 24, and that millions of young women become pregnant against their will each year. Many of them die from complications due to abortions that have been poorly carried out in secret or by quack doctors. Governments, teachers and parents around the world ignore the fact that young people have sex for pleasure, even though they are not married. Denying young people sexuality education, contraception, access to health-care services, and the rights to abortion and maternity care are critical to life and devastating in their consequences.

To achieve sustainable development, young people must be regarded as an essential resource, and not as a problem. Our participation at all levels is necessary to achieve the best results. It is also a democratic right. Using young people as informers is good per se, but in itself not enough. Our perspective is also needed in policy design, strategic activities and discussions of priorities, and also for evaluation.

Experience shows that sexuality education and access to contraceptives and health-care services enable young people to take safer and better informed decisions concerning their sexuality. Major campaigns advocating abstinence as the only method undoubtedly lead to the young postponing their sexual debut. But they are left swimming in deep water, without any knowledge of sex or sexuality. This has seriously dangerous consequences when they embark on a sexually active life.

Victor Bernhardtz

Good women are the last ones to eat

I was born into a nomadic tribe in eastern Turkey. We're four siblings in my family. Three girls and then the youngest, a boy. It's no accident that there's four of us. My mother would have continued to give birth until she had a son – a longed-for son. My father didn't want many children. "Two were enough," he said. But mum wanted to show that she was capable of producing a son.

A woman who doesn't give birth to a son is useless, and the man can – if he chooses – take a second wife.

Boys are their parents' pension fund. They are obligated to support their parents during old age. The state won't support its citizens, so people have to depend on their family and community. In order to survive, everyone needs to know their place and always put the good of their family first. Women take care of the children and the home. Men work and have a duty to support the family.

Money also distributes power.

If a family can afford to educate a child, the boys will be given priority. At big dinner parties, men eat together, and the women who cooked eat the leftovers afterwards. When I ask my grandmother why she waits to eat after the men, she says: "That's just the way it is – the way it has always been. Women have to wait for the men to be satisfied. Otherwise they won't consider us to be good women and people will begin to talk."

The community, which is ruled by men, has created traditions and norms limiting women's scope for manoeuvre as well as their legal rights. The housework is done exclusively by women and girls, even though they often work together with the men outside the home. Women have to marry the man offering the family the highest dowry, not the one she wants to share her life with.

The most important and strongest traditions concern the woman's right to decide over her own sexuality. Rituals symbolising the image – dictated by men – of the good and chaste woman are reproduced, and passed onto family life. Examples includes female genital mutilation, forced marriages, having to wear a hijab, arranged marriages, honour killing, child marriages, and laws limiting women's rights to divorce or to inherit.

When there is no safety net for women, they have no other choice but to accept the traditions and rules dictated by the community. The state can be a power, which – through its laws and institutions – gives further support and legitimacy to patriarchal oppression. According to the law in Iran, a woman has the right to divorce her husband if he can't support her and her children, is a drug addict, or is impotent. The man, though, does not need to give a reason. In Lebanon, Syria and several other countries, a less severe punishment is given to a person killing a woman who has dishonoured her family. In Kuwait, women are not allowed to vote, and in Saudi Arabia a woman can't go out without being escorted by a male relative without written permission.

The family and community is also a great source of happiness, love and belonging. But it's when an individual (usually a woman) isn't given the opportunity to follow her or his own desires and dreams that such belonging becomes a curse, and – all too often – a threat to life. Women must be given the same social, economic and legal rights as men. No collective beliefs should take priority over the individual's right to an independent and democratic life.

Dilsa Demirbag-Sten

Every abortion has its story

Ireland, 1982. Angela is young, unemployed, poor, and lives in rented accommodation. A longer relationship has just finished. She has realised she doesn't love this man enough to live with him. A month or so after they

Women are still dying because they are refused the right to abortion. For many, an illegal – and often unsafe – abortion is the only way out. Why should women be prevented from making decisions that concern their bodies, and their very lives?

split up, they have sex again – for old time's sake. Angela gets pregnant.

Although fascinated that her body actually functions, Angela realises she can't look after a child. She arranges a trip to an abortion clinic in London. Her ex-boyfriend is informed and he pays for the trip. No-one else knows where Angela goes that weekend. Angela worries about what might happen; should she die during surgery? How would her mother react if she found out that her daughter had died *and* had had an abortion as well? To be on the safe side, she invents a story that her ex can tell her mum if needed.

Ten years later Angela gets pregnant again. By now she's living together with the love of her life and their two-year old son, Michael. It would have been a good time for another child if it wasn't for the fact that Michael is severely brain damaged. He requires care twenty-four hours a day. The thought of another child, combined with the fear that this child too may be brain damaged, terrifies Angela. She can understand women who risk their lives by trying to terminate their pregnancies with knitting needles or coathangers. At this point, she's desperate enough to consider it herself.

Angela cries and cries. She feels so stupid. She's always used a diaphragm, but this time she'd forgotten to add the spermicidal gel. Another trip to London is arranged, a whole weekend away from her beloved son.

To admit to *one* abortion isn't a problem for Angela. But she'd rather not confess she's had two. Angela finds it difficult to disregard the anti-abortion activists' talk of in-sensitive women who have one abortion after another, even though she knows it's not true.

Angela's story is included in the book *The Irish Journey, Women's Stories of Abortion,* published by the Irish Family Planning Association (IFPA). Every abortion has its story. Mary's story is about her unlawful backstreet abortion twenty years ago. Sinead's is about being pregnant at sixteen, accepting her parents' demands to go to a home in Dublin, have the baby, and put it up for adoption after one week. None of the women in the book thought that they would have an unplanned pregnancy and all are aware of what it means to raise a child. They suffer from the silence – of not being able to speak of the fear of being condemned in their local neighbourhood.

From a Swedish point of view, these stories may sound like something from another age. Abortion has been legal here since 1975. No political party is against the abortion legislation, although there are pronounced anti-abortion groupings in Sweden's Conservative and Christian Democratic parties. But, outside Sweden, abortion isn't a given thing. Support for abortion inside the EU is weak. Swedish politicians have claimed it's a complicated issue. Have we forgotten how important the right to legal abortion is, in both Europe and the rest of the world? Or are we afraid to confront those – like the Pope – who view abortion a threat to world peace?

Irish women can go to England, but women in other parts of the world don't have the same travel opportunity. An estimated 500 women die every day from unsafe abortions. Knitting needles, pens, malaria medication – there are many ways. If these women had access to safe abortion methods, hardly any of them would die.

In an ideal world, all pregnancies would be welcomed, but life isn't that simple. Abortion is an emergency solution, and a necessary one. A right!

Ulrika Lorenzi

Why is it so provocative when two people of the same sex love each other? Here, Swedish politicians demonstrate at the annual "Pride" festival in support of the rights of lesbian, gay, bisexual and transgender persons.

The closet and respect

The final scene in the Swedish youth film "Fucking Åmål" ("Show me Love"). A secondary school. A rural town. The two girls Elin and Agnes have locked themselves into one of the schools crowded toilets. Outside a gang, shouting, banging on the door. Everyone thinks the cool Elin is snogging a boy – "Come on, we want to know who you've got in there!" Nobody suspects that Elin has locked herself in with the school's most commonly bullied girl. And nobody can even begin to consider that Agnes and Elin are in love – with each other. The situation eventually becomes unbearable. And finally Elin makes up her mind.

Everyone holds their breath. On the screen and in the cinema. The door opens.

"Ta-da! Here I am. And this is my new girlfriend. Move out of the way, please. We're about to go for a shag."

Elin's words hit like a fist.

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"Never again." That's what I remember most clearly from all that happened that night. The first time in another man's arms. I was in love, horny – and scared.

The morning after. Three steps at a time. Quickly out onto the street. As if running away from myself – just when I'd found out where I belonged. "Never again," I kept whispering quietly to myself. And continued to whisper. For the whole year ahead.

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To come out of the closet. No wonder it's become a symbol for LGBT people all over the world. Most of us have lived in there. We know the feeling.

And we're everywhere. The closet may take many different shapes. Just like life inside it – and outside. In some parts of the world it's darker and more threatening than in others. When the longing for love and closeness becomes illegal – even carries the death penalty – most people lock the closet from inside. But there are some who stand up against oppression, who won't accept it and, like Elin, open the door. Right now, there are people in prison solely because of their sexual orientation. A great number of countries have laws forbidding or limiting the rights of LGBT persons. No-one knows how many are silently humiliated.

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A lot has been written and said about homosexuality. For, against, when, where, how – and not least, why. The closet issue is about something else. It's about every human's unrestricted right to define who she is and how she wants to live her life. And how many want to live their lives stuck inside a closet?

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"Never again, never again, never again…". I need to remind myself sometimes. Move back in time to that particular feeling. To the years before – and the time after, to refuse to forget the suffocating fear inside the closet. I think of Elin then. She doesn't apologise. Doesn't hide. Doesn't plead for understanding. "Move out of the way, please", she says. Just like that. Don't mean any harm. Have no intention to hurt you. Just don't stand in my way. Don't stop me. Not my life.

Thomas Östlund

What's a real family?

A friend of mine was left by her partner when their son was just two weeks old. "I don't love you any more," he said. Everyone thought he was an idiot – a betrayer. No-one supported him because he had to follow his own feelings, that the most important thing is to be in love. This ideology of love – to which we think we abide – gets very fragile when a child arrives.

What family ideology holds true in the world? UN documents are striking. Sometimes, negotiation battles shine through the text. Formulations expressing different approaches to life stand side by side. The

document gives an on-the-spot picture of the strongest ideologies at the time document was written.

The fifth chapter in the Programme of Action from the Population Conference in Cairo 1994 deals with the family. The first sentence states that the family is the basic unit of society which must be protected and supported. That society should contribute to the stability of the family can be found a little later on. So what is this? Family fundamentalism?

Well, not really! The first sentence in the chapter states that there are different types of families. Society should support a diversity of family types, not least the increasing number of single parents. In addition, emphasis is placed on promoting equal opportunities for the different individuals within the family. The rights of women and children are paid particular attention.

Is it possible to both support family stability and strengthen the position of the individual at the same time? To both protect the family and support the individual? It becomes a question of striking the right balance and that probably is how it must be. If it is not the patriarch who decides, but rather that decisions must be taken democratically, then the voices of the weaker need to be strengthened. This doesn't always have to lead to families splitting up, but sometimes it will happen. And then support is needed for the new family constellations that arise.

There are forces in the world that do not approve of this balancing act. Family fundamentalism seems stronger today than it was ten years ago. The family with a capital F, mother–father–child, must be protected. At follow-up conferences after Cairo, the USA and their allies pressed for the removal of formulations concerned with the diversity of family types.

That is why it is important to emphasise that there are *families*, not just one type of family. Single parents are the largest group, but such formulations can also be used to support homosexual families or constellations where a child is brought up by more than two adults.

Today, the conflict is mainly about preserving the original documents and ensuring they are not rewritten. This is good, but I believe that advocates of a less rigid view also need to formulate this in positive terms. Families are important when it comes to population issues, since it is in families that children grow up. Stability is needed when children are growing up; they need to know there is somebody there for them. But this person does not need to be the biological mother or father. But the reverse side of the coin is that stability can also border on imprisonment – especially for weaker groups in society, such as women and children.

I think that my friend and her partner would have done less harm to each other if they had had a more realistic view of the family and parenthood. They might still have chosen to live apart, but cooperating and sharing custody of their child would probably have worked out better. To demand, like Bush that society should do everything to keep them together would not have been good for them or the child. To end their worries that they might have hurt their child, they would have needed better guidance on what kind of stability a child needs. And, with strong support, separated parents can provide this stability just as well as other family constellations.

Ulrika Lorenzi

Choose your words carefully – why we refer to "reproductive health services"

Some terms are important to safeguard. *Reproductive heath (RH) services* is one such expression. RH services secure both human reproductive and sexual health. The negotiations about words and concepts that have taken place over the previous decade have led to a common acceptance that the concept of "*RH services"* is a more progressive option than the more traditional *"care"* alternative, which has nursing overtones. *Services* put the focus on the right to information, contraception and advice, and cover various ways of controlling fertility – including abortion in countries where it is not against the law. The services concept also covers the prevention of unwanted pregnancies, HIV/AIDS and sexually transmitted infections (STIs), and the right of individuals to control their sexuality and reproduction.

It is still not self-evident that women should be able to plan their childbearing or protect themselves against HIV/AIDS. Many women are forced to hide contraceptive pills from their husbands, and insistence on the use of a condom when intercourse takes place may lead to abuse, maltreatment or rape.

But access to information, advice and care should not be a special privilege. Everyone – irrespective of their gender, age or sexual orientation – has the right to expect to be treated with respect, and that the information given should be free from prejudice.

Hence, *RH services* must focus on the client's questions and wishes. The client must personally choose

between various methods of contraception, and pregnant women must have an opportunity to decide between giving birth to a child or terminating their pregnancy. People must have access to objective information, based on facts, if they are to take the final decision, and they must be respected and supported by *RH* personnel, irrespective of their choice.

For many years, the *family planning* concept provided a model for what is now termed *reproductive health services*. The realisation that family planning also covers young people, single adults and lesbian, gay, bisexual and transgender (LGBT) persons has resulted in extension of this concept. In addition, an integrated and broad approach to prevention and treatment is essential if the HIV/AIDS pandemic is to be beaten.

People who are opposed to sexual and reproductive health and the rights (SRHR) are also against *RH services*. There are many factors at work, but opposition is often based on conservative, religious views. In addition, there is the idea that there is only one kind of family – husband, wife and children – and that young people can be corrupted by sexuality education.

The various methods currently employed by young people looking for treatment entail considerable risks. They tend to solve their problems by taking inappropriate products obtained on the local market. Chloroquine (an anti-malaria medication), for example, is a substance still commonly used by young women who want to terminate their own pregnancy.

Youth Friendly Services (YFS) must be developed to provide a model in which young people feel they are welcome to seek advice and treatment. Priority must be given to ensuring that the staff employed by health clinics as well as traditional midwives and nurses have a positive attitude to young people's problems and queries.

Since men exert power over women and their sexual behaviour, "male-friendly services" also need to be developed. The experience gained by RFSU's Reception Centre for young men indicates that men who visit the Centre take responsibility for their own sexuality and for the well-being of their partner. The RFSU "Young Men as Equal Partners" (YMEP) project in Zambia and Tanzania demonstrates that men who have access to information about sexuality and who are encouraged to think about their male role realise that equality between men and women helps to ensure better relationships and safer sex for everyone concerned.

People who oppose the individual's right to sexual and reproductive health say that *RH services* are merely a euphemism for advice about and the conducting of abortions. In their view, people should live god-fearing lives, and not use condoms or other contraceptives. The rhetoric and rules employed by the Catholic Church and the Bush Administration make it extremely difficult, or quite impossible, for people to protect themselves against both unwanted pregnancies and HIV/AIDS.

All human beings are entitled to be treated with respect, and to have access to information not subject to prejudice, and also to condoms and other contraceptives. *RH services* take human needs seriously – irrespective of gender, age or sexual orientation.

Ann Svensén

When Baby came into the world

Halving the proportion of the world's population who suffer from extreme poverty is the first item on the United Nations' list of Millennium Development Goals. Freedom from poverty also enables individuals to exercise control over their own bodies and sexuality. But this is hardly feasible today for many girls and women in different parts of the world.

Baby was born in Zambia in May 1986, in the midst of yet another drought. She was the fifth child in the family, and no-one thought she would survive, since she was so small and puny. Two of her older brothers had died before the age of three, and two of her younger sisters subsequently died in infancy. But Baby survived.

She learnt a great deal in her life, but she never discovered that the UN's solemn "Millennium Declaration" was about her and her family. In the year 2000, when the world celebrated a new millennium, a summit meeting took place in New York at which national leaders took the historic decision to establish eight quantifiable goals for global development. The first of these goals was to eradicate extreme poverty and hunger by 2015 (see box on page 54). A large proportion of the Millennium Development Goals – maternal mortality, child mortality, gender equality and efforts to combat HIV/AIDS – have direct links with the lives of women like Baby. And there are indirect links with the other goals.

In point of fact, the global poverty trend is positive, but this did not apply to Baby and her family, who found it difficult to find enough food for all their children (Goal 1). Baby's mother had a hard life. She gave birth to her first child soon after her 17th birthday, and then there was one pregnancy after another. She spends several hours a day fetching water and firewood for the family's daily diet of maize porridge, since the trees have been felled in the immediate vicinity. The boys are fed first, then the girls, and finally their mother – if there is anything left (Goals 1, 3 and 7).

Their father works in Kabwe, the nearest town, and he only comes home now and again – sometimes

She is free so far. But many girls have a hard life as a woman in front of them. How many women in Africa are aware of the UN's promises about reduced mortality and the empowerment of women?

bringing a sack of cornmeal with him. His goal is to earn enough to provide schooling for all his children, but he cannot get work every day, due to unemployment, and his pay is poor. As a result, there is never enough money. He drinks, brags and fights in the bar in the village when he is at home. Baby is relieved when he returns to Kabwe, although her mother assures her that their lives in the village would be a great deal worse if they did not have male protection – even at a distance. Women with children who have no male support are more exposed to violence and theft (Goal 3).

Something starts to happen to Baby's mother. She

gradually becomes weaker, and no-one understands why. Well, actually many people do understand, but they prefer not to talk about such matters. When Baby's father return to his village, he talks about all the women he had had. "That's what men are like," Baby's mother says apologetically if anyone raises the subject. "And this time he brought two sacks of flour with him, so it's only fair that he should do what he likes …"

Baby's mother knows about condoms – that they can provide protection against additional pregnancies and other dangers – but she is not really sure. The nuns say there are small holes in the rubber, and Baby's father will not hear of them. He regards condoms as an insult and an accusation, and this gives him a reason for getting into a fight before returning to other pleasures (Goals 3 and 6).

Somebody has to take over family responsibilities when Baby's mother becomes too sick to fetch water and firewood any more. And so Baby – who has attended school for several terms and learnt to read (What's

The Millennium Development Goals that were adopted by the world's leaders in 2000 are scheduled to be achieved at the latest by 2015.

Goal 1: Eradicate extreme poverty and hunger. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day, and the proportion of people who suffer from hunger.

Goal 2: Achieve universal primary education. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Goal 3: Promote gender equality and empower women. Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.

Goal 4: Reduce child mortality. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

Goal 5: Improve maternal health. Reduce by three quarters, between 1990 and 2015, the maternal mortality rate.

Goal 6: Combat HIV/AIDS, malaria and other diseases. Have halted by 2015 and begun to reverse the spread of HIV/AIDS. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Goal 7: Ensure environmental sustainability. Integrate the principles of sustainable development into country policies and programmes and reverse the losses of environmental resources. Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation. Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers.

Goal 8: Develop a global partnership for development. Among other aims, develop further an open, rule-based, predictable, non-discriminatory trading and financial system, and provide access to affordable essential drugs in developing countries.

she got to complain about?) – has to leave school to take care of her younger brothers and sisters. School fees, books and uniforms for her older brothers have higher priority and, in addition, the school is too far away to give her time to manage everything (Goal 2).

Baby's father returns to the village, and he is sick too. Although he has heard about some new infection, he doesn't understand what it is. It makes him sad to see that Baby has to leave school. He knows how important education is, but what can he do?

Baby's mother has no strength left when she becomes pregnant again. After giving birth, she develops fever and passes away. The infant, which is the smallest ever seen in the village, dies shortly afterwards (Goals 4 and 5).

After the various funerals, the relatives take over. The children inherit a small plot of land, but an uncle and aunt move in to "help out". Baby becomes an unpaid skivvy and childminder, and receives countless bruises and tugs at her hair. All her brothers and sisters have to leave school because her uncle can only afford to pay for his own children (Goal 2).

By this time, Baby is 11, and she runs away from home.

Her dream is to continue her education, get a good job and be able to look after the younger members of the family. In the big town, Kabwe, she starts working as a housemaid, but has to pack her bags and run away after the man of the house forces himself on her. He is beginning to feel weaker and has heard that sex with a virgin can cure his sickness (Goal 3).

Baby shares a metal shack in one of Kabwe's shanty towns with other orphaned children. Rural poverty is driving a large number of adults and abandoned children into the towns. Baby has stomach pains. It is hard to find drinking water in a slum area, and there are no proper toilets (Goal 7).

Baby is always hungry. Suddenly she sees an opportunity. One of the other girls knows how she can make money fast. "The buses stop at the local bus terminal for a few hours a time. The drivers pay well, it's all very quick and it doesn't even hurt," her friend says. "And the younger the girl, the better the pay. There are even girls who get their entire education paid for by their sugar daddies," she claims enthusiastically. "They sit on the benches at the bus station in their school uniforms, doing their homework while they wait."

But Baby never manages to get her school uniform.

If she had known her date of birth, she would have realised that her abortion – on a filthy bunk under a naked fly-smeared light bulb – was taking place on her 13th birthday. The next day, in May 1999, she bleeds to death (Goal 5).

Six months later, the world leaders sign the Millennium Declaration.

Karin Alfredsson

The Millenium Goals – hard to achieve

The grand Millennium Declaration – framed in a similar manner to all UN programmes and plans – does not mention sexuality and reproduction. But a deliberate focus on population issues is essential if the goals are to be achieved.

"People must be able to influence their lives, and fertility is a key component in this context," says Christina

Larsson, who is in charge of sexual and reproductive health issues at the Swedish International Development Cooperation Agency (Sida).

"Sweden has upgraded this issue and has made it one of its four high-priority goals for development co-operation" Christina Larsson adds. (The other goals are measures to deal with HIV/AIDS, narcotics, and conflict management.)

"Sweden is one of the few countries that can promote issues like birth control and safe abortion without getting involved in internal, domestic conflicts. That gives us special responsibilities."

How is fulfilment of the Millennium Development Goals working out? "So-so", according to the UNDP's Human Development Report for 2003 (from which the following figures are extracted). The Poverty Goal (Goal 1) is the only objective which looks as if it might be met by 2015. The major advances are being made in countries like China and India, while median incomes in countries like Zambia have fallen back. Sub-Saharan Africa will not achieve the objective of halving poverty until 2147 if the present trend continues. Women in rural areas have become poorer. They often have no land-ownership rights.

In the case of Millennium Development Goals involving health (Goals 4–6), very little progress is being made for women, the rural population, ethnic minorities and other groups of poor people. The rate of progress is so slow that the objectives will not be achieved until 2165 – 150 years after the specified date.

Women are the main care-providers in virtually all societies. An educated woman means more for child health than an educated man.

But boys are allowed to continue longer in school than girls, and this is particularly clear in southern Asia and southern Africa. Experience indicates that more girls continue in education if the school is close to home, does not involve any additional costs for the parents, has flexible teaching hours and has women teachers – both as role models and to ensure the safety of female pupils. Otherwise, the girls have to stay at home, do household work and look after their younger brothers and sisters (Goal 2).

Educated women have fewer and healthier children. The infant-mortality objective is currently the least likely to be achieved (Goal 4).

Better educated and healthier women also lead to higher productivity. In addition, women who exert their influence – both individually and collectively – can establish a basis for rapid development (Goal 3).

More than 500,000 women a year – one a minute, every day – die as a result of pregnancy or childbirth. The risk is 100 times greater in sub-Saharan Africa than in high-income countries. On a worldwide basis, unsafe abortions account for 13 per cent of all maternal mortality, but there are considerable differences at national level. Unsafe abortions are the most common cause of death among young women in Brazil (Goal 5).

One of the problems with the health objectives is that simple solutions such as sexuality education, access to contraception and safe abortions are not permitted in many countries. The right of human beings to control their own bodies and sexuality is a controversial question – at least in the cases of young people and women. It is assumed that maternal mortality would be reduced by as much as a third if contraception was universally available, and if women themselves could decide how many children they were going to have, and when.

During the 1990s, more children died from diarrhoea than in all the armed conflicts that have occurred since the Second World War – due, for example, to lack of clean drinking water (Goal 7).

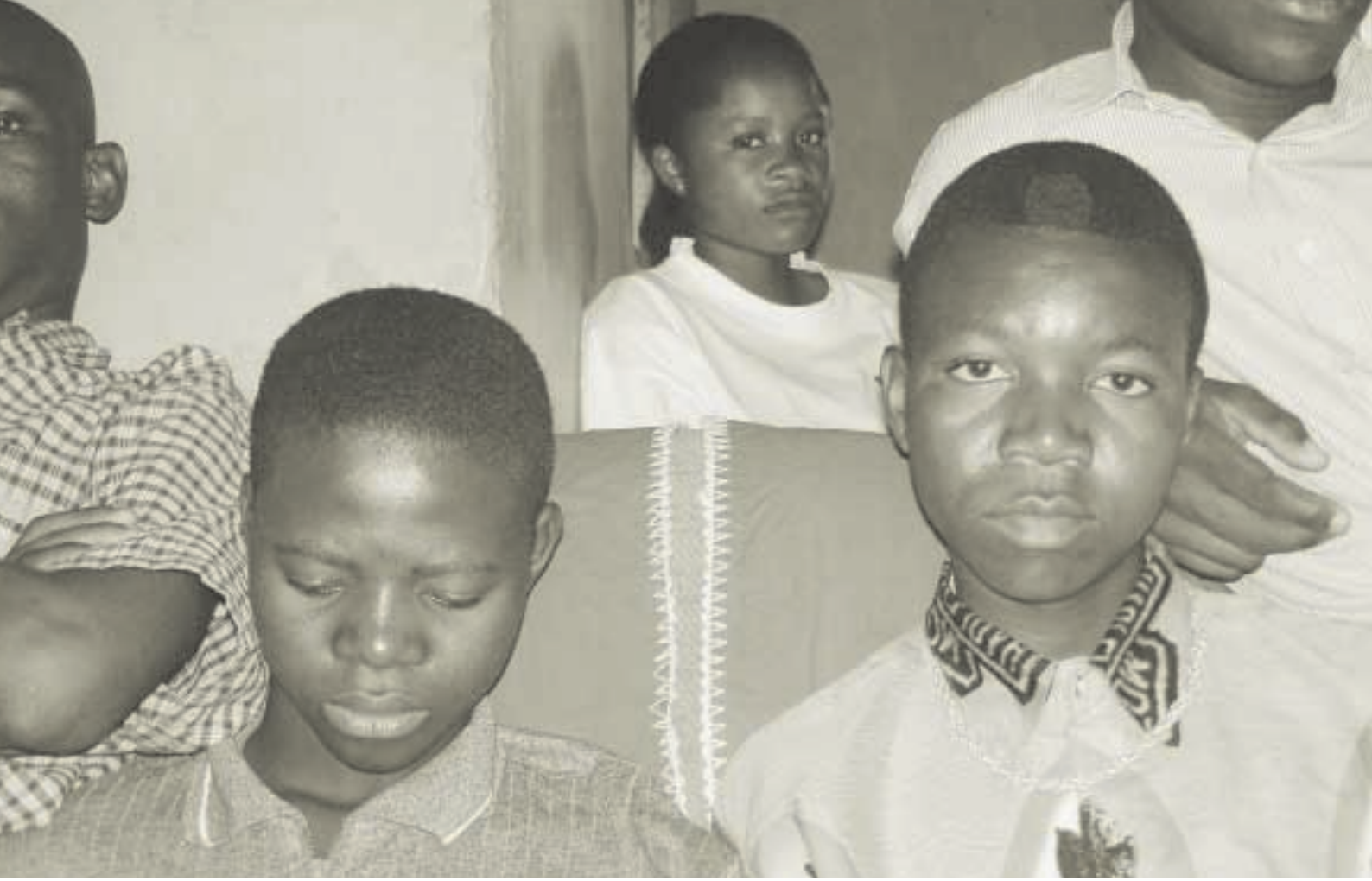
An increasing number of women are afflicted with HIV. More than half the new cases are in the age range 15–24, and 80 per cent of them are girls. One reason is that girls are infected more easily in sexual intercourse, and also that they are more likely to be the victims of sexual attack. In late 2002, more women were infected than men, and the proportion of women is expected to increase.

Poor women are particularly vulnerable to HIV, since they are undernourished, have poor education, and are not in a position to insist on safe sex. If they are infected, they apply for medical care later than men – due to their family responsibilities and the cost (Goal 6).

There are some examples of successful initiatives to counteract HIV/AIDS. In Thailand, it was discovered in 1989 that 44 per cent of the prostitutes in Chiang Mai were HIV positive. This figure was reduced to less than 10 per cent by 2001 – as a result of greater openness, and propaganda *in favour* of condoms and *against* the commercial-sex industry (Goal 6).

At an African research conference held in Tunis in December 2003, development experts urged African leaders to focus on population programmes. The Director-General of the UNFPA, Thoraya Ahmed Obaid, says that "We can learn from the countries that have invested in reproductive health and family planning in Asia and Latin America. Economic growth has improved and efforts to eradicate poverty have been successful. Investments in population programmes are crucial if we are to succeed in achieving the Millennium Development Goals".

Karin Alfredsson



There is a lack of contraceptives. There is a lack of medical equipment for safe abortions. There is a lack of money for all of this. What happened to the promises?

Where did the condoms go?

Total development aid for materials used in efforts to improve sexual and reproductive health (SRH) has sunk dramatically. New alarming reports indicate a shortage of, among other things, contraceptives and condoms. There is a great risk that this will lead to even more unwanted pregnancies, abortions and pregnancy-related deaths.

At the UN Conference on Population and Development in Cairo 1994, world leaders united on agreeing to work until 2015 to achieve access for all persons to adequate sexual and reproductive services, including contraceptives. Since then, a number of major successes have been achieved in this area. Experts from all around the world, however, consider that – in a number of countries – there is a shortage of condoms, contraceptives and also medical aids needed for child birth, maternity care, carrying out safe abortions, tests for sexually transmitted infections (STIs), and also various medicines etc.

Uganda is one of the countries which in recent years has experienced shortages of condoms,[1] and generally there is a major shortage of condoms in the whole of southern Africa. Studies indicate that there are less than 5 condoms per adult male per year in the whole of Africa, south of the Sahara.[2] This shortage is very serious, not least in relation to the HIV/AIDS epidemic. It turns out to be the case that increasing numbers are demanding condoms, but supplies are insufficient.

Reports on shortages of condoms also come from Asia. At a WHO meeting in the capital of Laos, Vientiane, it was stated recently that the use of condoms is still relatively low in the region. Despite this, around 15 billion more condoms are needed in South East Asia to meet this need.[3] Laos is also one of the countries in the region, which – in recent years – has experienced

1 See the homepage of Supply Initiative: www.rhsupplies.org

2 James D Shelton & Beverly Johnston, *Condom Gap in Africa: evidence from donor agencies and key informants*, 2001.

3 Dagens Nyheter, 19 August 2003.

shortages of not only condoms, but also contraceptive pills and intrauterine devices (coils).[4] And in January 2004, reports came in on shortages of contraceptive pills in Burma.[5]

In recent years there has also been talk of shortages of medical aids used for abortions, and for post-abortion care.[6] For example, access to medical abortions is very limited in many African countries.[7] RFSU has also been in discussion with sources concerned over the shortages of materials for carrying out Manual Vacuum Aspiration, a safe and relatively cheap abortion method.[8]

The shortages of medical aids for safe abortions is also very serious. Estimates indicate that on an annual basis around 20 million unsafe abortions are carried out throughout the world; of these, many result in severe complications and fatalities. One fourth are carried out on young women aged 15-19 years.[9] In Kenya alone, around 20,000 women are admitted to hospitals each year after complications arising from unsafe abortions.[10] Figures show that approximately one third of all mothers who die at an early age do so as a result of an unsafe abortion. [11]

Causes of a future shortage of these medical aids are many. According to the UN Population Fund (UNFPA), the intense advocacy of sexual and reproductive rights has led to increasing numbers of people asking for contraceptives and other sexual and reproductive services. At the same time, the number of people at a sexually active age is increasing each year, which increases demand still further.

But this is not how it has always been. One of the main causes of the shortage is that the positive effects of increased demand, and use of contraceptives and services, has –unfortunately – not led to increases in the donation of aid. Aggregate development assistance since 1996 for medical aids used in the efforts to improve sexual and reproductive health and rights has either remained at the same level or decreased. Between 1992 and 1996, aid covered 41 per cent of the total cost of all SRH materials needed in the Third World. This proportion has now sunk to below 25 per cent. Yet another reason for the existing shortage is that many developing countries do not have the capacity to handle increasing demand.[12] This is why it is important to assist countries to build up a functioning system of imports or production facilities, quality control

4 UNFPA, *Reproductive Health Essentials - Securing the supply*, New York, 2002.
5 Mary Stopes International, News release: *Contraceptive Pill Crisis in Myanmar*, January 2004.
6 Interim Working Group Infopack , *Meeting the Challenge*, 2001.
7 Ipas, *Medical Abortions - Implications for Africa*, Ipas, 2003.
8 Ipas, *Preliminary Estimates of the Need for Manual Vacuum Aspiration (MVA), A briefing note from Ipas*, 2002.
9 UNFPA, *State of the World Population,* 2003.
10 PAI et al. Info Pack – *Action Denied, The global Gag Rule and Maternal Deaths due to Unsafe Abortion.*
11 PAI et al. Info Pack – *Action Denied, Country in Focus: Kenya.*
12 UNFPA, *Reproductive Health Essentials – Securing the supply*, New York, 2002.

It pays to invest in prevention. The largest generation of young people in history is in the process of growing up, many of them lacking basic knowledge about their bodies. In the hardest-hit countries, one in ten risks being orphaned by HIV.

and distribution.[13] The trend towards reductions in aid donations for sexual and reproductive health services is in sharp contrast to the Programme of Action from the Cairo Conference in 1994. It is paradoxical that development towards better sexual and reproductive health is threatened by something as trivial as a shortage of medical materials needed for the work. The risk now is that this can lead to still further unwanted pregnancies, abortions, and HIV positives and fatalities from pregnancy-related causes. According to UNFPA, more money is needed in this area,[14] and it is now high time the world's aid donors treated the shortage of contraceptives seriously, and fulfilled the undertakings given in Cairo.

Olle Wängborg

13 Interim Working Group Infopack – *Meeting the Challenge*, 2001.
14 UNFPA, *Reproductive Health Essentials – Securing the supply*, New York, 2002.

Know-how is dying out

HIV leaves its mark at all levels in a society. Traditional agricultural know-how is dying out, and people are trying their luck in the towns instead. Governments all over the world must focus on strategies that increase people's opportunities to protect themselves against the ravages resulting from the virus by complying with the 1994 Cairo agreement. Women's rights, awareness of their sexuality and access to health-care services are the decisive factors in the battle against HIV/AIDS and the promotion of national development.

HIV affects the development opportunities of entire countries, since most financial resources and energy have to be devoted to caring for people who are dying of AIDS. The pandemic is undermining the progress made in agricultural and rural development over the past 40 years.[1] And, in contrast with other serious diseases, HIV/AIDS infects and kills people who are in their most productive years – in the 15-50 age range. HIV/AIDS is undermining the survival capability of entire societies.

Roughly 14,000 people a day are infected by HIV, almost half of them under the age of 25.[2] The HIV pandemic is a global phenomenon, but sub-Saharan Africa has suffered most. This area accounts for only 10 per cent of the world's population, but this is where 83 per cent of all HIV/AIDS deaths occur.[3] Africa has to live with the outcomes of HIV/AIDS in a more tangible manner than other regions, and this is where it has been possible to study the effects in their clearest form. The experience must be utilised to disseminate information and find ways of stopping similar catastrophic trends in other parts of the world.

1 FAO, *AIDS a threat to rural Africa.* http://www.fao.org/Focus/E/AIDS/AIDS1-e.htm

2 UNAIDS, 2003.

3 FAO, *AIDS a threat to rural Africa.*

The reverses and the major changes in the agricultural sector are particularly marked in areas hit by HIV. More than two-thirds of the population in the 25 countries that are most affected live in rural areas. And agriculture accounts for more than one-third of GDP in the hardest-hit countries.[4] When adults die prematurely, there are serious consequences, in terms of farming alone. Children no longer watch their parents cultivating their land, and the crucial know-how needed to run a farm is no longer automatically passed on. Fields run wild because there are no resources to cultivate them. The reduction in cultivated acreage means a change in the crops grown. Marketable crops are supplanted by crops that will meet the family's immediate food requirements. Unbalanced cultivation, resulting from fewer hands cultivating the land, depletes genetic plant diversity, which is a key factor for the agriculture of the future. Such diversity is essential in order to raise agricultural productivity in line with global population growth, which calls for education, training and research initiatives to develop more nutritious crops that are easy to cultivate.

Rural labour force particularly vulnerable

The rural population is particularly vulnerable to HIV/AIDS since the immediate survival of the family has higher priority than more time-consuming tasks, such as land improvement. AIDS has taken the lives of approximately 7 million agricultural workers since 1985, and it may kill another 16 million by 2020.[5] Women play a key role in the agricultural labour force, but they cannot participate to the same extent if they fall ill, or if an increasing proportion of their time has to be devoted to caring for the sick.

Many ministries of agriculture face major problems in implementing their HIV policies and new agricultural programmes. A study by the Food Agriculture Organisation of the UN (FAO) indicates that 58 per cent of deaths among the Kenyan Ministry of Agriculture's personnel are due to HIV/AIDS. In Malawi, at least 16 per cent of the corresponding ministry's personnel have HIV. Another study indicates that half the working hours of personnel working with agriculture have been lost in sub-Saharan Africa for reasons linked to HIV/AIDS.[6] The result is that the support people need is delayed or totally unavailable. Rural development comes to a standstill or is held up if essential local and regional support for the implementation of forestry and agricultural programmes is not provided.

But the threat to the labour force is not confined to agriculture. HIV/AIDS also has a serious impact on other labour-intensive sectors, such as transportation and mining. When workers – usually men – are away from home, they often have many new sexual partners and unprotected sexual relationships. The result is that HIV is passed on to the women waiting at home who, in their turn, may have other men, frequently with the objective of augmenting the household income. When

4 FAO, *AIDS a threat to rural Africa.*
5 Ibid.
6 Ibid.

production declines, all possible means have to be employed to ensure survival. It is understood that women and girls have to pay the price with their bodies and their sexuality. When a woman's only way of feeding her children and her family is to sell her sexuality, she may often do so.

Access to information, expertise and contraceptives (including condoms) is significantly more restricted in rural areas than in the towns. This also applies to health and medical care. One result is that it is more difficult for people in rural areas to protect themselves.

The lost generation

Children who see their parents fall ill and die a slow death are very seriously affected by this experience, irrespective of whether their families are rich or poor. But, as is always the case, the poorest suffer most. Those who are most vulnerable cannot afford anti-retroviral drugs, pay for nursing services, or get help in the home. The few adults who have the energy to work have less and less time for their children. There is less time to look after family hygiene or to produce and cook food, as the needs of the sick members of the family increase. The children – particularly the girls – often have to leave school to help in the home. [7]

Being forced to drop out of school has far-reaching, long-term consequences, both personally and for society as a whole. The result is that the level of national education will be very low for many years to come. The schools also deteriorate, since teachers die as fast as or even faster than new teachers can be trained. Most of them die from AIDS. According to the Zambian Ministry of Education, Zambia lost 1,300 teachers due to AIDS during the first 10 months of 1998. Fewer than 2,000 new teachers are trained each year.

HIV/AIDS is still surrounded by a wall of silence and the stigmatisation barrier is far from breached. A person who has died of AIDS is often alleged to have died from some other disease. Households that have members who are sick are isolated and are afraid to ask for help, which hits children who are abandoned by adult society particularly severely. Children often have no-one to turn to for help or advice about the situations they encounter in everyday life. This may be a question of how to cook food, how to care for a mother who is suffering from severe diarrhoea and is unable to stand up, or how to help a younger brother or sister who refuses to eat.

Many street children in different parts of the world have a relative whom they are legally entitled to live with, but they are denied both physical and mental care. These children live on the street and sell their bodies to get food. Most of them are girls but some are boys. One consequence, apart from the personal tragedy for the children, is the continued spread of AIDS.

The sexual exploitation of children is accentuated by the myth that HIV can be cured or prevented if an adult man has sexual contacts with very young girls – often children. And young women believe that they can reinforce their immune defences by having sex with an older man.

7 FAO, *AIDS a threat to rural Africa.*

Sexual exploitation and HIV lie in the wake of poverty – the daily struggle for food and dreams of a better life. Many women and girls are financially dependent on so called "sugar daddies" (which really involves sexual exploitation). Sugar daddies may give lifts to school, help with school fees, or pay for a meal in a restaurant in exchange for a sexual encounter.

A vicious circle

Lower productivity and reduced competitiveness make it more difficult to find work and provide fewer spin-off effects at the local level. Increased poverty also makes it harder to prevent HIV, and is a barrier to obtaining access to the medical treatment available. Anti-retroviral drugs for HIV/AIDS has been developed in recent years. Despite the side-effects, most people who receive such medication say that they have a better (and longer) life than they did before. Medicines of this kind have also been administered to women in connection with childbirth. This prevents transmission of HIV to the child in most cases. It also increases the probability of the mother surviving during the early years of her child's life. This, in turn, increases chances for the child to survive.

If satisfactory results are to be achieved, anti-retroviral drugs must be taken in a dosage developed for each individual patient. The various drugs must be taken at different times and in accordance with a prescribed schedule. Many of these medicines have side-effects, such as diarrhoea. Undernourished people have no margins to allow for continuous diarrhoea. This undermines both confidence in the drugs and their effectiveness, but is not to be interpreted as a criticism of the need to make them universally accessible. Poverty and weak infrastructure are the real obstacles to access to medical treatment. Accordingly, the battle for cheap medication, and the waiving of patents on medicines, must be fought in parallel with the struggle against poverty and the consolidation of infrastructure. Drugs cannot reach those who need them until this battle has been won.

Invest in new ideas

The problems involved in fighting the HIV pandemic highlight the importance of prevention. It is also clear that we must always integrate this battle with efforts to combat poverty. Since HIV is primarily sexually transmitted, there is a need for active sexuality education initiatives, and access to condoms and health care services. These, in turn, require comprehensive training measures for many different groups in society. It is essential to create a climate that makes it possible to talk about sexuality. And preventive efforts must be rooted in the local community and integrated into both education and health care services. It is essential to have the support of decision-makers, but endeavours must be based on the participation of the people concerned to ensure that they are not merely passive recipients of the message. There are several successful examples of such interventions, e.g. in Uganda and Thailand. But, if we are to arrive at a message that works, we must accept that young people have sex and, as a result, need advice and support.

New rural needs must also be identified, and methods to meet them developed. This applies, for example, to meeting the requirement for new, less

labour-intensive methods in the agricultural sector, which are nonetheless effective. One example is agro-forestry, in which impoverished and over-exploited land is planted with trees that can bind the soil and provide a return in the form of fruit, fodder and wood. Tree cultivation is less labour-intensive, and it does not require the same continuous attention as many other crops. This method has been employed successfully around Lake Victoria, which has suffered more than most regions in the world from HIV/AIDS.

Increasing access to a healthy diet calls for new ideas in food production and new agricultural initiatives. Research is required to develop more nourishing and more easily cultivated crops. A broad education in nutritional science and more sophisticated dietary-advice training in medical and health care services are also needed. If a genuine change is to occur, it is essential to regard HIV as the structural problem it is, and to take measures in all the areas concerned! This presents politicians and governments with an enormous challenge. One of the fundamental prerequisites for developing global and national strategies in the battle against HIV is political leadership, coalition-formation and cooperation – at both national and international level.

Since religion plays such an important part in many people's lives, religious leaders also have a key role, since they often determine what "morals" mean in a society. The attitude of the Catholic Church is decisive in this context. Representatives of the Church have condemned the use of condoms in various parts of the world. In South Africa, the bishops called condoms "an immoral and misleading weapon in our fight against AIDS" in their Message of Hope in 2001,[8] despite the fact that this is the only effective means of preventing the transmission of HIV.

The Catholic Church is making enormous efforts to care for sufferers, and is apparently providing care facilities for 25 per cent of all AIDS victims throughout the world.[9] This is an extremely valuable task, but it also means that nine million people suffering from HIV/AIDS may be looked after by people who do not want to provide access to condoms or information about them. But there are also people who question the Vatican's attitude to condoms. The French bishops have issued a statement that appears to support this approach. But in the UN, the Vatican continues to refer to the reservations it made in the final documents emanating from the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Women's Conference in Beijing – stating that the Church does not accept condoms as a protection against either HIV or unwanted pregnancy.

The struggle against HIV must be integrated into all areas of development cooperation. Global direct assistance for the battle against HIV must increases to

8 *Message of Hope from the Catholic Bishops to the People of God in South Africa, Botswana and Swaziland*, No 49, 2001. http://www.jctr.org.zm/bulletins/hope.htm

9 Address of Archbishop Javier Lozano Barragan, Head of the Holy See Delegation to the 26th Special Session of the General Assembly, 27 of June 2001. http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20010627_un-aids_en.html

Stop discriminating people living with AIDS! Nomfundo Dubule, a 29-year-old South African who is HIV-positive, seen here demonstrating outside the 13th "International Conference on AIDS and STIs" held in Kenya in 2003. HIV has destroyed entire communities. As the result fewer and fewer people being able to keep production going, knowledge is disappearing and families are coming apart. An estimated 40 million people now have HIV.

at least USD 10 billion a year, as soon as possible.[10] The rich northern hemisphere is responsible for ensuring that anti-retroviral drugs is available to poor people in the South. Such medication must actually be made available, and accompanied by appropriate testing and follow-up.

Government representatives in the North have a great responsibility, but this also applies to their counterparts in the South. Efforts are required to counter the stigmatisation of HIV/AIDS sufferers at community level. The isolation of households with members infected by HIV must cease, and strategies for ways of taking care of sick children and orphans have to be developed. Men and women must be given an opportunity to respect others, and to control their own sexual lives. The 1994 Cairo agreements must be complied with. It is a matter of survival.

Katarina Lindahl

10 UNAIDS, *Meeting the need,* 2003.
http://www.unaids.org/html/pub/publications/fact-sheets03/fs_meeting_need_en_pdf.htm

From words to action – ICPD in reality

Translating words into action is not always easy. In India, they have launched a new TV detective soap to improve equality. In Tanzania, the Swedish Association for Sexuality Education (RFSU) has been working on a project that focuses on men and young people. In the long run, this strategy is designed to promote women's rights and improved sexual and reproductive health.

Rumu Sen-Gupta is putting the final touches to her latest production at the BBC World Service Trust (BBC WST) office in New Delhi. She is in charge of editing the script of India's (maybe the world's) first detective soap opera, which is designed to make young men more skilled and responsible partners. Rumu describes how she tried to interweave gender, sexuality and protection against sexually transmitted infections in an interactive series of TV programmes, working in cooperation with a group of Indian scriptwriters. This kind of programme is classified as "edutainment" – a combination of education and entertainment for strategic mass communications designed to influence people's knowledge and behaviours.

"Men between the ages of 15 and 35 are the most vulnerable group in terms of HIV/AIDS in a sample of five areas in northern India," according to Suruchi Sood at the Johns Hopkins University. She is responsible for the scientific aspects of cooperation between BBC WST, the National Aids Control Organisation (NACO), the Doordarshan public-service TV channel, and several sponsors.

The idea is that the hero, Jasoos Vijay, is to provide a role model for young men. He is a really "good guy", who treats women decently. He very rarely resorts to violence, but he is an expert in taikondo. Edutainment is based on theories about the viewer's identification with role models who set an example, which – it is hoped – will be adopted in real life. A further motive is that dramas of this kind will lead to discussions of sexuality and personal relationships with friends and other members of the family.

According to Marianna Lipponen, "male violence and sexual abuse are global and heavily under-reported

problems. The power factor is often ignored in a sexual and reproductive-health context – as demonstrated, for example, in projects in Latin America funded by the EU." Marianna Lipponen works for the European Commission and one of her responsibilities is for the reproductive health budget. She cites a project in Mexico, which drew public attention to male violence in the home for the first time.

Kissing is banned on Indian TV. But, at the same time, in cities like Mumbai and New Delhi you can zap between 60 channels mostly showing violent action and horror programmes and/or artful writhing and jigging in time with music. Indian and other Asian action films have proved very popular in Eastern Europe and Russia.

"The messages about sexuality put out by the mass media are often a total disaster. It's not just Hollywood and Bollywood," says Adrienne Germain. Adrienne chairs the International Women's Health Coalition. It runs projects all over the world, but has its head office in the United States where it conducts lobbying and other opinion-moulding activities.

But, of course, double moral standards are not restricted to countries in the southern hemisphere or to the east. How can a sexuality, reproduction and health perspective based on individual rights become a global norm? This question was tabled in documentary form in Cairo in 1994, and was further clarified in Beijing in 1995 and at The Hague in 1999.

"The problem with promoting SRHR is more a question of fundamentalism than money," Adrienne Germain continues.

During his term of office as US president, George W. Bush has cut off American funding for the United Nations Population Fund (UNFPA), and for non-governmental organisations (NGOs) suspected of advocating abortion.

"It's election year in the USA, and Bush Senior failed to get re-elected because he didn't have the support of the conservative voters. Bush Junior doesn't intend to make the same mistake. It's a question of exploiting conservative stereotype family images, with two kids and a nice house."

Juggernauts are rumbling along the NH 8 highway between Jaipur and New Delhi. A jumble of small shops, shacks and hotels line the road. It bears little resemblance to the backdrops for Jasoos Vijay. I was curious about Indian viewers' reactions to this TV detective, so I went to Rajahstan, one of the five backward areas selected for the TV project. Literacy among adult women in Rajahstan is one of the lowest in the world – 36 per cent according to the local authorities. They have radios and access to state TV programmes, but not much else. Unemployment is rife, and there are plenty of migrant workers. Prostitution is widespread.

Drivers are out on the roads for 27–28 days a month, according to the American PMI Interlife organisation, which has offices at some of the truck stops. PMI has succeeded in winning some degree of confidence, after many years of information, consultations and the distribution of free condoms – which are used to an increasing extent. But back home in the villages, the women often do not know what a condom is, which means that well-meaning publicity on radio and TV can easily go over their heads. Another factor is, of course, that it is not easy for poor people in India to gain access to professional care and advice. Instead, they often fall into the hands of charlatans.

The violence of men and their sexual abuse are global problems. What messages are these children receiving about power and sexuality?

It is difficult to get a clear picture of what works and does not work when the Cairo and Cairo 5+ Programme of Action (PoA) is put into practice. In June, UNFPA is publishing a summary of what has been accomplished, and the EU is also preparing a status report. But, according to Adrienne Germain, not even the most obvious cost-effective angles, measured simply in terms of "value for money", have been followed up – with the exception of condoms. What are the measures that would yield the greatest dividends – in the forms of improved sexual and reproductive health and rights?

"Helping women on a broad scale calls for improvements in health and medical care, both at the administrative and the local levels. One major advance would be to train midwives who could take over deliveries and perform simple abortions. But this would be bitterly resisted by the doctors, for example in India and Vietnam," claims Adrianne Germain.

One woman a minute is said to die as a result of complications in childbirth. The cure is obviously effective basic health and medical care, education and a judicial system that ensures that human rights are observed. In addition, children and young people must be taken seriously and given satisfactory information and services that will enable them to handle their sexuality and safeguard their health. One way would be to provide sexuality education within the school system. But this is a long way off. Vaccination programmes do not give you the right to your own sexuality and control over your own body.

There is increasing talk of the need to get men involved, but few people have actually succeeded. However, Stefan Laack at RFSU does have experience of working with men and sexuality in a development-cooperation context. At the turn of the millennium, the "Young Men as Equal Partners" project received a grant of USD 1.2 million from the Bill and Melinda Gates Foundation for work in Tanzania and Zambia.

"You can break up traditional patterns if you kill the myths about the demands imposed by the man's role in society. Men provide a successful route to women's empowerment," says Stefan Laack, who has devoted a lot of time to workshops on attitudes concerning matters like the division of labour in the home – in cooperation with the Family Planning Association of Tanzania (UMATI). What it means to be a man varies in accordance with traditional cultural precepts. But the results are the same. Frustrated men work out their aggressions on women (who, in their turn, hit out at the children). In eastern Europe, for example, male alcohol abuse and propensity to violence have increased after the social collapse and unemployment that followed the transition from one social system to another. In Tanzania, alcohol is a major problem, and sexual demands are also considerable:

"In Tanzania, they have the idea that intercourse calls for three ejaculations. 'One game is three rounds'. It may be a bit difficult for a middle-aged man to manage this," says Stefan Laack.

According to the American Population Council research organisation, it is a myth that people don't want to talk about their sexuality. To the contrary, that's exactly what they want to do, since this is such a loaded subject. This was also Stefan Laack's experience, when he found himself working in Tanzania with both the Catholic Church and Muslim imams. In the course of his work, a textbook on sexuality and personal relationships was produced, called the "Y-Map":

"We had a teacher who refused to have anything to do with the book at first, since he felt it was too advanced. This teacher was eventually standing up in a school playground talking about masturbation to 500 young boys in such an absorbing manner that they all cheered!"

Stefan Laack would be happy to see this model transferred to European conditions. "The model would work just as well in northern Sweden or the Stockholm suburbs. In point of fact, it was easier to work in Tanzania. The men there don't have that veneer of political

correctness we have in Sweden," says Stefan Laack.

But back to the greater prudishness of northern India. What results did the Jasoos Vijay edutainment project achieve? This was the TV detective series that tried to get young Indian men to think about their sexuality, their relationships and sexually transmitted infections. Real changes in attitudes may take 15–20 years. So far, the result is that viewers now have a professionally produced detective soap, filmed in Indian environments and with a focus on young men. Masses of PowerPoint slides have been produced. Rumu Sen-Gupta, the script editor, is back in the London theatre, with a little more experience to her credit.

The TV series did not succeed in raising questions about relationships and sexuality as much as had been hoped, although BBC WST's Delhi office has received large numbers of letters and e-mails with questions and ideas about such matters as homosexuality, what is "normal" in a relationship, and how you approach someone you are interested in. These are the kinds of questions that young people are wondering about all over the world. There have also been reactions to topics like venereal diseases and a fear of HIV/AIDS.

But, on the whole, the local community was not prepared for this type of programme. The largest group of viewers turned out to be children. Further, sexuality is not something to be talked about in public in India. The stigmatisation of HIV is massive and heavy. In common with many others, Adrienne Germain of the International Women's Health Coalition considers that it is difficult to demonstrate what the impact of mass communications may be on SRHR. In her view, the best way of disseminating knowledge about sexuality and health is definitely compulsory sexuality education in school.

"Young people are our hope for the future!" she says.

Marie Närlid

Double agenda in the new Europe

The European Commission has promised EUR 300 million annually for sexual and reproductive health and rights from 2000 onwards. This is a promise that has not been fulfilled. And despite the fact that there are action plans for following up the International Conference on Population and Development (ICPD), held in Cairo in 1994, far too little is happening. Bureaucratic inertia is one reason. Another is that several member states in the European Union have elected new governments that do not give priority to issues concerning women's rights.

According to recommendations from the UN, at least four per cent of the budget for development cooperation should go to sexual and reproductive health and rights (SRHR).

But, of all the member states of the European Union (EU), only Luxembourg, Holland, Denmark and Sweden lived up to this minimum recommendation in their bilateral co-operation with developing countries in 2002.[1]

As regards development funds disbursed by the EU, an average of EUR 63.87 million a year was allocated to SRHR over the period 1994-2001.[2] In addition, the European Commission states that if aid from member countries is added to aid from the EU for the period 2000-2001, then the overall amount averages out at EUR 206 million per year. This is actually EUR 100 million less than was originally promised. But the data must probably be taken with a pinch of salt. Not even professional analysts at the Brussels Office of the International Planned Parenthood Federation (IPPF) can successfully identify how much the EU actually puts into SRHR, since the funds are channelled by means of a multi-faceted support system.

1 PAI, *European Union – Population and reproductive health assistance – Overall assessment.* http://www.populationaction.org/resources/publications/fair_share/dac98/european_union.htm
The European network, EuroNGOs, has also mapped out support given for SRHR by all EU member states and associated countries.

2 Source: Communication with civil servant at the European Commission.

However, a rough indication to the question is given by the Commission's annual report on development work in 2002.[3] Of support to former colonies in Africa, the Caribbean and the Pacific (ACP), only 9 per cent of EU investment goes to "health and education" – which includes sexual and reproductive health and rights. The budgetary item "roads" alone swallows 27 per cent of aid to these countries – some of the poorest in the world. If we only consider the countries south of the Sahara, then the figure is 30 per cent.[4] At the same time, it is stated in the Annual Report that not only "human rights" but also "equality between women and men" should permeate all aid.

This is symptomatic of how the EU has put into practice the Programme of Action (PoA) of the ICPD – good in theory, but poor in practice. A generous explanation is that the shortcomings arise because of an unwieldy bureaucracy inherited from the early days of the European Community. Development cooperation is governed through two different directorates, where the former colonies (the ACP countries) are handled as a distinct group, and other countries separately. Further, responsibility for implementation is undertaken by a third party, namely the EuropeAid Cooperation Office. This body, which is responsible for the implementation itself, in turn delegates planning and decision-making to regions and associated countries – which is, of course, good in itself. But neither health nor human rights are issues that tend to be given priority by elites in developing countries.[5] And nor is gender. Women are systematically subordinated to men when it comes to inheritance, opportunities for obtaining financial credit, schooling, and access to food – just to take a few examples. Thus, asserting the fundamental right of women to their own bodies, reproduction and sexuality is social dynamite!

In international contexts, the EU gives clear support to the Cairo agenda. The Commissioner responsible for development and humanitarian aid, Poul Nielsen – former minister for development cooperation from Denmark – receives high praise for his involvement. When the USA and the Bush administration severely cut their grants to the UN Population Fund (UNFPA) from 2001 onwards, the EU scored political points for filling the hole – by providing EUR 32 million to UNFPA. The former Commissioner, Manuel Marin from Spain, is also said to have pursued these issues energetically (despite allegations about

3 European Commission, *Annual Report 2003 on the European Community's Development Policy and the Implementation of External Assistance in 2002.*
http://europe.eu.int/comm/europeaid/reports/com_2003_0527_en.pdf#zoom=100

4 In all fairness, it should be said that the majority of aid for SRHR disbursed by the EU and the Commission goes to Asia; for the period 2002-2004, 43 per cent of support for this region goes to "Education, health, water and sanitation".

5 More information can be found in the World Bank's series of reports "*Voices of the Poor*".

corruption).[6] The same applies to the Council of Europe, and the EU member states and their heads of government, which generally have the approval of the IPPF (with the exceptions of Spain, Portugal, Ireland, and possibly Italy).

Language usage has been updated, and in the legally binding rules for cooperation with developing countries the "rights perspective" is well supported. "The regulation on support for strategies and measures concerning reproductive and sexual health and rights in developing countries,"was adopted by the EU Parliament in 2003, but not without opposition. The price paid was that, in return, the Parliament determined to freeze parts of the planned increase in the aid budget for sexual and reproductive health.

Thus, theory and practice do not match. According to the EuroNGO network, the reliability of the EU's aid statistics concerning sexual and reproductive health has deteriorated. The only way of following investments is to look at outcomes, i.e. what actually has been done, not what was planned to be done. Shifts in political power in the member states – largely from social-democratic to conservative – have started to be reflected in the EU Parliament in the last few years. At the same time, American and Vatican-based ultra-conservative lobbyists are increasingly showing greater interest in the EU. Hard-line "right-to-life" organisations have established offices in Brussels. And, in some former states of eastern Europe, the Church is regarded as a "liberator".

In the European Parliament, a working group, the European Parliament Working Group on Population, Sustainable Development and Reproductive Health (EPWG), and the Women's Committee have resolutely asserted the Cairo agenda. So far, opposition to SRHR has mostly been limited to a small group, to the right of the conservatives. The question is what will happen after the enlargement of the EU. On 1 May 2004 the EU will increase from 15 to 25 member states. The ten new countries from eastern and central Europe have little experience of running their own development cooperation. The most prominent, such as Poland, bring with them deeply conservative Catholic values into the Union. EU parliament elections will be held in June, and new commissioners selected.

Not a right's issue

Hypocrisy or realistic politics? Views differ when it comes to the double standards of the EU. Outwardly, the Union stands for human rights and the implementation of the Cairo agenda. However, on the inside, silence reigns. Sexual and reproductive rights are regarded as a health issue even within the EU – and, as

6 The whole Commission resigned in March 1999 after the EU's Socialist group forced a vote of no-confidence. This happened after severe criticism from the EU's expert group (composed of, among others, the head of Sweden's tax administration, Inga-Britt Ahlenius). Manuel Marin was criticised for having employed relatives and friends, and for having poor control over humanitarian aid to the Mediterranean countries (he was unable to account for an amount of GBP 400 million). Most notorious during the scandal was the French Commissioner, Edith Cresson, who gave her dentist consultancy work for carrying out assignments on AIDS issues.

Why are you ministers so quiet? Within the European Union few demands are imposed on member states that have failed to guarantee sexual and reproductive rights. Romani Prodi and ministers from the ten new member states.

such, actually a non-issue, since the mandate in this area is national. This is in accordance with the principle of subsidiarity – namely that decisions should be taken at the lowest possible administrative level.[7] The only legally binding directive in the area is prohibition of discrimination against pregnant women in the workplace. Otherwise, SRHR is not mentioned – either in the proposal for a new EU Constitution, the adoption of which is planned for later in the year, or in existing statutes for human rights within the EU.

"The issue of SRHR is politically dead. On both sides, there are strong groups that no-one wants to come

7 But this principle is far from clear; see for example www.europarl.eu.int/factsheets/1_2_2_sv.htm

up against," declares Lotta Wendel, from the Department of Law at Umeå University, who has studied the proposals for a new EU constitution from a gender perspective.

"Hypocrisy," thinks Christina Zampas, adviser to the European Council, from the Center for Reproductive Rights, in New York. "If women are not given the opportunity to take full control over their reproductive lives, then gender equality cannot be achieved."

Nevertheless, all the EU states have undertaken to respect human sexual and reproductive rights. The EU countries have been signatories to a number of international legally binding conventions. Among others, the rights to gender equality and health, and also the right to be able to plan one's own family, have been laid down (see also chapter on "*Why reproductive rights are human rights*"). The ICPD document is a morally binding declaration to which the EU member states have signed up. There, the idea that reproductive rights constitute a human right is clearly expressed.

So far, there has been no determined attempt to turn sexual rights into a Community-wide issue. In 2002 the Women's Committee in the EU Parliament, represented by Ms. Van Lancker from Belgium, adopted a broader approach when they obtained acceptance of the report "Health and Rights in Europe and the Accession Countries". This puts forward a number of recommendations concerning safe abortions, the

How EU development assistance is managed

Close to half of the EU's total aid in 2002 went to medium-income countries, above all to countries neighbouring the EU. Support for the new member states has mainly been for trade, infrastructure and security.

Development cooperation comes under two different directorates within the EU – based on whether the recipient countries are former colonies (the ACP) or not.

The implementation of what both directorates decide upon, however, lies under EuropeAid – something that Commissioner Poul Nielson, among others, has criticised:

"I still find it a real error in terms of management and policy responsibility that we have a tension between the upstream policy part and the 'do it' part … but it is better than it used to be."[8]

The money is split up into different so-called "budget lines". The budget line for "reproductive health" covers the period 2003-2006 and amounts to EUR 73.95 million (EUR 13.95m for 2003, EUR 17m for 2004, EUR 20m for 2005, and EUR 23m for 2006).

The Regulation "Poverty-related diseases" (which includes HIV/AIDS) covers EUR 351 million for the period 2003–2006. Other budget lines apply to funds for "NGOs", "Afghanistan", etc.

8 Qu. 183, *The Effectiveness of the reforms of European Development Assistance*, Second Report of Session 2001-02, Volume II, House of Commons International Development Committee.

compilation of statistics, and so on, but is in no way binding. In addition, the EPWG is working on the provision of training and information for representatives of the acceding member states. Non-governmental organisations are expected to pursue similar tasks in collaboration with health organisations in eastern and central Europe, but this is rendered difficult by the fact that the latter are often based on religious faith.

While 85 per cent of the British use modern contraceptives, the corresponding figure for eastern European countries is on average 35 per cent. During the 1960s and 1970s, Swedish women went to Poland for abortions, but today Poland has one of the most restrictive legislative regimes. In neighbouring Lithuania, the need for sexual information for youth is great, not least with regard to sexually transmitted infections, of which HIV/AIDS is naturally the most serious. However, ethnic minorities are regarded as the most vulnerable group. Compulsory sterilisation of Romanies has been reported from Slovakia.

The Netherlands, during its forthcoming presidency of the EU in the latter half of 2004, will take up the issue of sexual rights for women in ethnic minorities. It will be the first time that a presidency has given prominence to sexual rights. Even though the focus is limited to a specific group, it is nevertheless a step on the way towards gender equality, not only as a goal, but also as a shared value – locally, nationally, regionally and globally.

Between 500,000 and 800,000 women in the world die each year due to pregnancy-related disorders. The retiring member of the EU Parliament, Ulla Sandbaek, chair of the EPWG, expresses her concern that enlargement may have the effect of reducing the EU's commitment to the Cairo agenda. But the overriding threat globally is a shortage of money.

"We can also see a risk that SRHR may have to give way to HIV/AIDS – which is very unfortunate, since both areas are so closely connected to each other," says Ulla Sandbaek, who hopes the development and distribution of vaginal condoms for women will start in earnest.

Money and/or HIV/AIDS? In fact, the major obstacle to the EU's work on SRHR is silence. These questions must be given a place in development cooperation, as well as in the Union itself. The EU is often held up as a major player in the efforts to improve sexual and reproductive health and rights. In the final analysis, however, the Union is no stronger than the member states that comprise it.

"The governments of individual member states must pursue these questions and make demands on the EU. Here, Sweden has a good track record," says Marianna Lipponen at the Commission, inter alia responsible for the reproductive health budget. "If governments pay attention to these issues, then we will get more money. We will have to work out good models, which in turn we can place on the desks of the countries concerned."

Thus, the Commission is in fact dependent on political pressure to ensure that funds available benefit SRHR.

Marie Närlid

Power, politics and genital issues

A profile issue for Sweden. This is what the Swedish Government says about sexual and reproductive health and rights. But where are the ministers who express this publicly on the international stage? Ever more seldom does it feature on the media's agenda. How can a priority issue for the Government end up so low down?

Women should have the same fundamental freedoms and rights as men. Rape is punishable even when it takes place behind the walls of the home. The right to free abortion is self-evident – as too is sexuality education in school and access to contraceptives. Most Swedes would agree with this.

But this is not how it has always been. These apparently self-evident truths are the fruits of a century's persistent work, and they have nearly always been initiated by grass-roots enthusiasts beyond the confines of the political establishment. It has only been later on that parliamentarians have taken on board the message, and passed the laws that we take for granted today.

Now, the Swedish Government pats itself on the back when it comes to questions of sexual and reproductive health and rights (SRHR). Sure, we are good! Sweden has come a long way. And just like others in the Government, the Minister for Foreign Affairs, Laila Freivalds, protests that they are important issues for both the government and herself. But the fact that these issues are basically the responsibility of the Minister for Development Cooperation is not regarded as peculiar:

"The problems concerning SRHR and HIV/AIDS are greatest in the poorest countries, and these are handled in the economic and social fora and bodies of the UN," declares Laila Freivalds.

Sweden is also pursuing this issue within the EU – but it seems only in the context of development assistance policy. When Sweden's Ministry for Foreign Affairs and the Ministry for Health and Social Affairs receive a question on how the Government has pursued SRHR within the EU and Europe in general, where a number of countries are in breach of rights, they cannot refer to a single example (despite repeated questioning).

An area supposedly given priority by the Swedish

Government thus appears to be one that is to be pursued only in the poorest countries.

Why is it that such questions are not publicised on a wider scale, and particularly in policy with respect to other EU countries? One reason would appear to be that there is a belief that they are so controversial that they could disrupt important negotiations if they are mentioned at all. Perhaps, there is a fear that the country pursuing what might be called "genital issues" will become losers in the negotiating game, and also gain a highly dubious reputation. Are these issues being downgraded for tactical reasons?

Sweden's former Minister for Development Cooperation, Jan O Karlsson, provides support for this view when responding to the question of how Sweden pursued SRHR during accession negotiations with new members to the EU.

"It may be that insufficient pressure had been exerted on the acceding member states. On the other hand, it would have been very difficult to pursue these issues in such a situation," he says. "We must bear in mind that Sweden has come further than the majority of other countries in these areas. This applies not least to the extremely sensitive issue of abortion."

Taking up such questions might, according to Jan O Karlsson, have deadlocked the negotiations. Instead, the Swedish Government chose to adopt a low profile.

"I believe that psychologically it was politically astute not to raise discussions on issues that were too sensitive at the negotiating phase," he says. "But now that some of the countries have taken the step of joining the EU, we can put pressure on them to live up to human freedoms and rights."

He may well be right. But, surely, membership negotiations offered a golden opportunity! Would the acceding countries have been prepared to make concessions? For them, the dream was to secure much-prized membership of the EU.

It is doubtful whether it will be much easier to impose demands on these countries after they become members. Ireland, for example, has scarcely experienced any pressure from the EU to change its very stringent legislation on abortions. And yet the country has been a member of the EU since the mid-1970s.

Views on how questions about sexual and reproductive health and rights should be handled differ between EU countries, which Jan O Karlsson can also confirm.

"When George W. Bush became President, development aid to UNFPA, among others, was stopped – because of the organisation's views on abortion. Sweden and some like-minded countries succeeded in getting the EU to issue a statement that supported UNFPA and criticised the American administration," he says. "But, in order to achieve this, we had to leave out the abortion issue. Otherwise, we would never have got support from countries such as Portugal, Spain and Ireland."

This reveals the whole problem in a nutshell. A few countries voicing their opposition on any one issue is sufficient for other EU countries diplomatically to refrain from pursuing it. Adopting such a strategy runs the risk that the struggle for women's right to safe abortion will become a lost cause. In the negotiations on membership, Malta and Poland succeeded in incorporating formulations guaranteeing that they could keep their strict abortion laws when they became EU members. But when these countries become members of

the EU in May 2004, the opponents of abortion and the Catholic Church will in all probability increase their influence.

And, as we now know, there is a high probability that sensitive issues such as abortion will not be taken up in important negotiations. As if this were not enough, there are powerful lobbying groups in the corridors of EU power. One is the Vatican, which has its own office in Brussels to safeguard its interests and maintain close contacts with politicians and officials.

"When Margareta Winberg spoke about the Vatican as a key power factor in the EU and important for issues concerning SRHR and women's rights, she was ridiculed by some," says Marie Fredriksson, political secretary to Marianne Eriksson (MEP for the Swedish Left Party). But she was totally right! For those of us working here in Brussels, the Vatican and its influence is simply a reality.

Even the Swedish Prime Minister, Göran Persson, found it difficult to believe her. In an interview with the Swedish mainstream daily newspaper, Svenska Dagbladet, last year, he joked about the fear that the EU would become a superstate with its own army. At the same time, he took the opportunity to dismiss the Vatican as a power factor with regard to family policy.

There is evidently a great need for politicians with values different from those of the Vatican, and who regard it as an important player in issues concerning sexuality, to make their voices heard.

As is so often the case, these issues deal more or less with clear value conflicts, as Anders Mellbourn, Head of the Swedish Institute of International Affairs in Stockholm, emphasises.

"A number of studies show that questions of gender and sexuality are extremely sensitive," he says. "In Europe, there is a clear dividing line on these views, which in all probability can be attributed to the fact that Protestant and Catholic countries have different degrees of secularisation. This has meant that sensitive issues concerning sexuality in many countries have been relegated to the private sphere, outside the bounds of politics."

Marie Fredriksson in Brussels believes that the most important reason for the Swedish Government to adopt such a low profile on these issues in the EU is that it wishes to avoid conflict with other countries.

"The Government is frightened of damaging the reputation it has built up," she says. "There is a fear of conflict, and this was evident in the negotiations for membership."

And if this is the case, it probably relates to oversensitivity on the part of the Swedish Government. At least, this is what Anders Mellbourn believes.

"Sweden has for a long time been closely associated with family planning and similar issues," he says. "That is why I find it difficult to believe that it would be harmful if we took a stronger position on these issues internationally."

Former Ambassador, Lars Olov Edström, agrees with this.

"Way back in the 1960s, Sweden took up the issue of contraception when we were discussing development issues in international contexts," he relates. "We were a pioneer on a controversial issue, but there is no question that we lost influence as a result of this, even though many did react strongly."

It is undoubtedly true that a politician who pursues such issues may be subject to abuse from others.

But this is all part of the job of being a politician. What is more, the turbulence is often temporary. When the former EU Commissioner, Anita Gradin, took up the issue of trafficking in the EU, she was confronted by sniggers, and statements that she was marginalising herself. Today, the situation is quite different. Trafficking is on the agenda, and Anita Gradin is regarded as a pioneer.

Anders Mellbourn emphasises that it is much easier for small countries to choose such issues to promote.

"Small countries, such as Sweden, do not need to assert their position against the major powers, but can instead find issues of their own to pursue," he explains. "As a result of the end of the Cold War, there was scope to pursue various issues in an international context, as opposed to the security items that had totally dominated the agenda earlier. We have already seen this, not least in the work of the UN. Sooner or later, issues concerning sexual and reproductive health and rights should also come to be given greater prominence in the international negotiating arena. The countries that have most obviously pursued these issues are hardly likely to lose any prestige."

"Now, it is time to put 'genital issues' on the mainstream political agenda," says Lisa Pelling, who is on the editorial staff of the Swedish evening newspaper, Aftonbladet. Amnesty points out in a recent report that male violence against women is the greatest safety risk we face in the health arena. Reluctance to bring such issues into the foreign-policy area would be a clear sign of being disconnected from reality.

It must, of course, be admitted that this is attempted from time to time, even though we have not always succeeded in getting the policy formulations we want. Both before and during the Population and Development Conference in Cairo, Swedish delegates raised some of the most controversial issues. Lars Olov Edström, who was present, relates the following.

"We succeeded in getting the majority to accept that the then-prevailing concept of family planning was out of date. Following negotiation, we reached agreement on viewing sexual and reproductive health from a broader perspective. On the abortion issue, however, we had to be content with a formulation different from what we originally wanted. This was also true of our proposal to give prominence to the rights of young people. This was far too controversial, but we still managed to put the question up for discussion."

An important piece of the puzzle in determining the political agenda is, of course, the media. Its role cannot be underestimated. And this is a problem – since many of the issues that fall into the arena of sexual and reproductive health and rights do not obviously fit into the media's reporting "templates".

"In news journalism, there is always a hunt for the dynamics of conflict," explains the TV journalist, Lars Aduktusson. "We have to rush off and report on catastrophes – especially conflicts that might be expected to lead to war. The current focus on international terrorism and the USA means that many issues are neglected in our foreign-affairs reporting.

"But if this is a prioritised area, then I can affirm that its importance has not been successfully confirmed. Nonetheless, political priorities leave their tracks. It may be possible to find a number of statements that the Government has made to this effect, but I haven't seen them."

However, he firmly denies that certain questions

are not covered because they have lower status.

"I don't decide that I have to neglect these issues because they have lower status or because I would be viewed negatively as a journalist if I took them up. But of course, I am part of a much larger operation, and it may be the case that I dismiss some of them unconsciously."

Consciously or unconsciously, issues concerning sexual and reproductive health very seldom feature on our television screens. The media's pursuit of drama also means that what is more complicated is disregarded. It also means that such issues tend to be left off the political agenda. If politicians themselves do not choose to see the importance of pursuing these issues, then extra-parliamentary organisations must continue to beat the drum and emphasise the importance of making progress. Possibly, they must find a way of clarifying their implicit tragic drama. In such cases, the interest of the media may be aroused, and the pressure on the politicians of the world thereby increased.

In domestic terms, Sweden has come quite far, but we cannot rest on our laurels if we do not pursue the issues with the same dedication abroad. If the Government were serious, it would give them greater prominence. And the Minister for Foreign Affairs must give the area political legitimacy by publicly stating that sexual and reproductive rights must be respected throughout the world, and also in the Western world. Then it would be taken seriously.

Sweden's Minister for Development Co-operation, Carin Jämtin, on the Swedish position:

"We must be tactical"

We rarely hear the Swedish Government talking about sexual and reproductive health and rights. Do you really believe that it is giving priority to these issues?

"Yes. These issues are high on the agenda of the Swedish Government, and I take them up in almost all contexts. But I do think that perhaps we haven't taken them up enough in Sweden. In general terms, issues such as these are not particularly controversial in Sweden, and this might explain why interest in them isn't so great. It could be one reason why it is difficult to get media coverage."

Why is it you and not the Minister for Foreign Affairs, Laila Freivalds, who is responsible for SRHR?

"I am often in situations where I meet representatives of developing countries. I also meet development cooperation ministers. Because of this, I have greater opportunities than Laila to influence money issues and views on SRHR related to these countries. She works on the issues in a different way."

SRHR should also be given prominence within the EU. Are you going to try to get the EU to make a united statement of support for what emerged from the Population and Development Conference in Cairo 10 years ago?

"Yes, that's what I will be doing. It is extremely important that we try to adopt a common stance. And, if we don't think this will be good enough, then we will adopt a national position on our own, or together with other countries."

Will it be more difficult for Sweden to make her voice heard on these issues when new countries become members of the EU later in the spring?

"I have thought a lot about this. There are ten new members coming into the EU now, and of these Poland and Malta have a strong Catholic Church. In other countries, women have had a strong position – going back to the time before the Wall fell. I can well imagine that politicians would like to get their votes. Women want to work again and exercise control over their lives as they did before. That's why I'm not completely certain accession will be negative. But, on the other hand, nor am I entirely convinced that the other eight countries are strongly interested in SRHR issues.

Is the Vatican a power factor to be reckoned with in Brussels?

"No. On the other hand, the Catholic Church, and here – of course – the Vatican has great influence, but I don't feel their guiding hand at ministerial meetings. It depends on how much importance we attach to what they say. What is important is that the member states themselves make their own decisions on these issues. And it is national politicians themselves who must tackle them. In the first instance, they are influenced by the Catholic Church at home, not in Brussels.

Recently there was a question raised in the Swedish Parliament about midwives in Portugal who were sentenced to prison for carrying out abortions. Freivalds's response was that the law on abortion is Portugal's own business. What you think of that?

"She couldn't have answered in any other way. In the EU abortion is a national issue, and we have no right to interfere and demand that this should be a right in all countries. The only thing we can do is to take a broad view on human rights and everyone's right to health and to determine over their own lives. It can also be argued that legal abortions cost less than illegal ones. Otherwise, we have no good means of exerting pressure, which I can only regret."

Mona Sahlin, the Minister for gender equality, has clearly stated that access to safe abortion is a human right. What do you think?

"I don't know if you can be as general as that. It's certainly true that it is a human right to be able to live one's life in good health. And if we're talking about safe abortion, then this is connected with health. But I haven't thought about abortion in this way. I have to think a bit more about it.

But isn't SRHR about human rights?

"Yes, but all negotiations involve compromise. We have to "package" it in various ways on different occasions. We have to think about how we take up issues, and be tactical. Abortion, for example, is also a health issue."

The UN recommends that 4 per cent of development aid goes to areas such as sexual and reproductive health and rights. RFSU says 10 per cent. What do you think?

"I don't want to answer that. It is difficult to measure exactly how much is really allocated to which issue. But we will continue to invest in SRHR in development aid programmes, although the most important thing – I believe – is to keep on discussing at policy level. In the long run, it is the countries themselves who must take responsibility for these issues."

Silvia Sjödahl

It used to be cool to make a girl pregnant

Society has changed since RFSU put the focus on men. The number of teenage pregnancies has dropped, and there is less sexual harassment. The same applies to the incidence of physical violence. These days, using a condom is an obvious step, and young people often employ double protection. Teachers have learnt how to talk about sex. Parents are proud of their youngsters, who take their responsibilities more seriously than the older generation did at their age. The efforts of the Swedish Association for Sexuality Education (RFSU) to get men to take responsibility for their sexuality and make them participate in preventive measures seems to be an unprecedented success.

RFSU initiated its "Young Men as Equal Partners" (YMEP) project in Tanzania and Zambia in the year 2000, based on funding from the Bill & Melinda Gates Foundation. In the past, sexuality education was primarily targeted at women, but now RFSU wanted to try a new approach.

"Experience in Sweden teaches us that men want to participate, but many people were sceptical. They said that men were simply not interested. I think that is very unfair –to both men and women. And this view simply consolidates traditional sex roles," says Stefan Laack, Manager of the RFSU's YMEP project.

The aim was to change attitudes to sexuality and responsibility. More than 800 boys were interviewed about their attitudes to sex in a ground-breaking study designed to determine the existing state of affairs.

"These kids said that if they got a girl pregnant, they would feel proud – and so would their parents. But they would never think of marrying a girl who had a child. They would stick to virgins," according to Stefan Laack.

Within three years, attitudes changed completely. Today, young men say that it is not fair to the girl to get her pregnant, and their friends think the same way. Real men don't get girls pregnant before marriage.

These days, the demand for condoms ensures that

Four men are on their way home from work and have decided to go and have a beer. But one of them says no – he's going home to do the dishes. Short plays like this are being put on by the YMEP Theatre Group in Choma, Zambia, often provoking heated discussions. Most of the plays are about gender equality.

clinics have to order new stock on a continuous basis. Men who enter into new relationships get themselves examined first, for safety's sake.

"They used to come only if they had symptoms," comments Stefan Laack.

The clinic in Kikatiti in northern Tanzania has had to extend its opening hours in order to cope with a growing stream of visitors.

The girls feel safer

The project has covered three townships and two rural districts. In all, it is estimated that its message has reached approximately 100,000 people.

The education programme has been launched at different levels. RFSU has trained its PPAZ and UMATI sister organisations in Zambia and Tanzania in ways of working with men. Peer educators have received training, alongside teachers and health care personnel in each location.

"Parents and teachers can see a major change in the behaviours and attitudes of their young people," says Stefan Laack.

Schools note that the number of teenage pregnancies has fallen by half. Teachers consider that they have better contacts with their pupils, and note that the girls are not subjected to harassment to the same extent.

"Both teachers and parents say this is due to courses on gender roles. If something happens today, the girls report it. They know that the teachers are on their side," says Stefan Laack.

In Songea in southern Tanzania, a father was so proud of the fact that his teenage daughter was a peer educator that he had actually helped her to distribute condoms in the evenings – to give her a chance to get some sleep!

"Quite remarkable for a father to allow his daughter to do this, and that he was proud of it," was Stefan Laack's comment.

Condoms in church

The final conference summarised the progress made.

Local leaders have noted considerable benefits in their communities, and they want operations to continue. They consider that crime and drug abuse have declined, for example. Local pub owners have made their premises available for meetings; people have lent their video recorders for education sessions; and, the Lutheran church in Kikatiti now provides information about condoms after the Sunday service.

The Mayor of Kikatiti teases us by saying he wants to receive advance warning of termination of the project to enable him to make his getaway before people get to know about it," says Stefan Laack.

But it is hoped that the project will continue. The PPAZ will probably take over the project in Zambia, and run it with funding from the World Bank. Sponsors are being sought in Tanzania.

"Peer educators row up and move on. I would like to see a serious focus on teachers. They meet a great many children, they have high status, and they are often active over a longer period," says Stefan Laack.

The Swedish International Development Cooperation Agency (Sida) is currently discussing continuation of the projects in Tanzania and Zambia with RFSU, and also their extension to other countries in the region.

Ylva Bergman

Reproductive rights are human rights

Is it a human right to be able to decide over one´s sexuality and reproduction? Christina Zampas, legal advisor at Center for Reproductive Rights in New York explains why.

Ten years after its adoption, the ICPD Programme of Action continues to influence national-level laws and policies on reproductive and sexual health, population, and development and most governments remain committed to the ICPD agenda. Over 90 per cent of countries have adopted laws, policies or programs aimed at achieving these goals and as a result millions of individual and couples worldwide have greater choices in the areas of their sexual and reproductive rights.[1] While the international community has come far in advancing and promoting women's rights, specifically women's reproductive rights, there is still a long way to go in establishing protections and consideration for women's health and for effective recognition that reproductive rights are human rights. Below is a description of the evolution of the international recognition of reproductive rights followed by a description of governmental duties to promote reproductive rights, including a few examples of where governments face challenges or where they fall short in protecting and promoting these rights.

The right to health in early treaties

Reproductive Rights are grounded in some of the oldest recognised human rights, but the explicit recognition of a woman's right to make choices in matters of reproduction can be traced to the late 1960s. In 1968,

1 *Report of the Secretary-General on the review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the International Conference on Population and Development,* Commission on Population and Development, 37th Sess., 31, U.N. Doc. E/CN.9/2004/3 (2004).

participants at the First International Conference on Human Rights in Tehran recognised that "[p]arents have a basic human right to determine freely and responsibly the number and spacing of their children."[2]

This right was reaffirmed at international conferences several times throughout the following two decades. It evolved by 1984 at the International Conference on Population in Mexico City, from a general recognition of parent's right to control the spacing of their children to recognition of the individual right to reproductive self-determination and autonomy. In turn, this recognition led to an acknowledgement that widespread gender inequality must be addressed before women are able to exercise *any* of their rights. Thus, the right had been reformulated to state that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so…"[3]

The right to health, including the right to reproductive health was also enumerated in human rights treaties, beginning with the International Covenant on Social Economic and Cultural Rights (1968). Ratified by 174 countries, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979, provides the strongest legal support for the right to reproductive health and choice of any international human rights treaty. In addition to guaranteeing equality and the freedom to determine family size, CEDAW guarantees non-discrimination in access to health care including information and advice on family planning.[4]

While two major international UN conferences of the early 1990s supported the articulation of the rights to plan one's family, it was not until the 1994 International Conference on Population and Development in Cairo where population and development policies were situated in a human rights framework and where reproductive health was specifically articulated as a human rights, representing a groundbreaking shift in the international community's approach to these issues. The Program of Action thus moved emphasis from policies and programs that coercively control women's fertility to empowering policies that emphasise non-discrimination and non-coercion. It was women's rights activists who discredited fertility reduction policies as threats to fundamental human rights that protect an individual's physical and psychological health and that successfully established gender equity, equality and women's empowerment as fundamental components of population and development strategies.

Since ICPD the international community has expanded its recognition of reproductive rights and reaffirmed its commitment to reproductive rights many

2 *Proclamation of Tehran, Final Act of the International Conference on Human Rights,* Tehran, Iran, Apr. 22-May 13. 1968, ¶ 16, U.N. Doc. A/CONF.32/42 (1968).

3 *Recommendations for the Further Implementation of the World Population Plan of Action, Report of the International Conference on Population,* Mexico City, Mexico, Aug. 6-14, 1984, Ch. 1 ¶ 26, Recommendation 30, U.N. Doc. E/CONF.76/19 (1984).

4 *Convention on the Elimination of All Forms of Discrimination against Women*, adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, arts. 16.1(e), 12.1 and 14.2(b), U.N. Doc. A/34/46 (1979).

times over at different international fora. The Platform for Action issued during the Beijing Conference in 1995 takes the key language from the ICPD Programme of Action one step further by recognising women's rights to control their own sexuality and sexual relations on an equal basis with men. The Rome Statute of the International Criminal Court has created a permanent International Criminal Court to investigate and punish genocide, crimes against humanity and war crimes and reflects the international community's growing recognition that reproductive rights are protected human rights. The treaty recognises that rape and other forms of sexual violence are among the most serious crimes under international humanitarian law.[5] (FNS)

Governmental duties and challenges

The rights to life and health place a duty on governments to ensure the availability of comprehensive reproductive health services and to remove existing legal barriers to reproductive health care. In guaranteeing the right to life and the right to health, governments have a duty to adopt measures aimed at preserving life and thus, provide services that are available, accessible, attainable, and of high quality. Many women around the globe, however, still do not have access to comprehensive reproductive healthcare leaving them vulnerable to death or injury during childbirth, unwanted pregnancy and HIV/AIDS and other sexually transmitted infections (STIs). Take, for example, the hundreds of women in Mali who die each year during childbirth due to lack of emergency obstetric care or the young Polish woman who dies after having an unsafe abortion because it is illegal and unavailable in safe setting.

The right to plan one's family and to freedom from interference in reproductive decision-making is rooted in the broader principle of the right physical integrity or bodily autonomy. The right to plan one's family gives rise to a governmental duty to ensure that men and women have equal access to a full range of contraceptive choices and reproductive health services and that they have information about sexual and reproductive health. The right to physical integrity protects women from unwanted invasion or intrusion of their bodies and other non-consensual restrictions on women's physical autonomy. While more women have access to modern contraceptives than ever before and while the trend since 1994 has been toward recognising a woman's right to choose abortion through liberalisation of

5 *Programme of Action of the International Conference on Population and Development,* Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13 (1994); *Beijing Declaration and the Platform for Action, Foruth World Conference on Women,* Beijing, China, Sept. 4-15, 1995, U.N. Doc. A/CONF.177/20 (1995); *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*, U.N. GAOR, 21st Special Sess., New York, United States, June 30-July 2, 1999, U.N. Doc. A/S-21/5/Add.1 (1999); *Further actions and initiatives to implement the Beijing Declaration and the Platform for Action*, U.N. GAOR, 23rd Special Sess., Ne York, United States, June 5-9, 2000, U.N. Doc. A/Res/S-23 (2000); Rome Statute of the International Criminal Court, adopted July 7, 1998, arts. 7.1(g) and 8(2)(b)(xxii) UN Doc.A/CONF.183/9 (1998) *reprinted in* 37 I.L.M. 1002 (*entered into force* July 1, 2002).

abortion laws, women face many forms of coercion and violence that impinge on their right to reproductive self-determination. Take, for example, the Romani woman in Slovakia who discovers years after giving birth to a child by Caesarean section that she was also forcibly sterilised during the procedure or the recent law that was passed in the United States banning a medically sound abortion procedure or laws and regulations passed in 2001 in the capital of China's Sichuan province making it a crime to marry anyone living with HIV/AIDS and suggesting that pregnant HIV-positive women should be persuaded to have abortions.

Despite these setbacks, the international community has come a long way in the recognition of reproductive rights. In addition, governments have expanded efforts to improve women's reproductive health and promote their rights. However, much work still lies ahead to ensure women's full enjoyment of their sexual and reproductive rights and to shape a future where reproductive rights are recognised worldwide as human rights.

Christina Zampas
Center for Reproductive Rights

Key facts on…

Maternal mortality

Up to a third of the deaths, injuries and infections that occur in connection with childbirth could have been avoided if women had better access to methods of preventing pregnancy.[1]

- 1,400 women die every day
- 529,000 women die every year

Causes of maternal mortality:

- Unsafe abortions – 14 per cent
- Severe bleeding – 21 per cent
- Infections – 8 per cent
- Eclampsia – 13 per cent
- Obstructed labour – 8 per cent
- Other direct causes – 11 per cent
- Indirect causes (anaemia, malaria, cardiac diseases) – 24 per cent.[2]

The risk of death due to complications during pregnancy and delivery is twice as high for girls aged 15-19 as for women over the age of 19. At the same time, more than 50 countries allow girls under the age of 16 to marry. In seven countries, the age limit is 12.

In addition to women covered by maternal mortality statistics, a further 50 million have serious complications, and 15 million incur long-term disabilities or illnesses.[3]

Unsafe abortions

- 20 million unsafe abortions are performed every year.[4]
- 78,000 women die each year as a result of unsafe abortion.[5]
- 15,000 women become seriously disabled each year as a result of unsafe abortion.[6]
- In some low and medium-income countries, 50 per cent of the hospital budget is spent on complications resulting from unsafe abortions.[7]
- In India, 4 million women die every year as a result of unsafe abortion.[8]

1 UNFPA, *Reproductive Health Essentials: Securing the Supply*, New York, 2002.

2 UNFPA, *Fast Facts on Maternal Mortality and Morbidity.* http://www.unfpa.org/rh/mothers/facts.htm

3 Mirsky Judith, *New Approaches to Safe Motherhood*, PANOS, 2001. http://panos.org.uk/PDF/reports/BirthRightsSafeMotherhood.pdf

4 WHO, *Unsafe abortion: Global and regional estimates of incidence of mortality due to unsafe abortion with a listing of available country data 1995-2000 (3rd ed.).* http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html

5 Ibid.

6 Mirsky Judith, *New Approaches to Safe Motherhood*, PANOS, 2001.

7 WHO, *Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data 1995–2000 (3rd ed.).*

8 Push Journal, 15 March 2004.

The link between unsafe abortion and maternal mortality must be made clearer. For example, in some parts of Kenya, 50 per cent of maternal mortality is due to unsafe abortions,[9] and the corresponding figure in Latin America is 21 per cent.[10] The figure for Bolivia is 25-30 per cent.[11]

Condoms

UNFPA estimates that approximately 1 billion condoms were used in developing countries in the year 2000.[12] UNFPA also estimates that 9 billion condoms would have been needed in 2002 to prevent the spread of HIV and other STIs.[13]

Sexuality education

A recently published study indicates that 44 countries out of 107 have no AIDS education in their school curriculum.[14]

Contraceptives

In the mid-1960s, 10 per cent of all couples in developing countries used contraceptives. The current figure is 60 per cent. Nonetheless, 350 million couples in various parts of the world still do not have access to modern contraceptives.[15]

Fistula

50,000-100,000 women suffer from fistula each year. Young girls going through obstructed labour, are the ones who are most likely to contract fistula. A delivery may take five days or more if a Caesarean operation is not a feasible option. The woman's tissues are damaged to such an extent that they decay, leaving an opening (a fistula). If the opening is between the vagina and the bladder, there is a risk for incontinence. If, instead, it is located between the vagina and the rectum, it may be difficult to control defecation.

In developing countries, there are 2 million women who suffer from fistula without receiving treatment.

9 Oguttu Monica, Peter Odongo, *Midlevel Providers' Role in Abortion Care, Kenya Country Report*, A Paper for the Conferen- ce" Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care" South Africa, 2-6 December 2001.
http://www.ipasihcar.net/expacc/reports/KenyaCR.PDF

10 AGI, *Sharing Responsibility: Women, Society and Abortion Worldwide,* Special report, 1999.
http://www.guttmacher.org/pubs/sharing.pdf

11 UNFPA, *Proposed Projects and Proposals, Bolivia 1998-2002.*
http://www.unfpa.org/latinamerica/bolivia/2bol9802.pdf

12 Based on donor-country production.

13 UNFPA, *Condom Programming for HIV Prevention,* Notes and References 1.
http://www.unfpa.org/hiv/prevention/hivprev6f.htm

14 UNFPA, *State of the World Population*, 2003.
http://www.unfpa.org/swp/2003/pdf/english/swp2003_eng.pdf

15 UNFPA Fact sheet: *Meeting the Demand for Reproductive Health Essentials.*
http://www.unfpa.org/issues/factsheets/essentials_demand.htm

Fistula can be treated surgically with a 90 per cent success rate. The operation costs USD 100–400, but this is too expensive for many women in developing countries.[16]

Sexual violence

Throughout the world, half the women who are murdered are the victims of their current or former husband or partner. Almost one woman in four is likely to be exposed to sexual violence, committed by her partner, at some time in her life. In Britain, 30 per cent of women are subject to violence at the hands of their current or former partner. The corresponding figure is 52 per cent on the West Bank, 21 per cent in Nicaragua, 29 per cent in Canada and 22 per cent in the USA.

700,000 reports of rape or sexual harassment of women are lodged each year in the United States. A study conducted in Peru indicates that 90 per cent of girls in the 12–16 age range who gave birth to children had become pregnant as a result of rape.[17]

Female genital mutilation

Female genital mutilation (FGM) is practised in 25 African countries, and by certain minorities in Asia and immigrant groups in Europe, Australia, Canada and the US.

It is estimated that 130 million women have been subjected to genital mutilation, and it is assumed that a further 2 million are exposed each year.[18]

In 1998, the proportion of mutilations performed varied from 5 per cent of all women in Uganda and the Congo to almost 98 per cent in Somalia and Djibouti.[19]

Dry sex

In accordance with the dry sex tradition, women dry their vaginas prior to intercourse by wiping them with for example stones, leaves, powder or toilet paper. This is considered to enhance the sexual act, but it may also damages the mucous tissue and enhence the risc of infections. As a result it increases the risk of attracting HIV. It is difficult to estimate how widespread the practice of dry sex is, but it is practised in South Africa, Senegal, Zaire, Cameroon, Malawi, Zambia, Kenya, Zimbabwe, Saudi Arabia, Haiti and Costa Rica.[20]

HIV/AIDS

- 40 million people all over the world live with HIV/AIDS.
- In 2003, 3 million people died as a result of AIDS. 500,000 of them were children under the age of 15.

16 UNFPA, *Campaign to end fistula.* http://www.unfpa.org/fistula/index.htm

17 UNIFEM, *Not a minute more.* http://www.unifem.org/campaigns/november25/index.php

18 ibid.

19 Panos, *Women's Health, Using human rights to gain reproductive rights*, Panos Briefing No 32, 1998.

20 Kun, Karen E. *Vaginal Drying Agents and HIV Transmission*, publ. in: Family Planning Perspectives, Volume 24, No. 2, June, 1998. http://www.guttmacher.org/pubs/journals/2409398.html

Young people, 15-24, living with HIV/AIDS, by sex. December, 2004.

Region	Proportion of young woman (per cent)	Proportion of young men (per cent)	Total
Sub-Saharan Africa	67	33	8,600,000
North Africa and Middle East	41	59	160,000
East Asia and Oceania	49	51	740,000
Southern Asia	62	38	1,100,000
Central Asia and Eastern Europe	35	65	430,000
Latin America and Caribbean	31	69	560,000
Industrialised countries	33	67	240,000
World	62	38	11,800,000

Source: UNICEF/UNAIDS/WHO. [23]

• 5 million people were afflicted by HIV during 2003, of whom 3–3.4 million were in Africa.[21]
• 95 per cent of all new HIV infections occur in developing countries.
• There are 14,000 new cases every day – 6,000 of them in the age range 15-24.
• In all, 11,800,000 young people between 15-24 have HIV/AIDS, and 62 per cent of them are young women.
• 13 million children under the age of 15 have lost at least one parent as a result of AIDS. In sub-Saharan Africa, it is estimated that there are 25 million orphans as a result of the AIDS pandemic.[22]

Sexual Orientation

Lesbian, gay, bisexual and transgender (LGBT) persons are persecuted and ridiculed in various ways all over the world. For example:
• in India, homosexual acts are prohibited and people are arrested on the street for sodomy.
• in Afghanistan, three men were convicted of sodomy and punished by being crushed with a bulldozer towards a wall. They were then buried alive.
• in Turkey, the police have raided gay clubs, arrested transgender people and shaved their heads.
• in Brazil, activists have documented the murder of 2,000 LGBT persons, both men and women, between 1980 and 2000. The police assisted in many cases.
• there is legislation prohibiting sodomy (i.e. sex between two people of the same sex) in at least 90 countries.[24]

A recent Swedish study indicates that young LGBT persons live under considerable psychological stress, and that this results in a disproportionate number of suicides. This study also reports that LGBT persons are subjected to violence due to their sexual orientation.[25]

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21 UNAIDS, *Epidemic Update*, 2003. http://www.unaids.org/wad/2003/Epiupdate2003_en/Epi03_00_en.htm
22 UNFPA, *State of the World Population*, 2003.
23 Ibid.
24 IGLHRC, *Sexual Minorities and the Work of the United Nations Special Rapporteur on Torture*. A paper submitted by the Gay and Lesbian Human Rights Commission to Sir Nigel Rodley, June 5, 2001.
25 Hanner Hans, *Psykisk hälsa och ohälsa hos ungdomar 16-24 år som attraheras av personer av sitt eget kön,* Master's Dissertation at the Department of Psychology, Stockholm University, 2003.

Abbreviations and acronyms

ACP African, Caribbean and Pacific Group of States
AGI Alan Guttmacher Institute
AIDS Acquired Immune Deficiency Syndrome
CDC Center for Disease Control and Prevention,
CEDAW Convention on the Elimination of All Forms of Discrimination against Women
CERD International Convention on the Elimination of All Forms of Racial Discrimination
CRC Convention on the Rights of the Child
ECLAC Economic Commission for Latin America and the Caribbean
EPWG European Parliament Working Group on Population, Sustainable Development and Reproductive Health
EU European Union
FAO Food Agriculture Organisation of the United Nations
FGM Female Genital Mutilation
FWCW United Nations' Fourth World Conference on Women
HIV Human Immunodeficiency Virus
ICC International Criminal Court
ICCPR International Covenant on Civil and Political Rights
ICESCR International Covenant on Economic, Social and Cultural Rights
ICPD International Conference on Population and Development
IGLHRC International Gay and Lesbian Human Rights Commission
IFPA Irish Family Planning Association
IPPF International Planned Parenthood Federation
LGBT Lesbian, Gay, Bisexual and Transgender
MDG Millennium Development Goals
MVA Manual Vacuum Aspiration
NACO National Aids Control Organisation
NGO Non-governmental organisation
PAI Population Action International
PoA Programme of Action
PPAZ Planned Parenthood Association in Zambia
PRI Population Research Institute
RH Reproductive Health
RFSU Swedish Association for Sexuality Education
Sida Swedish International Development Cooperation Agency
SRHR Sexual and Reproductive Health and Rights
STI Sexually Transmitted Infection
UDHR Universal Declaration of Human Rights
UMATI Family Planning Association of Tanzania
UMP Union pour un mouvement populaire
UN United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDP United Nations Development Programme
UNFPA United Nations Population Fund
UNIFEM United Nations Development Fund for Women
WHO World Health Organisation
YFS Youth Friendly Services
YMEP Young Men as Equal Partners

PASSION FOR RIGHTS

The coming together of the international community in Cairo in 1994 at the International Conference on Population and Development (ICPD) signalled a radical change in the approach to population issues. Sexual and reproductive health and rights (SRHR) replaced the narrower, demographically oriented perspective. The right of the individual to information and reproductive health services in order to take control of his/her own sexuality was brought into focus, as was the importance of gender equality at all levels of society. Objectives and an action plan to achieve them were adopted by 179 countries in the ICPD Programme of Action (PoA). Five years later, countries met again at a follow-up conference named ICPD+5.

This book is the second in a series of publications presented by the Swedish Association for Sexuality Education (RFSU) in conjunction with the 10th anniversary of the ICPD.

The book consists of a collection of articles about the ICPD and sexual and reproductive health and rights. It mixes reflections and accounts of personal experiences with political analyses of the debate surrounding SRHR. It also discusses the activities of the so-called "Opposition", and of the EU's double agenda in relation to the ICPD, in addition to texts on controversial subjects, the impact of HIV/AIDS on society and much more.

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