FOKUS

KVINNER SAMMEN

Nr. 2 - 2012

Egne valg over egen kropp

Temanummer om kvinners seksuelle og reproduktive rettigheter

■ DAGLIG LEDER HAR ORDET

Rettigheter under angrep – på tide med massiv mobilisering

I Norge ble abort først tillatt i 1964, mens vi ventet helt til 1978 før dagens lovgivning om selvbestemt abort ble vedtatt. Mange kvinner kjempet hardt, sammen med mange menn, for retten til å bestemme over egen kropp og retten til å bestemme selv i spørsmål som er så vanskelige.

34 år senere har vi fremdeles diskusjoner blant enkelte leger om rett til å reservere seg i forhold til å delta ved provosert abort. Etter en endring i ekteskapsloven i 2009, som likestilte heterofile og lesbiske og homofile ektepar, dukket en ny debatt opp. Denne gangen gjaldt det legers mulige rett til å reservere seg mot assistert befruktning til lesbiske. Disse holdningene oppnår ikke stor støtte, og i hvert fall ingen forslag til endring av lovgivning.

Samtidig ser vi, i ly av den globale økonomiske krisen, en utvikling globalt hvor kvinners rett til å ta egne valg gjennom seksuell og reproduktiv helse og rettigheter, er under angrep i mange land. Det har vært mye politisk fokus på at mange land i Latin-Amerika i løpet av det siste 10-året har fått regjeringer som er mer på den politiske venstresiden. Selv om vi skulle tro at dette fikk konsekvenser for kvinners rettigheter, så står den katolske kirke sterkt i store deler av dette kontinentet.

I Nicaragua ble det i 2008 totalforbud mot abort, også der hvor svangerskapet er resultat av voldtekt og incest. Dette er dessverre ikke en unik lovgivning, Chile, El Salvador, Honduras, Nicaragua og den Dominikanske Republikk er i samme gruppe. I regionen Latin-Amerika og de karibiske stater er det kun Cuba som gir mulighet til abort inntil 12 uke i svangerskapet. Fra Brasil fikk vi nylig informasjon om jenta på 9 år som ble voldtatt og utsatt for overgrep over lengre tid fra morens samboer. Hun ble gravid med tvillinger og det måtte foretas abort for å redde livet hennes. Den katolske kirken i Brasil utestengte av den grunn moren hennes og legen som utførte den livreddende handlingen. Mannen som begikk de grove overgrepene gjorde kirken ingenting med.

Under årets møte i FNs Kvinnekommisjon opplevde vi at FNs medlemsland ikke fikk på plass en slutterklæring, såkalte «agreed conclusions», fordi et økende antall medlemsland enten foreslo tekst inn i forslaget som ville ført oss bakover, eller som forsøkte å «vanne ut» allerede vedtatt språk fra tidligere. Vatikanet bruker sin observatørplass i FN effektivt, og allierer seg på kryss og tvers med land hvor de tror de kan oppnå noe støtte. Det gjelder afrikanske land hvor konservative kristne fra vestlige land har drevet evangelisering i løpet av de siste 10-15 årene, land som Iran, Jordan og Egypt, og nå også land innen EU, som Polen, Irland og Malta, som trekker unionen mot høyre i spørsmål om kvinners rettigheter.

I Russland har byen St.Petersburg i mars i år vedtatt en lov som gjør det ulovlig å «spre propaganda i form av offentlige handlinger i favør for homofili og transseksualitet» til barn og ungdom under 18 år. Samme lov er nå foreslått å skulle gjelde for hele Russland. I de baltiske landene, Polen, Kroatia og Ungarn blir Gay Pride markeringer angrepet av en blanding av hooligans og høyreekstreme. I enkelte land i Afrika forsøker konservative kristne misjonærer å påvirke lovgivere til å forby homoseksualitet. Alle disse forsøkene og hendelsene har ført til økt voldsnivå. Såkalt «corrective rape», hvor lesbiske voldtas for å få dem til å «komme på bedre tanker» er så alvorlig at det ble løftet inn i USAs innlegg på styremøte til UN Women i mai i år.

Fra norsk side har regjeringen og FN ambassadør Morten Wetland vært forbilledlig tydelig på at dette er rettigheter man fra norsk side vil fortsette å forsvare. Fra FOKUS side vil vi fortsette å dokumentere, synliggjøre og jobbe sammen med nasjonale og internasjonale partnere for å forsvare.

Gro Lindstad
Daglig leder FOKUS

FORUM FOR KVINNER OG UTVIKLINGSSPØRSMÅL

Kvinner Sammen kommer ut fire ganger i året. Abonnementet er gratis.

Kvinner Sammen tar opp internasjonale miljø- og utviklingsspørsmål i et kvinneperspektiv med prioritering av spørsmål knyttet til kvinners situasjon og rolle i Sør, kvinnerettet bistand og internasjonal solidaritet mellom kvinner. Artikkelforfatter er selv ansvarlig for de synspunkter og meninger som kommer til uttrykk. Kvinner Sammen opererer etter redaktørplakaten.
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ISSN: 0803-8589

Trykket på Svanemerket papir.
Lisensnr. 344.043

Ansvarlig utgiver: FOKUS, 15. årgang
Redaktør: Mette Moberg
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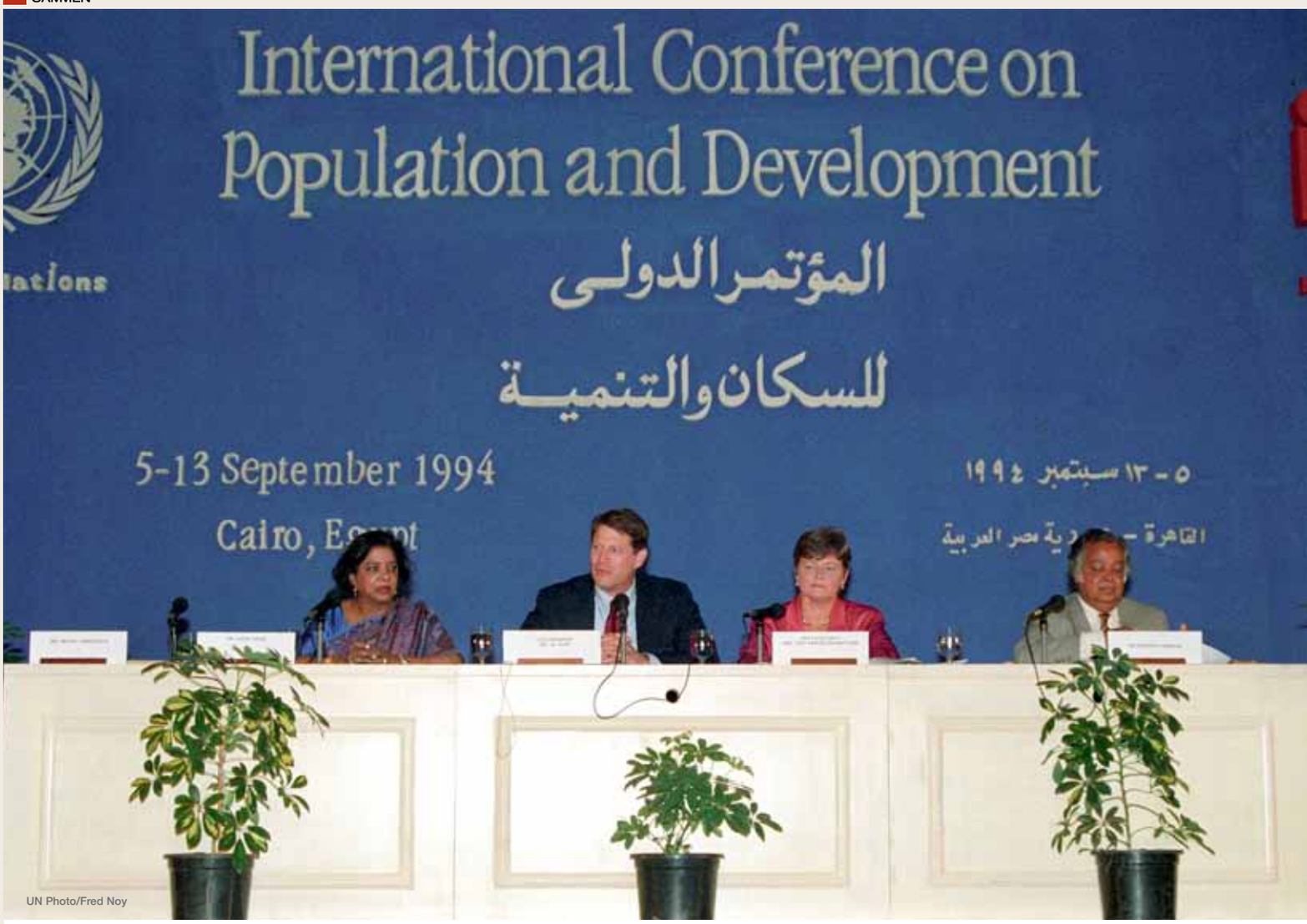
Design og repro: OKTAN
Forsidefoto: UN Photo/Martine Perret
Trykk: Elanders Novum
Opplag: 4.500

FOKUS – Forum for Kvinner og Utviklingsspørsmål er et kompetanse- og ressurssenter i internasjonale kvinnespørsmål. Gjennom bistands- og prosjekt-arbeid skal FOKUS medvirke til å bedre kvinners sosiale, økonomiske og politiske situasjon internasjonalt med hovedvekt på landene i Sør. Gjennom informasjonsvirksomhet skal FOKUS medvirke til økt kunnskap om og forståelse i det norske samfunn for kvinners situasjon og rolle i et utviklingsperspektiv.

INNHOLD



UN Photo/Fred Noy

Reproduktiv helse nesten 20 år etter Kairokonferansen – hva nå?

TEKST: **BERIT AUSTVEG**

« Da Tusenårsmålene ble formulert, var det mange av oss som ble veldig begeistret over at reduksjon av mødredødelighet, altså dødelighet knytte til svangerskap, fødsel og abort, var ett av åtte overordnete mål som verden skulle strekke seg mot. »

PARADIGMESKIFTE I 1994, OG STORE UTFORDRINGER

Den internasjonale konferansen om befolkning og utvikling (ICPD), Kairokonferansen, fant sted i september i 1994. Like før FNs konferanse om bærekraftig utvikling i Rio i1992 ble det blitt innført at de frivillige organisasjonene skulle involveres på en mye mer omfattende måte enn tidligere i forhandlinger om globale handlingsplaner, selv om de ikke deltok på selve forhandlingene. I forkant av Kairokonferansen organiserte kvinneorganisasjoner seg verden over på en måte som viste seg å være meget konstruktiv. De ga gode og samstemte innspill som det i stor grad ble tatt hensyn til og som fikk stor betydning for bestemmelsene som ble tatt. Handlingsprogrammet som ble vedtatt representerte et paradigmeskifte, dvs en dramatisk omlegging i hvordan et problem oppfattes, og dermed hvordan det skal takles. Kortversjonen er at før ICPD var det befolkningskontroll som ble sett på som det aller viktigste, og etterpå var det seksuell og reproduktiv helse som sto i fokus.

Dette er naturligvis en forenkling. Også tidligere har det vært fokus på helseaspekter og på rettigheter, og det har også i tiden etter 1994 vært de som har sagt at det aller viktigste som må gjøres for klodens framtid, er å redusere befolkningsveksten, også om individers rettigheter brytes.

Den endring i oppfatning av hva som var problemet og den retningen for løsninger som ble staket ut, har fått stor betydning på globalt nivå og på landnivå. Men seksualitet, reproduktiv helse og rettigheter knyttet til dette er og blir kontroversielle temaer. De politiske motsetningene, som topper seg når det kommer til abort og ungdomsseksualitet, spilles ut i rikt monn. De underliggende faktorene som er viktige for den reproduktive helsen, som kjønnsroller og likestilling, seksualpolitikk og rett til god seksualopplysning, er i seg selv svært omfattende. Det er krevende med en omlegging av helsetjenester til tjenester som legger an til et livsløpsperspektiv og beskytter individers rett til kvalitet og verdighet når de søker helsehjelp for å sikre god seksuell og reproduktiv helse. Hvis rettighetene skal bli oppfylt, må tjenestene dessuten være tilgjenglige i praksis. Det betyr at alle som trenger dem må ha råd til dem. Særlig for ungdommer og for marginaliserte grupper er betaling en stor utfordring. Reproduktive tjenester må ofte være gratis eller nesten gratis for at de som trenger dem skal få dem, og dette er vanskelig å få gjennomført i helsetjenester som kommersialiseres i økende grad.

Den begeistringen som ICPD medførte var berettiget; det var helt banebrytende avgjørelser på globalt nivå. Mange stats- og regjerningsledere sluttet seg til handlingsprogrammet. Men for å få alt på plass som trengs er det veldig mange beslutninger som skal tas, og på ulike nivåer. De aller fleste land, både industrialiserte og utviklingsland, har desentralisert mye av beslutningsmyndigheten for hvordan helsetjenestene skal drives. Det er altså mange som må trekke sammen for at de gode idealene skal settes ut i livet.

TUSENÅRSMÅLENE: GODE INTENSJONER OG UTILSIKTEDE VIRKNINGER

Da Tusenårsmålene ble formulert, var det mange av oss som ble veldig begeistret over at reduksjon av mødredødelighet, altså dødelighet knytte til svangerskap, fødsel og abort, var ett av åtte overordnete mål som verden skulle strekke seg mot. Ut fra en faglig synsvinkel er dette et gyldig og pålitelig mål for tilgang til hele spekteret av reproduktive helsetjenester og for de underliggende faktorene.

Men det er en tendens til at når noe blir altfor komplekst, kan reaksjonene bli en overforenkling. Slik var det også med det komplekse handlingsprogrammet fra ICPD. Tusenårsmål 5, bedring av mødrehelse, har dessuten vært sentralt i giveres prioritering i utviklingsarbeid; det gjelder også mye av den norske støtten. Og bistand har en tendens til å bli vertikal, altså at det satses på avgrensede intervensjoner, som lett kan måles og helst også der resultater kan tilskrives de pengene som er satt inn. Til sammen har dette ført til at mye av satsingen har vært på isolerte tiltak som har rettet seg mot kvinner som har født. ”Mødrehelse” blir ofte forstått som at det dreier seg om helsen til mødrene, og det kan ha vært politisk opportunt å se bort fra de mer omdiskuterte sidene av reproduktiv helse. Paradoksalt nok har familieplanleggingsarbeid mange steder blitt grovt neglisjert etter ICPD.

UN Photo/Fred Noy

Da det viste seg at Tusenårsmål 5 hadde utilsiktet ført til vertikalisering og til at familieplanlegging kom i bakleksa, ble tusenårsmålet utvidet til også å omfatte tilgang til reproduktiv helse[1]. Det gjenspeiler en erkjennelse av at det trengs langsiktige endringene med integrering av reproduktive helsetjenester i primær- og spesialisthelsetjeneste.


UN Photo/Martine Perret

BEDRING, TROSS ALT!

Når verden ikke har nådd det målet som ble satt på et så viktig område, er det naturlig å se etter årsaker. Men det er viktig også å slå fast at det har skjedd bedring. I følge de siste anslagene ble antallet kvinner som dør av graviditet, abort eller fødsel halvert fra 1990 til 2010 (World Health Organization, 2012). Da tilgang på reproduktiv helse ble føyet til som mål, ble det utviklet indikatorer for å følge med i utviklingen, og to av disse omfatter familieplanlegging (både andel som har tilgang, og de som er utelukket).

HVA ER ALLER VIKTIGST FRAMOVER?

Det produseres masse kunnskap om reproduktiv helse verden over. Noe av utfordringen er å produsere kunnskap som er strategisk og relevant for å få til nødvendige endringer. Ikke alt som er relevant på globalt plan eller i ett land, er til nytte i et annet. Men noen områder peker seg ut på globalt nivå.

Betydningen av sosial rettferdighet

Et område der kunnskapen har økt, gjelder betydningen av sosial rettferdighet. Mens det tidligere har vært snakk om at det er fattigdom som er skadelig for reproduktiv helse, har det nå blitt stadig klarere at den sosiale ulikheten som fins på dette området er betydelig større enn på de fleste andre helseråder. Den mest groteske ulikheten er tilgang til trygg abort, der det nesten utelukkende er de fattige og marginaliserte i et samfunn som løper en betydelig risiko, mens alle som har tilgang til penger kan kjøpe seg en trygg abort, enten lovlig eller ulovlig.

Det store ungdomskullet

Verden har aldri hatt en så stor andel ungdommer som nå, og fordi fruktbarheten er synkende, vil heller ikke i framtiden en så stor del av verdens befolkning være ungdommer. Dette gir store muligheter, men er også en utfordring. De unge skal ha meningsfulle liv, og de trenger hjelp for å håndtere sin seksualitet og gjennomføre valg om hvorvidt og når de vil ha barn. Ungdommer er særlig avhengige av helsetjenester som tar utgangspunkt i faktiske behov og som møter dem på en respektfull måte. Tjenestene må dessuten være gratis eller nesten gratis, fordi ungdommer gjerne har liten disposisjon over penger – særlig i fattige land.

Rettighetsperspektivet

Menneskerettigheter anvendt på seksualitet og reproduksjon er også et viktig aspekt av ICPD. Rettighetene omfatter de underliggende forholdene, tilgang til helsetjenester, og kvaliteten av tjenestene. Det har etter hvert blitt en god del erfaring med å fremme reproduktiv helse ved å bruke menneskerettighetene, særlig for graviditetsrelatert helse. Men rettighetsbaserte tilnærminger er ingen garanti for suksess, og som all annen kraftig virkende "medisin", kan de ha uheldige bivirkninger.

En særlig utfordring er å fremme rettighetene til de seksuelle minoritetene. Selv om homofili er vanlig verden over, og et stort rettighetsproblem, er det et uhyre betent tema i FN-sammenheng. Det har til og med vist seg omtrent umulig å få til en samling om fordømmelse av grov diskriminering mot homofile.

FRAMTIDEN

FNs generalforsamling har bestemt at prinsippene fra ICPD skal stå fast, de skal ikke forhandles på nytt. Men handlingsprogrammets kvantifiserte målsettinger løper ut i 2015, og Tusenårsmålene går også til 2015. Det betyr at verdenssamfunnet snart må bestemme hvordan spørsmålene skal tas videre, og hvis det skal lages nye kvantifiserte målsettinger, hvordan de skal være. En mulighet er å bygge på de tre punktene som er nevnt over: prinsippet om sosial likhet, ta behørig hensyn til det store ungdomskullet, og å bygge videre på rettighetsperspektivet. Kanskje trengs det også mer sammensatte indikatorer enn de vi har hatt til nå, for å unngå at målsettingene utilsiktet fremmer vertikalisering. Det er mye erfaring for å bruke indekser, som reflekterer flere dimensjoner. En kan for eksempel tenke seg indekser som kombinerer reproduktiv helse-utkomme med sosial ulikhet. □

Referanser:

World Health Organization 2012: Trends in Maternal Mortality 1990-2010. WHO, UNIFEC and The World Bank estimates.

[1] Uttrykket "tilgang til reproduktiv helse" er nokså ulogisk og det er upresist. "Tilgang til reproduktive helsetjenester" ville vært mer korrekt, men det vekker så mye politisk motstand at poenget kunne gått tapt. Noen ganger i globale forhandlinger må en akseptere ulogiske formuleringer.

Behind the scenes with Hilde Kroes

TEKST: **ODA GILLEBERG**

A groundbreaking resolution on sexual and reproductive health rights for adolescents and youth was adopted in New York at the 45th UN Commission on Population and Development (CPD) in April 2012.

The International Sexual and Reproductive Rights Coalition (ISRRC), consisting of more than one hundred organisations worldwide, took part in the formulation of the resolution and preparations to the CPD, working into the early hours for months, without funding, but with passion. Hilde Kroes at Rutgers WPF in the Netherlands held a coordinating role in the joint effort. Kroes tells FOKUS how it all went down.

What is the ISRRC?

The International Sexual and Reproductive Rights Coalition (ISRRC) is a global coalition of organisations that are pro sexual and reproductive health and rights (SRHR). The coalition offers a secure space where intelligence on SRHR is shared.

A network of more than 100 SRHR-organisations was established during the CPD 2011. We decided to continue the momentum and work towards CDP 2012. Already in June we divided responsibilities into working groups. A core group of 20 people oversaw it all. It proved to be a successful strategy. No funding, extra time nor capacity was allocated to this joint effort. The success is due to participants' genuine interest in the topic.

How does the ISRRC do international lobbying?

The CPD is a high level UN platform for discussing SRHR, thus international lobbying prior to such an event is crucial. The CPD attracts civil society from both sides of the fence, the pro SRHR-partners, but also the anti-choice groups that oppose everything related to SRHR. ISRRC's presence is important in order to make sure that country delegations address and include the right issues in resolutions. Civil society groups from the global south are increasingly involved in the process. What the governments commit to at the UN can be used as advocacy tools at home.

How did the ISRRC approach the government delegations at the CPD?

Country delegations, consisting of either experts on the issues or diplomats who are not necessarily SRHR experts, make decisions at the CPD on behalf of their governments. The role of civil society in approaching delegations, giving advice and putting forward demands, is important. Some civil society representatives are included in the official delegations. I think this is where civil society can have the greatest influence, by taking part in the strategic discussions inside the negotiation room. About 16 countries had civil society on their delegations this year.

ISRRC partners engaged in information sharing, collaboration and strategizing prior to and during the CPD. How was the atmosphere amongst the ISRRC partners during the CPD?

The atmosphere was great! We have been working towards the CPD for the last ten months. We were prepared. On the Sunday before the CPD kicked off we met for a strategy meeting, and every morning during the CPD we would come together for two hours before the official meetings started.

It was great to meet so many partners in New York this year. High attendance is a reminder to the delegations that SRHR are important issues, and perhaps it keeps them extra sharp because they know that we keep an eye on them. Sometimes, due to lack of knowledge, delegations make statements that contradict with their country's national policies. If diplomats don't know their government's position, they often convey their own personal values, which can be rather conservative when SRHR is on the agenda. It is civil society's job to inform delegations about SRHR and country policies.

Who are the most vocal objectors to SRHR, and what was your experience with these actors during this year's CPD?

We face a lot of opposition from the Vatican. They have observer status in the UN, they take the floor a lot, and they don't recognize sexual and reproductive health rights at all. Secondly, Egypt speaks on behalf of 24 Arab countries. These countries tend not to prioritise the CPD, hence Egypt gets to set conservative standards without facing any objections.

But there are a great number of supporters too. South-Africa, Zambia, Brazil, to mention a few, tends to send big, vocal and well informed delegations. They recognise SRHR challenges in their countries.

From your point of view, what was the most important outcome of the CPD 2012? Did you see concrete results of the joint mobilization and networking?

First of all, the resolution is groundbreaking. It is the first time that reproductive rights for adolescent and youths are being recognized at this level. Now it is up to us to make sure it is implemented at country level.

We succeeded in reaching out to governments. For example in Indonesia, civil society mobilised and put SRHR on the government's agenda. This was important considering that the Indonesian government was the chair of the CPD 2012. A shift has come about also in Pakistan who was less difficult in negotiations this year, perhaps as a result of constructive working relations with civil society. Governments cannot neglect information and suggestions received from hundreds of organisations. Organisations working closely together like we did, disseminating the same messages and materials, symbolise a strong front.

Perhaps we can reap the benefits of such a well-established network after 2014 when the International Conference on Population and Development Programme of Action (ICOD) will be renewed and also when a new development framework replaces the Millennium Development Goals in 2015. Whatever new development framework is in the loop, SRHR need a lot of investment and attention. It is our ambition to put SRHR high on the agenda of any new development framework.

What are the main issues ahead, and how can efforts be coordinated?

The Cairo Program of Action has not been fully implemented. We will push for a system that can hold governments accountable. There are always nice words on paper, and nice country policies, but implementation is lacking.

Funding is another challenge. It is difficult to raise funds for SRHR and gender equality. SRHR needs to get back on the agenda, and we need to find ways to explain that SRHR have positive economic implications.

We are evaluating our coordination strategies and systems right now. The trust is there, but we hope to raise funds that can finance a coordination secretariat. □

Utfordringer og utvikling i FN

TEKST: **MORTEN WETLAND**

FNs konferanse om befolkning og utviking i Cairo i 1994. Det hadde vært et lurveleven i ukene og dagene før konferansen. Kjernen i striden gjaldt om konferansen skulle slå fast kvinners rett til å bestemme over egen kropp, seksualitet og fruktbarhet. Gro Harlem Brundtland er invitert til å holde åpningstalen. Det var en fortettet spenning i salen i det Gro entrer talerstolen.

Å "TA AV SEG HANSKENE" er en metafor som er hentet fra slåssing i ishockey og boksing, så den passer ikke her. Men Gro hadde aldri vært redd for å diskutere prevensjon, heller ikke med Paven selv, og hun bestemte seg i Cairo kvelden før konferansen for å si det som det er. Særlig ville hun fortelle alle dem som anfører moralske hensyn mot å gi kvinner informasjon og tilgang til prevensjonsmidler, hvilket ansvar de påtok seg for andre menneskers liv, helse og verdighet. Så Gro la seg frampå og sa:"Morality becomes hypocrisy if it means accepting mothers suffering or dying in connection with unwanted pregnancies and illegal abortions".

HANDLINGSPROGRAMMET FRA CAIRO i 1994 ble vedtatt noen dager senere. Det er blitt stående som det sterkeste og ærligste uttrykk for helsetilbud og rettigheter for kvinner, menn og par som vi i Norge har temmelig bred enighet om.

HER I FN BRUKER VI mange ord og uttrykk som forutsetter at vi har jobbet med sakene en tid før begrepene gir mening. "Reproduktiv helse" er et slikt begrep som striden sto om i Cairo og som den står om den dag i dag. Reproduktiv helse innebærer at kvinner og menn har rett til å motta informasjon og ha tilgang til "effective, affordable, and acceptable family planning of their choice...." og til helsetjenester som tar vare på mor og det nyfødte barn. "Reproduktive rettigheter" er et annet uttrykk med beslektet innhold. Det henviser til menneskerettigheter som bygger på at menneskene har rett til fritt å bestemme hvor mange barn de vil ha og hvor lang tid det skal gå mellom barnefødslene. I Cairo ble altså disse rettighetene klart artikulert, og de kan ikke oppheves eller ignoreres av myndigheter eller konservative kirkesamfunn.

VATIKANET OG EN DEL land reserverte seg mot hele avsnitt eller ord og uttrykk i Cairo-programmet. Men millioner hadde fått et sterkt vedtak mellom hendene, som de siden har konfrontert myndigheter og kulturkonservative religiøse og tradisjonelle ledere med.

DETTE ER NÅ SNART 20 år siden. I årene som har gått har det ikke manglet på forsøk på å snu utviklingen tilbake i tid. For millioner av mennesker er det slett ikke slik at det gis seksualundervisning og informasjon, noe som burde være en nødvendig selvfølge, eller at de fritt kan skaffe seg de prevensjonsmidler de foretrekker.

DE SISTE FIRE ÅRENE har jeg deltatt i forsvaret for Cairo-vedtakene i FN i New York. Noen observasjoner sitter igjen. For det første er det ganske bred enighet mellom progressive land om at vi ikke må ta sjansen på å åpne forhandlinger om begrepene og rettighetene som ble nedfelt i Cairo. Dette skyldes at antallet land som er villig til å vanne ut rettighetene, er økt i antall. Vi finner dem i Europa, ja i alle verdensdeler, men først og fremst er det et stort flertall av de muslimske landene som er de mest aktive og etter vårt syn reaksjonære. De støttes av særlig amerikanske konservative krefter som har godt med penger og er godt organisert.

DENNE VÅREN I FN har jeg undrende stått og sett på frenestiske rådslag i møterom og korridorer hvor innslaget av kvinner, også yngre kvinner, har vært sterkt. Det undrer meg å se hvor sterkt disse kvinnenes engasjement er når det gjelder å få vedtatt at familiene har rett til å kontrollere hvilken informasjon som skal gis til unge mennesker om deres seksualitet, eller hvordan de rent forhandlingstaktisk kan bidra til at ordene "reproduktive rettigheter" blir strøket. Det er opprivende når vi vet at millioner av kvinner ikke sluttfører utdannelsen sin pga uønsket graviditet.

MEN DET ER IKKE bare kvinner som motarbeider kvinner. Historisk sett er det først og fremst menn. I FN ser vi menn i svarte gevanter og stive krager som er aktive på grensen til det fanatiske. Vi skulle gjerne sett dem vise det samme glødende engasjementet i kampen for andre menneskerettigheter, eller i saker som gjelder overgrep mot mennesker og hele folk.

VI SER OGSÅ KOALISJONER som er så man må gni seg i øynene, som når Vatikanet og Iran uttrykker varm støtte til hverandres syn. Men også en del europeiske land danner baktropp når menneskers frihet skal utvikles. I EU har vi en håndfull konservative katolske land som drar i bremsene, og som bidrar til at EU har vanskeligheter med å samles om positive felles holdninger.

FRIVILLIGE ORGANISASJONER er temmelig aktive på den konservative fløy. De er godt organiserte, og driver et iherdig påvirkningsarbeid. De skjemmer seg ikke for å komme med anførsler og påstander som savner sidestykke. Sist under årets møte i FNs befolkningskommisjonen fikk vi høre fra Vatikanets representant at seksual-

UN Photo/Marie Frechon

UN Photo/Rick Bajornas

undervisning innebærer å oppfordre selv små barn til "forferdelige handlinger" og at tekstene som vi andre ønsker oppfordrer til aborter. Det svært aktive amerikanske "Family Watch International" hevder at seksualundervisning ikke forhindrer "sodomi", og sidestiller prevensjon og abort.

DA ER DET GODT å sitte i møtesalen bak et skilt det står Norge på og vite at vi ved FN-delegasjonen har regjeringen og flertallet solid i ryggen når vi imøtegår det vi oppfatter som angrep på menneskers frihet og mulighet til å oppleve lykke.

VÅRT STERKESTE ARGUMENT er kanskje vår egen økonomiske utvikling. Selv med fortsatt kjønnsdelt arbeidsmarked så avslutter de fleste norske kvinner sin utdannelse. Mange kan velge både familie og yrkesliv, og de fleste bestemmer selv når det passer å bli gravide.

90-ÅRENE VAR PÅ MANGE måter spesielle i FN-sammenheng. Vi fikk den store miljø- og utviklingskonferansen i Rio i 1992. Vi fikk Cairo i 1994, Kvinnekonferansen i Beijing i 1995, og det sosiale toppmøtet samme år. Klimakonvensjonen og Kyotoprotokollen så dagen lys. Den kalde krigen var over, og det hersket en generell positiv holdning til at de store FN-konferansene kunne bringe verden framover. De internasjonale nettverkene av kvinner var relativt sett sterke da. Og det sier jeg uten forkleinelse for de internett-baserte sosiale nettverk som nå har vokst fram.

JEG ØNSKER MEG at progressive regjeringer som vår kan skape en bredere koalisjon sammen med andre land fra ulike verdensdeler, med frivillige progressive organisasjoner, og med religiøse organisasjoner som forfekter et mer menneskevennlig syn enn de konservative. Denne koalisjonen kan rette et sterkere søkelys mot de dogmatiske konservative og hvordan de undergraver særlig kvinners rettigheter og muligheter til å bestemme over sine egne liv. I det lange løp er jeg ikke i tvil om at ånden fra Cairo vil seire. Kunnskap vil vinne over tradisjon og overtro. Både fødselstall og det synkende antall aborter viser at folk bruker prevensjonsmidler, også der religiøse og politiske ledere mener at de ikke skal gjøre det.

OG TIL SLUTT: Saken handler grunnleggende sett om trangen til å bestemme og begrense andre mennesker seksualitet og dertil å bekjempe abort. Det første kan de gi opp. Og aborttallene går ned når det gis informasjon og adgang til prevensjon. Det er nå engang fåfengt å bekjempe sex som sådant. De som har prøvd dette noen århundrer har egentlig ikke lykkes særlig godt. Sex er faktisk ganske populært og, som Groucho Marx sa, det er nok kommet for å bli. □

« Da er det godt å sitte i møtesalen bak et skilt det står Norge på og vite at vi ved FN-delegasjonen har regjeringen og flertallet solid i ryggen når vi imøtegår det vi oppfatter som angrep på menneskers frihet og mulighet til å oppleve lykke. »

Å våge der andre tier

TEKST: **ANJA SLETTEN**

Seksualiteten er en viktig del av menneskers liv. Det er en kilde til nytelse, glede og samhørighet, men dessverre også til lidelse, sykdom og skam for mange kvinner og menn verden over. Det er en sentral menneskerettighet at de seksuelle relasjonene vi inngår i skal være frivillige.

UN Photo/Martine Perret

DET ER OGSÅ RETTEN til den høyest oppnåelige standard av helse. Ordlyden forteller oss at fravær av sykdom ikke er nok for å ha en god helse, men at god helse er sterkt forbundet med velvære - både somatisk og psykisk. Seksualiteten griper inn i begge, og er samtidig sterkt forbundet med samfunnets normer. Den er dypt personlig, men også et politisk anliggende.

DET TUNGE OG UENGASJERENDE begrepet «seksuell og reproduktiv helse og rettigheter» handler om at mennesker skal gis muligheten til å kunne treffe frie beslutninger i spørsmål knyttet til sin egen kropp, kjærlighet, seksualitet og det å få barn - og at alle skal ha tilgang til helsetjenester og informasjon som sikrer en god seksuell og reproduktiv helse. Eksempler på slike helsetjenester er god oppfølgning under og etter svangerskap og fødsel, lovlige og trygge aborter, og behandling av seksuelt overførbare sykdommer, inkludert hiv. Men å arbeide med disse spørsmålene handler om mer enn å ha de riktige helsetjenestene. Likestilling, maktforhold og sosial og økonomisk ulikhet har stor betydning for helse knyttet til seksualitet og reproduksjon. Et normativt arbeid og politisk mobilisering, påtrykk og prioritering er derfor helt nødvendig. Derfor bør seksualitet og kvinners rett til å bestemme over egen kropp få økt oppmerksomhet i norsk utviklings- og utenrikspolitikk. Spesielt er det viktig at unge, ugifte og fattige kvinners behov og rettigheter settes i fokus, og at seksuelle minoriteters situasjon adresseres.

KVINNERS HELSE OG RETTIGHETER på dette området er særlig viktige fordi kvinner er gitt det biologiske ansvaret å bære frem barn - og fordi kvinners seksualitet har vært, og fortsatt er, et kontroversielt tema for mange, inkludert for kvinner selv. Det er helt urimelig at kvinner skal fordømmes sterkere enn menn for aktiviteter begge parter helt tydelig er involvert i, men at kvinner i tillegg skal være nødt til å møte store helsemessige risikoer er en uakseptabel urettferdighet det internasjonale samfunnet er nødt til å ta tak i - både i internasjonale fora og i sitt bilaterale samarbeid.

DE NYE TALLENE FOR svangerskapsrelatert dødelighet estimerer at 287 000 kvinner dør hvert år i forbindelse med sitt svangerskap og fødsler. Estimater forteller oss også at 215 millioner kvinner i utviklingsland ønsker, men mangler tilgang til effektive prevensjonsmidler. Norge gjør en god jobb for å redusere mødredødeligheten internasjonalt, men selv om dette er et område hvor man endelig ser en nedgang, så går det for sakte. Det femte tusenårsmålet om å redusere mødredødeligheten med 3/4 innen 2015 og å gi universell tilgang til reproduktiv helse er fortsatt det tusenårsmålet som er lengst unna å bli oppfylt. Det er derfor svært viktig at norske myndigheter arbeider for å sikre at det femte tusenårsmålet tas med videre når verdens ledere lager nye utviklingspolitiske forpliktelser etter 2015.

TILGANG TIL LOVLIGE, trygge og rimelige aborter er et svært viktig tiltak for kvinners helse - særlig for fattige og marginaliserte kvinner. Vi vet at jenter og kvinner velger å ta aborter selv om de er ulovlige. Forskjellen er at ulovlige aborter ofte betyr utrygge aborter - i alle fall for dem som ikke har råd til å betale nok. Dette problemet er så omfattende at 13 prosent av den svangerskapsrelaterte dødeligheten globalt sett skyldes utrygge aborter. Kvinners rett til selvbestemt abort er dessverre et tema som møter intensivert motstand internasjonalt, blant annet er det en bekymringsfull utvikling i flere øst-europeiske land. I dette spørsmålet er det helt nødvendig at Norge tar en rolle som hærfører i internasjonale fora og at spørsmålet løftes frem i sterkere grad i Norges bilaterale arbeid. Ikke minst er det viktig at det gis økonomisk og politisk støtte til organisasjoner som arbeider for kvinners rettigheter og tilgang til selvbestemte aborter.

SEKSUELL OG REPRODUKTIV helse er et område hvor det er enorme forskjeller mellom fattige og rike kvinner. Å ta tak i problematikk knyttet til seksualitet og reproduksjon, er derfor også å ta tak i sosial og økonomisk ulikhet. Å gjøre informasjon, prevensjonsmidler og helsetjenester, inkludert trygge aborter tilgjengelig og rimelige slik at alle kan få tilgang til dem, er svært viktige likestillingstiltak i seg selv, men det er også et svært viktig virkemiddel i det bredere likestillingsarbeidet fordi det øker jenters mulighet til å beskytte seg mot uønskede graviditeter, fortsette sin utdannelse og delta i arbeidslivet. Dersom prevensjonsmidler, informasjon og helsetjenester kun er forbeholdt de med penger, lages det nok en barriere for fattige jenter og kvinners tilgang til utdannelse, god helse og sosial og økonomisk mobilitet. Det er en ulikhet vi ikke kan være kjent med.

VERDEN HAR I DAG den største unge befolkningen noensinne. Unge og ugiftes seksuelle helse og rettigheter er fortsatt kontroversielt og neglisjert. Under årets FN-kommisjon for befolkning og utvikling var nettopp ungdom temaet. Som følge av sterk mobilisering fra progressive stater og sivilt samfunn fikk man gledelig nok en god resolusjon som blant annet appellerer til myndigheter om å beskytte «(...) the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health» (OP7). Resolusjonen slår videre fast at unge skal ha tilgang til seksualundervisning, til konfidensielle helsetjenester, til trygge aborter der det er lovlig, og at helsearbeidere skal trenes og utstyres slik at de kan sørge for at aborter er trygge og tilgjengelige. Norge var en tydelig aktør under kommisjonen og det er svært viktig at Norge fortsetter sitt sterke engasjement for kvinners seksuelle og reproduktive helse og rettigheter i FN-sammenheng i årene som kommer, og at disse spørsmålene inkluderes i de internasjonale prosessene hvor verdens fremtidige utviklingsmål diskuteres og fastsettes.

PROSESSER I FN ER VIKTIGE for å sette normer, mål og danne handlingsrom, men resolusjoner fører ikke til endring uten at de anvendes. Det er derfor tilsvarende viktig at norske myndigheter nå oppskalerer den politiske og økonomiske innsatsen og tar en lederrolle arbeidet med å gjøre resolusjonens ord om til virkelighet for unge mennesker. Dette er et område hvor vi kan gjøre god bruk av våre nasjonale erfaringer og utgjøre en stor forskjell for unge menneskers liv og helse - dersom vi har mot og vilje nok. □

« **Likestilling, maktforhold** og sosial og økonomisk ulikhet har stor betydning for helse knyttet til seksualitet og reproduksjon. Et normativt arbeid og politisk mobilisering, påtrykk og prioritering er derfor helt nødvendig. »

Human rights accountability for maternal death and failure to provide safe, legal abortion: the significance of two ground-breaking CEDAW decisions

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ABSTRACT: In 2011, the Committee on the Elimination of Discrimination against Women (CEDAW) issued two landmark decisions. In Alyne da Silva Pimentel v. Brazil, the first maternal death case decided by an international human rights body, it confirms that States have a human rights obligation to guarantee that all women, irrespective of their income or racial background, have access to timely, non-discriminatory, and appropriate maternal health services. In L.C. v. Peru, concerning a 13-year-old rape victim who was denied a therapeutic abortion and had an operation on her spine delayed that left her seriously disabled as a result, it established that the State should guarantee access to abortion when a woman's physical or mental health is in danger, decriminalise abortion when pregnancy results from rape or sexual abuse, review its restrictive interpretation of therapeutic abortion and establish a mechanism to ensure that reproductive rights are understood and observed in all health care facilities. Both cases affirm that accessible and good quality health services are vital to women's human rights and expand States' obligations in relation to these. They also affirm that States must ensure national accountability for sexual and reproductive health rights, and provide remedies and redress in the event of violations. And they reaffirm the importance of international human rights bodies as sources of accountability for sexual and reproductive rights violations, especially where national accountability is absent or ineffective.

KEYWORDS: human rights, maternal mortality, safe abortion, accountability, remedies and redress, access to justice, UN treaty monitoring bodies, Convention on the Elimination of All Forms of Discrimination against Women, Peru, Brazil

In 2011, the Committee on the Elimination of Discrimination against Women (CEDAW Commit•tee) issued two groundbreaking decisions: *Alyne da Silva Pimentel v. Brazil and L.C. v. Peru.*[1,2] The cases involve two critical issues for women's sexual and reproductive rights: access to appropriate and quality maternal health services, and access to safe, legal abortion. They build on recent developments in the interpretation of international standards on sexual and reproductive health rights.

This article focuses on these two important decisions. It begins by providing a summary of the facts and relevance of the cases. It then proceeds by ana-lysing the decisions, including the recommenda•tions made by the CEDAW Committee to Peru and Brazil. These recommendations are based on the Committee's analysis of the international human rights obligations of States under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[3] Whether or not Brazil and Peru will implement the recommendations is an open question at this writing. These cases have global significance because they provide authorita•tive interpretations of CEDAW, which is binding on its 187 States Parties. This article explores the global implications of these decisions, highlighting some of the international human rights procedures which may be used to hold States to account for their obligations if national accountability is absent or ineffective.

THE FACTS OF THE TWO CASES

Alyne da Silva Pimentel v. Brazil concerned a 28-year-old Brazilian woman of African descent. She had a five-year-old daughter and was six months' pregnant with her second child when she died in late 2002, following inadequate treatment at a local health centre and the failure of the centre to provide timely referral to emergency obstetric care. The health centre was private but partly state-financed, and was in one of Rio de Janeiro's poorest districts. Alyne was near the end of her second trimester of pregnancy when she went there, complaining of high-risk pregnancy symptoms, including severe abdominal pain, nausea and vomiting. Staff at the health centre misdiagnosed these symptoms and sent her home, delaying emergency medical care. She went back to the health centre two days later and was finally admitted. Doctors could no longer detect a fetal heartbeat, and therefore induced delivery. After the stillbirth, Alyne's nausea, vomit•ing and abdominal pain persisted and worsened, and she became disoriented. 14 hours after delivery she underwent surgery to remove portions of the placenta. After the operation, her condition con•tinued to worsen; she began severe haemorrhaging and vomiting blood. Her blood pressure was also low, and she refused food. However, staff at the health centre assured her family that she was well. The following day, her condition further worsened, but the health centre failed to perform any additional tests to determine what was wrong. Although she required referral to a hospital, she had to wait to be transferred for hours, as only one municipal public hospital had an available bed and refused to send its only ambulance to collect her. After she had been waiting in critical condition for eight hours, the municipal hospital finally agreed to authorise the use of their ambulance to transport her. Upon arrival at the hospital, she was placed in a corridor because there was no longer a bed available. She did not receive immediate medical attention. The hospital staff did not know that she had just delivered since her medical records had not been transferred with her; instead, the treating doctor was provided with a brief verbal account of her symptoms. Alyne died in hospital the following evening. Her death could have been prevented.[1]

The case of L.C. v. Peru concerned a young

girl from a very poor area of Peru. Over the course of four years, L.C. had been repeatedly raped by different men in her neighbourhood. When in 2006, at the age of 13, she discovered that she was pregnant, she became seriously distressed and threw herself from the roof of a building, but her suicide attempt failed and she was taken to hospital. The following day, L.C. was assessed to be at risk of permanent paralysis. The head of the neurosurgical department recommended immediate realignment of her spine, but the available surgeon refused to perform the surgery due to her pregnancy. The medical board of the hospital refused to perform an abortion, even though Peruvian law permits abortion in cases where a woman's health or life are at risk. It was only after she miscarried, three months after being admitted to hospital, that doctors were willing to perform the necessary surgery. The enormous delay dramati•cally diminished the success of the intervention, and, as a result, L.C. is now quadriplegic.[2]

Alyne's death and L.C.'s tragedy involved circumstances which are all too common for pregnant women in many countries: a lack of access to appropriate emergency obstetric care; unjustifiable delays in referral and treatment; denial of access to safe and legal abortion; discrimination and inequalities faced by marginalised women, including women living in poverty, ethnic and racial minority women, indigenous and afro-descendant women, and adolescents; and a lack of appropriate remedies and redress at the national level. These problems lead to poor health outcomes and deaths.

The families of both Alyne and L.C. pursued but failed to obtain appropriate remedies or redress at the domestic level. After Alyne's death, her family sought civil redress, but the case languished in court for over four and a half years. No preliminary hearing was ever held, and it took the court three years and ten months to appoint a medical expert, although court rules require that this be done within ten days. In the case of L.C., there was no protocol in place that would have allowed her to demand that medical personnel and the authorities guarantee her access to a legal abortion within the limited period of time that exists under such circumstances. For these reasons, two women's rights organisations, Advocaci (in Brazil), and Promsex (in Peru), with the families of Alyne and L.C. respectively, supported by the Center for Reproductive Rights, took their cases to the CEDAW Committee, using what is called the optional communications procedure under the

Foto: Mette Moberg

Convention. This procedure allows individuals and groups of women or girls who believe that they have been victims of violations of the rights protected under the Convention to bring cases against States which have ratified the optional protocol.[4]

THE CEDAW COMMITTEE'S DECISIONS AND RECOMMENDATIONS

In their decisions on these cases, the CEDAW Committee made concrete recommendations to Brazil and Peru that highlight some of the important actions required of States to ensure the highest attainable standard of sexual and reproductive health and rights for women and girls.
In total, there are nine core UN human rights treaties, as well as a range of regional human rights treaties in Africa, the Americas and Europe. Some of the treaties include explicit protections for sexual and reproductive health rights, while other treaties include more general provisions which have been applied in the context of these rights. Various international monitoring bodies and regional human rights mechanisms have developed an increasingly rich jurisprudence on sexual and reproductive health rights. The key elements of these decisions build on existing jurisprudence under CEDAW and other international human rights treaties. However, the two decisions mark the first times that a UN treaty monitoring body has established that States have violated the right of access to health care services as an aspect of non-discrimination on the basis of sex, by failing to provide adequate and quality reproductive health services in conditions of equality.

ENSURING WOMEN'S RIGHT TO SAFE PREGNANCY AND CHILDBIRTH

In the Alyne decision, the Committee examined whether the government had put in place adequate measures to ensure equitable access to good quality maternity services. The Committee concluded that Brazil had failed to do so since it had not ensured timely emergency obstetric care or referral for Alyne. The Committee also established that Alyne had not only been discriminated against because she was a woman, but also because she was poor and of African descent, thereby exposing the multiple forms of discrimi•nation that women may experience when access•ing maternity services. In the decision, the CEDAW Committee stated that:

> *"The lack of appropriate maternal health services in the State party clearly fails to meet the specific, distinctive health needs and interests of women… [and] has a differential impact on the right to life of women." (Para. 7.7)*

The Committee had previously established that denying women health services which only they need constitutes sex-based discrimination.[5] The case of Alyneisthe first-decisioninwhich the Committee has specifically required that a State provide adequate and quality maternal health care services as part of its non-discrimination obligations. The Committee recommended that Brazil ensure women's right to safe motherhood and affordable access for all women to emergency obstetric care and reaffirmed that state policies should be action-oriented as well as adequately funded.

This decision must be seen in the context of increasingly widespread recognition amongst international and regional human rights bodies that maternal mortality is a human rights issue, as well as an increasingly prominent issue on the public health and

development agenda.[6] CEDAW and the International Covenant on Economic, Social and Cultural Rights[7] contain explicit references to the obligation to protect the rights of women during pregnancy and childbirth. The content of these obligations has been specified by the UN treaty monitoring bodies[5,8,9] as well as by the Human Rights Council,[10–12] the Special Rapporteur on the right to [the highest attainable standard of] health,[13,14] and the Office of the High Commissioner for Human Rights.[15] They have highlighted that States' obligations to ensure safe pregnancy and childbirth include ensuring accessible, adequate and quality maternal health care services; eliminating all barriers in laws, policies and practices that are detrimental to women's health; ensuring the underlying determinants of health; and allowing women to make autonomous decisions regarding their sexuality and reproduction.

Maternal mortality has also been a focus of decisions by certain domestic courts. Most recently, the High Court of Madhya Pradesh held that the "inability of women to survive pregnancy and childbirth violates her fundamental rights as guaranteed under Article 21 of the Constitution of India".

It emphasised that "it is the primary duty of the government to ensure that every woman survives pregnancy and childbirth, for that, the State of Madhya Pradesh is under obligation to secure [16,17] their life".

ACCESS TO SAFE AND LEGAL ABORTION ON THE GROUNDS OF RAPE AND HEALTH

Human rights treaties, UN treaty monitoring bodies, regional and national courts have increasingly recognised – and have been producing a growing body of jurisprudence that establishes – that the respect, protection and fulfillment of sexual and reproductive health rights require States to:

- ensure that abortion is legal in cases where the health and life of the woman are at risk and/or where pregnancy results from rape and incest, and that in these cases States must ensure that women can access safe abortion services;
- amend laws that criminalise medical procedures needed only by women and/or that punish women who undergo those procedures;
- provide rapid access to post-abortion care regardless of the legal permissibility of abortion.[9]

In L.C., the CEDAW Committee reinforced the above standards, calling on Peru to:

> *"Review its laws with a view to establish a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health, prevent further occurrences in the future of violations similar to the ones in the present case; and to review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse."* (Para. 9(b)(i))

As in its Alyne decision, the Committee found L.C.'s rights were violated because the State had failed to take all appropriate measures to eliminate discrimination and to ensure men and women access to health care services on a basis of equality. L.C. did not have access to any effective, accessible procedure that would have allowed her to establish her entitlement to the medical services (spinal surgery and therapeutic abortion) that her physical and mental health condition required. The Committee found this even more serious because she was a minor, a victim of sexual abuse and in poor mental health, as evidenced by her suicide attempt.

L.C. is the second decision by a UN human rights treaty monitoring body in recent years that has focused on the denial of access to legal therapeutic abortion. The case of *K.L. v. Peru* (2005),[18] decided by the Human Rights Committee, which monitors the International Covenant on Civil and Political Rights, concerned a 17-year-old who was diagnosed with an anencephalic fetus at 14 weeks of pregnancy. Even though her pregnancy endangered her physical and mental health, and Peru's law permits therapeutic abortion, she was denied a legal abortion and was forced to carry the pregnancy to term and breastfeed the baby until its death four days later. The Human Rights Committee found that Peru had violated the right to be free from cruel, inhuman and degrading treatment and the right to privacy and special protection as a minor under the International Covenant in this case. However, Peru has yet to implement the recommendations which the Human Rights Committee made to them in this decision.[19]

The L.C. decision reinforces the findings in K.L. by emphasising that where abortion is legal, States have a duty to ensure access to it. The L.C. case additionally establishes that access to legally permitted abortion is a matter of non-discrimination against women. It also provides a refined analysis of selected requirements to guarantee accessibility of legal therapeutic abortion. The Committee considered that:

> *"…since the State party has legalized therapeutic abortion, it must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee necessary legal security, both for those who have recourse to abortion and for the health care professionals that must perform it… It is essential for this legal framework to include a mechanism for rapid decision making, with a view to limiting to the extent possible, risk to the health of the pregnant woman, that her opinion is to be taken into account and that there is a right to appeal." (Para. 8.17)*

There are legal restrictions in many countries on access to abortion. These are often justified on the basis that they will result in fewer abortions. However, evidence shows that legal restrictions on abortion do not result in fewer abortions, and that making abortion unlawful does not decrease the need for, nor prevent, recourse to abortion. Rather, the principal effect of legal restrictions is to force women either to pay a lot of money for a safe abortion, seek unsafe abortion because safe abortion is not affordable, which contributes to pregnancy-related mortality and morbidity,[20,21] or travel for an abortion to other countries, which is costly and makes the abortion later than necessary. This set of options, none of which is acceptable, are indicative above all of social inequity.[22]

ACCOUNTABILITY OF THE STATE FOR THE PRIVATE SECTOR

According to international human rights standards, States have an obligation to protect human rights not only against violations by their representatives, but also against harmful acts by private persons or entities.[23] Due diligence provides an entry point to ensuring the prevention, investigation and punishment of those responsible for any harm caused by private persons and for the provision of effective remedies. States must also ensure that the privatisation of health services does not threaten the availability, accessibility, acceptability and quality of care in them, on the basis of equality and non-discrimination.[24]

Evidence suggests that privatisation and outsourcing of sexual and reproductive health services often results in an authority vacuum, without any State body sufficiently in charge of ensuring that the highest attainable standard of health is secured for all.[25] In the Alyne case, the CEDAW Committee held that Brazil must exert due diligence to ensure that private health care facilities comply with relevant national and international standards for reproductive health care and ensure affordable access for


UN Photo/Marie Frechon

all women to adequate emergency obstetric care. The Committee confirmed that the State is responsible for the actions of pri•vate institutions when it outsources its medical services, and always has a duty to regulate and monitor private health care institutions. The Committee's finding was based on the obligation of States parties under CEDAW to take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise (CEDAW, Article 2.e).

ACCOUNTABILITY OF HEALTH CARE PROVIDERS

The CEDAW Committee observed in both cases that negligence by health care providers was involved and, in the case of L.C., also stereotyping. In the Alyne case, the Committee pointed out that there had been professional negligence and that Alyne did not receive the medical care that she required. In the case of L.C., doctors failed to recognise the risk of permanent disability and provide appropriate services that could have protected L.C.'s health, a right enshrined in the Peruvian Constitution. The Committee found that postponing the provision of abortion and surgery was "influenced by the stereotype that the protection of the fetus should prevail over the health of the mother". The Committee explained that the State failed to fulfill its obligation to eliminate all practices which are based on stereotyped roles of women, since the timely access to necessary medical treatment was made conditional on carrying to term an unwanted pregnancy. The "stereotype" concerned was explained as placing L.C.'s reproductive function above her fundamental human rights (Para. 8.15 and 9).

The CEDAW Committee's recommendations in both decisions highlighted States parties' obligation to provide adequate professional training for health workers, including for care involving women's sexual and reproductive health rights. This helps to ensure quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care. In L.C., the Committee called on Peru to take measures to ensure that reproductive rights are understood and observed in all health care facilities:

> *"Such measures should include education and training programmes to encourage health providers to change their attitudes and behavior in relation to adolescent women seeking reproductive health services and respond to specific health needs related to sexual violence. They should also include guidelines or protocols to ensure health services are available and accessible in public facilities."*
> (Para. 9(b)(2))

MONITORING AND REVIEW

In Alyne, the CEDAW Committee recommended that Brazil implement its National Pact to Reduce Maternal and Neonatal Death, including through establishing more maternal mortality committees to monitor the number and causes of maternal deaths. Maternal death audits and reviews are conducted in many countries worldwide.[26] The data generated provide an important basis for determining policy and funding priorities for addressing these causes and reducing maternal deaths. Such data are increasingly used in the field of human rights. Human rights-based approaches to policy and programming emphasise the importance of indicators, including reliable qualitative and quantitative data, to enhance their effectiveness and sustainability. Reliable data are also increasingly used to review progress or in human rights accountability processes.

A strong capacity in countries to collect such data, including on the health of women, is essential to determine where investments should be focused and whether progress is being made.[27]

ACCESS TO JUSTICE, REMEDIES AND REDRESS

The inaccessibility of justice and effective remedies impedes the realisation of sexual and reproductive health and rights. Often when a pregnant

woman is denied access to urgent life-saving and health-preserving medical services, there are also multiple obstacles to accessing justice and remedies afterwards. Alyne's family was obstructed by the failure of the domestic authorities to establish professional responsibility and by severe delays in judicial proceedings. L.C. was faced with the absence of an appropriate administrative mechanism that would have allowed her to terminate her pregnancy for therapeutic reasons and have surgery, as well as access to an effective judicial mechanism to provide redress for the violation of her rights.

Victims of human rights violations have a right to effective remedy and reparation. Remedies take a variety of forms, including: restitution (re-establishing the situation before the violation took place); rehabilitation (e.g. medical or psychological care or social or legal services); compensation (payment for financially assessable damages); satisfaction (e.g. acknowledgement of a breach or an apology); and guarantees of non-repetition (e.g. legislation, organisational improvements).[28] Some of these measures primarily address the individual victims of violations, others are more directed at the general population, to proactively protect their rights. Depending on the situation, full reparation for a violation may require a combination of these measures.[29]

In both decisions, the CEDAW Committee recommended remedies that not only addressed the violations suffered by Alyne and L.C., but also called for systemic changes in the health care and justice sectors, and in the law itself, to prevent similar abuses occurring in the future. In Alyne, the Committee recommended that Brazil provide appropriate reparation, including financial compensation, to the daughter of Alyne, commensurate with the gravity of the violations against her. The Committee also recommended that Brazil ensure access to effective remedies in cases where women's reproductive health rights have been violated, and provide training for judiciary and law enforcement personnel.[1]

In L.C., the Committee recommended that Peru:

> *"provide reparation that includes adequate compensation for material and moral damages and measures of rehabilitation, commensurate with the gravity of the violation of her rights and the condition of her health, in order to ensure that she enjoys the best possible quality of life... [and] review its laws with a view to establishing a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health and prevent further occurrences in the future of violations similar to the ones in the present case."* (Para 12.a,b)

Further, the Committee also recommended that Peru "review its legislation with a view to decriminalising abortion when the pregnancy results from rape or sexual abuse." The Committee also made recommendations to Peru to take steps to increase awareness about reproductive rights in all health care facilities, including through training of health care providers, and implementation of guidelines and protocols to ensure health services are available and accessible in public facilities.[2] These recommendations require Peru to take proactive measures to ensure that similar violations can be avoided in the future and women and girls in similar situations to L.C. can have better access to services.

UN Photo/Kibae Park

THE GLOBAL RELEVANCE OF THESE CASES

CEDAW requested that the States of Brazil and Peru submit, within six months, a written response detailing any action taken in the light of decisions and recommendations. These responses are due in the first quarter of 2012. Under CEDAW, States are required to submit periodic reports on their imple•mentation of the treaty every four years. The State party reporting process under CEDAW will provide formal opportunities for follow-up by CEDAW.

Whilst the CEDAW Committee's legal and policy recommendations were made to Brazil and Peru , they can and should influence law and policy-making and implementation in other States, since the circumstances of these cases exemplify some of the key obstacles to sexual and reproductive health care worldwide. While the decisions are not in themselves legally binding on all States parties to CEDAW, they are authoritative interpretations of this treaty, which does impose legally binding obligations on its 187 States parties.

The decisions can also provide guidance to other treaty monitoring bodies, regional human rights bodies and domestic courts on the application of human rights in relation to maternal health and abortion. Furthermore, the standards established in the decisions will be taken into account in the policies and programmes of United Nations agencies and international organisations working on sexual and reproductive health.

These cases highlight that international human rights mechanisms can be used to hold States to account for sexual and reproductive health rights, including where domestic accountability is absent, inaccessible or ineffective, as it was for L.C. and the family of Alyne. As well as CEDAW, other UN human rights treaty bodies, the UN Human Rights Council and regional human rights mechanisms are among the key bodies which may play a role. Most of these bodies operate periodic reporting procedures involving the scrutiny of States' human rights performance. Some of these bodies, like CEDAW, also have complaints procedures which can be used by individuals and/or groups.

A new independent Expert Review Group was established in September 2011, with responsibility for reporting to the UN Secretary-General on progress towards implementing the Global Strategy on Women'sand Children's Health. It has also been tasked with following up on the recommendations of the Commission on Information and Accountability, which identified accountability as a missing element for the improvement of women's and children's health worldwide.[30] The Review Group has a human rights purview and this provides a new, potentially important opportunity for improving maternal health in a broader women'srightsand sexual and reproductive health framework.

CONCLUSION

Women's right to access sexual and reproductive health care, including good quality maternity care and safe, legal abortion are protected under international human rights law. In addition UN treaty monitoring bodies, regional and national legislative and human rights bodies are increasingly recognising that safe abortion services should be legal and accessible at a minimum on the grounds of protecting the life and health of the woman and in cases of rape and sexual abuse.

The Secretary General's Global Strategy on Women's and Children's Health, and the Commission on Information and Accountability for Women'sand Children's Health which was established in its wake, have highlighted that accountability is an essential, but often neglected, strategy for improving women's and children's health, including for reducing maternal mortality and morbidity.30

The decisions highlight the key role that human rights can play in seeking to hold States accountable for sexual and reproductive health, in order to protect the health and lives of women like Alyne and adolescent girls like L.C. Brazil and Peru need to take urgent steps to implement the recommendations of the Committee. Implementation of these decisions will not only have significance from the domestic perspective and the perspectives of the families affected, but would also impact global normative developments in this regard. ☐

NOTE The views in this article are those of the authors alone, and do not necessarily represent the positions of their organisations. Human Rights Committee. K.L. v. Peru. Decision CPR/C/85/D/1153/2003 22 November 2005.

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The Dual Role of the Catholic Church in Latin America:

Between Politics and Religion

The strong historical and cultural presence of the Catholic Church in Latin America has allowed the Church to enjoy a religious monopoly in the region, thereby forging a privileged status in comparison with other religious institutions.

TEXT: **MARÍA CONSUELO MEJÍA, CATHOLICS FOR CHOICE** PHOTO: **ROSAAMARILLA/FLICKR.COM**

AS SUCH, IT HAS BEEN a common practice of the States to delegate regulation of the moral order to the Church, allowing for the establishment of legal norms in which the notion of crime is based largely on Catholic discourse on sin. As a result of the religiosity of political leaders and the misguided assumption that the Catholic Church represents the majority of the population in Latin America, the Church hierarchy is deemed uniquely qualified to provide the rules to be followed by both government and society.

AT THE SAME TIME, politicians across the political spectrum still cling to the idea that securing the Church's blessing wins votes, and many so-called progressive parties have used women's rights as a bargaining chip in exchange for this support. An emblematic recent example is the complete ban on abortion supported by Nicaraguan President Daniel Ortega, the Sandinista revolutionary turned devout Catholic, which eliminated the legal indication for abortion even when the woman's life is at risk.

HOWEVER, IN RECENT decades, Latin America has witnessed a decrease in the number of self-identified Catholics, as well as an increasing diversity of Catholic identities, in which many people continue to take part in rituals of spiritual and cultural importance, such as baptism, but do not necessarily attend mass regularly and do not agree with the hierarchy's attempts to influence public policy in accordance with Catholic morality. This shift in Catholic identity has also signified a growing divide between the teachings of the Catholic hierarchy and the beliefs and practices of Latin American Catholics, particularly in regards to sexuality and reproduction.

IN RESPONSE TO this loss of social influence, the Catholic hierarchy has stepped beyond the pulpit to take on a more proactive role in the arena of public policy. Although the Catholic Church has a long history of political intervention in the region, the new climate established by UN conferences such as the 1994 ICPD and the 1995 World Conference on Women, and recent cultural and legal changes achieved by the feminist and LGBTTI movements have reactivated fundamentalist Catholic leaders who find their priority agenda in the defense of a strongly patriarchal and heteronormative social order.

CATHOLIC FUNDAMENTALISTS in the region have increased their power through building "secular" alliances with conservative entrepreneurs, far-right political forces, and the media to promote their agenda at varying levels, from attempts to affect international agreements on human rights, to obstructing the approval and implementation of policies and laws, as well as limiting access to reproductive health services and sexuality education programs. The Catholic hierarchy has also promoted the formation of secular "pro-life" or "pro-family" NGOs, think tanks, lawyers' associations, and academic organizations to appear as though its fundamentalist demands are coming from civil society rather than from the institutional Church. In an effort to provide a "secular" defense of the Catholic hierarchy's moral agenda and in response to the effective human rights discourse employed by sexual and reproductive health and rights (SRHR) advocates, religious fundamentalists have begun to distort human rights concepts to their advantage, including campaigns to promote the "human rights of the unborn" and the establishment of the Day

« **Catholic fundamentalists** in the region have increased their power through building "secular" alliances with conservative entrepreneurs, far-right political forces, and the media to promote their agenda at varying levels »

of the Unborn in many countries of Latin America. To counter the overwhelming number of public health arguments in favor of SRHR, religious fundamentalists are also increasingly citing results of flawed research or making biased scientific assertions that are not evidence-based.

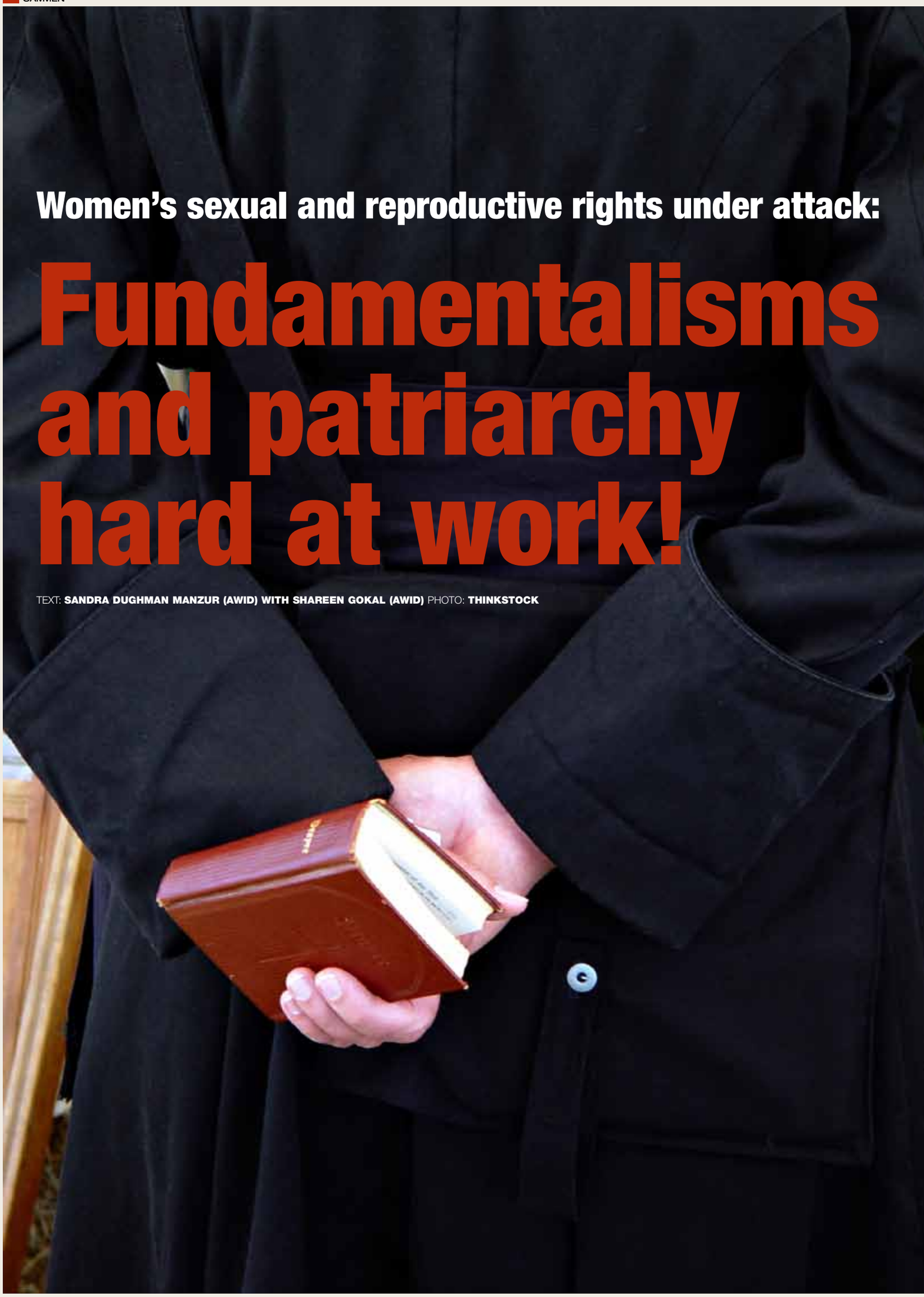
IN ORDER TO RESIST and counteract these actions by Catholic fundamentalists, the Latin American network of Católicas por el Derecho a Decidir (Catholics for the Right to Decide, CDD) has politicized the growing religious pluralism in the region and is opening important channels for SRHR activism in Latin America through the use of progressive Catholic messaging. CDD activists repeatedly challenge what it means to be Catholic by promoting visibility of the diversity of Catholic beliefs and defending freedom of conscience, while also pointing out the inconsistencies between the patriarchal stances of the Catholic hierarchy and the struggle for social justice and the egalitarian spirit found in Catholic tradition. CDD's arguments in favor of SRHR provide key elements for engaging in debate with the Church hierarchy, advocating with decision makers, and reaching out to empower broad sectors of the population. By unmasking the harm caused by Catholic fundamentalism, CDD activists are making the way for a new brand of Catholicism, that not only reflects traditional teachings of love and compassion but also responds to the new realities faced by Catholics in the 21st century.

MARÍA CONSUELO MEJÍA is the Executive Director of Católicas por el Derecho a Decidir (Catholics for the Right to Decide-Mexico). Católicas is a nonprofit organization, formed by Catholics, who defend women's and young people's human rights, especially their sexual and reproductive rights, including access to safe and legal abortion, from an ethical, Catholic, and feminist perspective. More information can be found at www.catolicasmexico.org ☐

Women's sexual and reproductive rights under attack:

Fundamentalisms and patriarchy hard at work!

TEXT: **SANDRA DUGHMAN MANZUR (AWID) WITH SHAREEN GOKAL (AWID)** PHOTO: **THINKSTOCK**



WOMEN'S SEXUAL and reproductive rights, their autonomy and ability to make choices about their bodies and sexual relationships are a source of conflict around the globe. Forces of patriarchy and sexism routinely exert control over women's sexuality in an effort to subjugate women and present a normalized fundamentalist view of sexuality and women's role in society. Justifications based on religion, tradition, culture, and public morality have served as effective tools to attack women, their bodies and their human rights. Given this scenario, the Association for Women's Rights in Development (AWID) has created new and strategic research to address the rise of religious fundamentalisms and its negative effects on women's rights, their sexual rights and their reproductive rights and choices.[1]

THE ATTACKS ON women's sexual and reproductive rights are evident at all levels: the international, regional, national and local. Fundamentalist forces are increasingly using international platforms to make declarations and interpret treaties with a biased and restrictive view of rights, with the aim of establishing the superiority of certain rights like freedom of religion over any others recognized by international human rights instruments. These include interpreting concepts like family, sexuality, and women's role in society, all through an ultra-conservative lens, and forward a fundamentalist social perspective.

IN OCTOBER 2011, Anand Grover, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, presented before the UN General Assembly a groundbreaking report (A/66/254) [2]. Grover made clear and courageous statements condemning the negative impacts that criminal laws and other legal restrictions have over women's reproductive freedoms, decision-making processes, and autonomy. This spurred outraged reactions from organizations such as Family Watch International which accused the rapporteur of overstepping his mandate, ignoring parental rights, and "subvert[ing] a clearly guaranteed right of religion in favour of an imaginary right to abortion".[3]

ALSO, EARLY THIS YEAR (Feb. 2012), the Human Rights Council Advisory Committee discussed a draft report entitled "The Preliminary Study on promoting human rights and fundamental freedoms through a better understanding of traditional values of humankind" (A/HRC/AC/8/4)[4] in which the UN uses concepts such as religion, values, tradition and the role of the family in the international human rights system. For many activists this has raised questions about the pressures that ultra-conservative and fundamentalist agendas have put on a structure such as the UN and the international human rights system, which is meant to promote and protect the rights of all people.

ANOTHER IMPORTANT international venue, the 56th Commission on the Status of Women (CSW), ended in a political deadlock and stalemate between women's rights advocates and ultra-conservative forces earlier this year. Culture and tradition were invoked to stall progress on critical women's rights issues. Ultra-conservative States and non-governmental groups again pushed for the recognition of "parental rights" and lobbied for the exclusion of the right to comprehensive sexuality education, the right to abortion services, and contraception as part of comprehensive reproductive health. In this way, fundamentalist forces are promoting the notion that sexual and reproductive rights should not be recognized as human rights.

AT A LOCAL AND NATIONAL level, in countries in Latin America and in the United States for example, fundamentalist strategies consist of active lobbying to reform laws and policies with the objective of restricting access to abortion services, contraception or comprehensive sexual education. Fundamentalist forces have tried to push forward their anti-abortion agendas through the use of "personhood clauses" and "the protection of life from conception", mainly, by bringing forward emblematic cases in front of the judiciary arguing the right to life of the fetus. Other tactics include the presentation of bills before congress, the recognition of conscientious objection to justify hospitals or individual physicians from refusing to provide abortion services, and insisting on previous judicial authorizations to access a legal abortion. These tactics are accompanied and reinforced by broader social pressures imposed through selective fundamentalist interpretations of religion and the burden of social stigma and shame forced on women who decide to interrupt pregnancy.

EVEN WHEN RIGHTS are legally granted to women, religious fundamentalisms mobilize forces to obstruct public policies that would allow for effective implementation of these rights. For example, in a recent victory for Argentina, the Supreme Court ruled that abortion on the grounds of rape was accessible to all women without exception. This ruling included removing the requirement of prior judicial authorization for a legal abortion and called on the government to implement protocols for the provision of safe abortion. However, many provinces and hospitals have declared that they have no intention of implementing this ruling and that such protocols will not be put into place because it represents a direct violation to their religious beliefs.

« **Justifications based on** religion, tradition, culture, and public morality have served as effective tools to attack women, their bodies and their human rights. »

CHOICES OVER AREAS such as sexuality and reproduction are basic human rights and must be promoted and guarded at all levels. Governments have the responsibility to be accountable to their citizens and take actions which protect reproductive and sexual rights, including access to safe abortion services, contraception and maternal health care. Culture, religion, tradition or any personal belief cannot be used to undermine the rights of women or be promoted as superior to the human rights recognized by international instruments or national constitutions. As activists, we need to hold States and international human rights bodies accountable for the promotion, protection and fulfillment of women's human rights and fundamental freedoms and to reject attempts to invoke traditional values or morals that infringe on these rights. □

[1] AWID's research and publications on Religious Fundamentalisms can be found at http://www.awid.org/AWID-s-Publications/Religious-Fundamentalisms
[2] http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254
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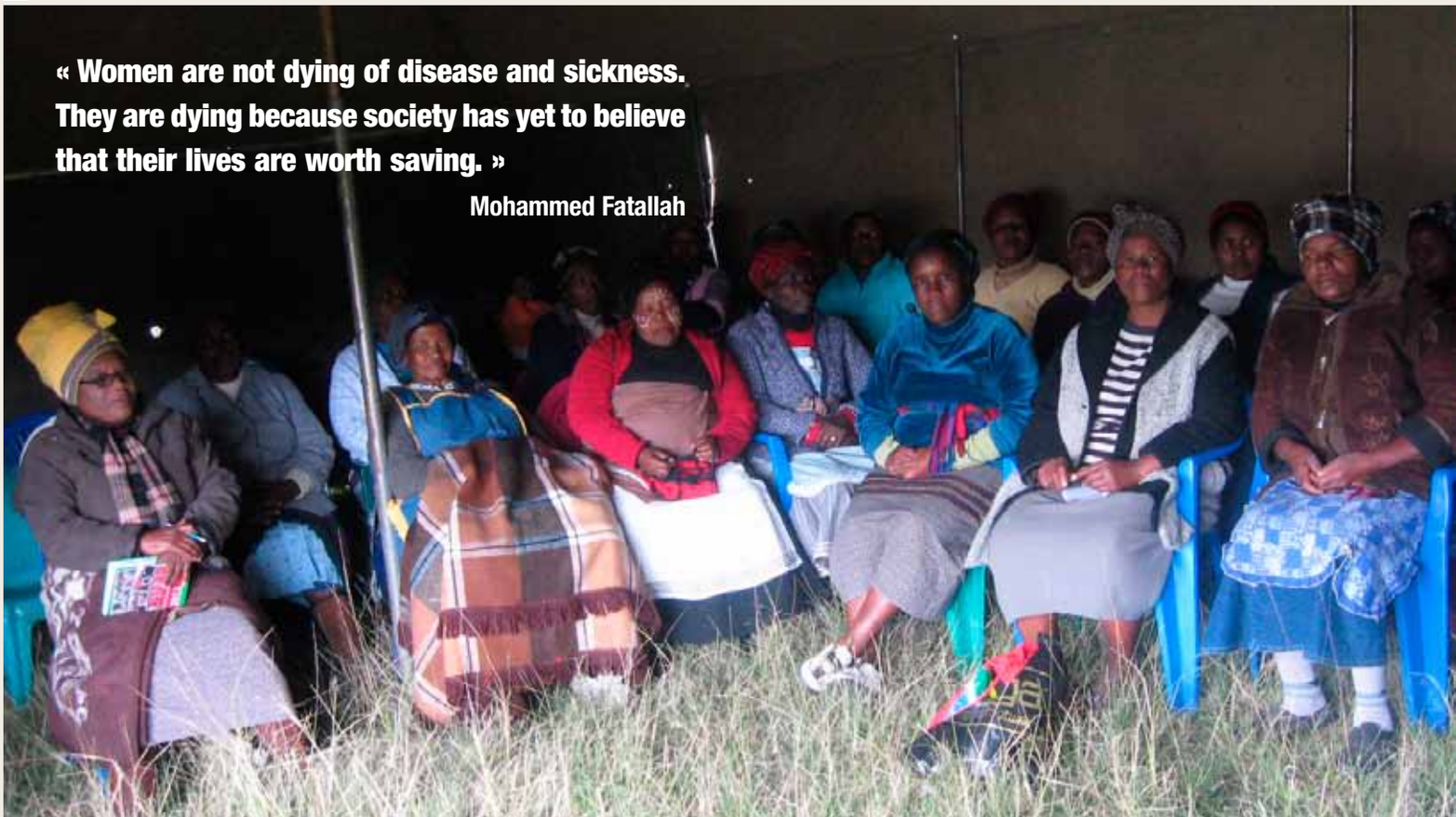

« Women are not dying of disease and sickness. They are dying because society has yet to believe that their lives are worth saving. »

Mohammed Fatallah

Their lives are worth saving

HIV and AIDS affects more than 5,7 million people in South Africa. The most infected and affected group are women and girls aged 15-29 years of age. While HIV affects people across all racial, ethnic, cultural, educational, economic and other divides, in South Africa the most infected people are poor black women. HIV and AIDS is a disease spread largely through inequality and in justice.

TEXT: **LESLEY ANN FOSTER, MASIMANYANE**

THE RESEARCH IN the country has indicated that poverty, a lack of autonomy and decision making, limited access to basic services and violence against women are some of the key drivers of this pandemic. Women and girls remain the most vulnerable to being infected because of the high levels of rape and domestic and sexual violence in the country. These high levels of men's violence towards women is leading to increased levels of teenage pregnancy which in turn affects the education and work opportunities of young women. Many difficulties face teenagers who fall pregnant including having to leave school and many not returning to complete their studies which in the long term affects their ability to work and earn a decent living. Some teenagers resort to unsafe abortions which compromises their reproductive systems, sometimes leading to infertility and even death. There are still a large number of deaths due to unsafe abortions in South Africa inspite of the government supposedly providing free termination of pregnancy services. Stigma and discrimination from conservative and religious health workers does not assist young women in accessing those services.

MASIMANYANE WOMEN'S Support Centre is one of the leading women's rights organisation's in South Africa working on the inter-linkages between violence against women, HIV/AIDS and Sexual and Reproductive Health and Rights. The organisation has a dedicated office that renders a prevention programme aimed at creating widespread community knowledge and education on HIV and AIDS. This programme conducts HIV Counselling and Testing as a means of prevention those who are HIV negative from becoming infected and those who have the virus to protect themselves from further infection, learn to take care of themselves so that they do not develop aids and to teach them to protect their partners.

MASIMANYANE HAS FOUND that women with HIV are vulnerable in many different ways. The story below illustrates some of the challenges that women face.

I was a single women and a devoted Christian. I never had intimate relationships with a man until I met my husband at church. He was very charming and a devoted Christian like me. I married him after one year of us courting. When I fell pregnant, I was tested and found to be HIV positive. I was devastated because I knew that I had never had sex with anyone else but my husband. When I confronted him, he accused me of being unfaithful to him and threw me out of the house. The house was mine and everything in it I had worked for before we got married. I was very angry at this attitude after giving me this disease and throwing me from my own house when I was pregnant. He cut me off from his medical aid which was the only support he ever gave me.

MANY WOMEN ONLY find that they are infected when they are pregnant. They then have to face the challenge of possibly infecting their new born babies. Worse still, South Africa's maternal deaths have risen to 625 per 100 000 live births which is one of the highest on the continent. Many of these maternal deaths are due to HIV or to male violence against their pregnant partners.

FORCED AND CHILD marriages are still practised in rural communities in South Africa. Young girls are abducted by men wanting to "marry" them and arrangements for the abduction and marriage are agreed to between the man and the girls family. This leads to rape and pregnancies that result from such rapes are very difficult on the lives of the girls involved. Most often, these young brides have no decision making ability over their lives and no support from the family or community that they are married into. Fistulas, still births, post partum bleeding are the result of these pregnancies leaving the girls badly injured, scarred or even dead. Many young women get infected with HIV in this brutal manner. Other infections with older women occur when their partnership have multiple concurrent partners. Infidelity and polygamy is the driver of the pandemic in older women.

MASIMANYANE'S INTERVENTIONS focus on prevention because we believe that we have a responsibility to bring the correct knowledge to women and girls and to build their agency so that they can resist coerced sex, prevent violence against them and develop safety nets in families and communities for their protection.

WE OFFER 4 PROGRAMMES to communities across our province. We recognise the need for support services so Masimanyane has 10 offices spread across the province (8 million people in out province) where women and girls who survive sexual violence can get counselling, paralegal services, legal support and medical treatment if they require it.

OUR SECOND PROGRAMME is the Community Education and Awareness raising programme. We focus know building community knowledge on human rights and responsibilities. We work across 30 schools where we have developed a model of human rights clubs which aim to teach young people about gender equality and human rights.

A VITAL PROGRAMME for us is the women's leadership programme. Recognising that South Africa has a huge skills deficit due to apartheid and the lack of access that black people had to high education, we aim to build women's leadership and capacity to address issues critical to their specific communities and contexts. Our leadership programme has resulted in many women's establishing groups in their communities that provide support and training and they conduct advocacy that leads to changes in policies.

THE MOST IMPORTANT programme remains the advocacy programme which aims to change the laws, policies and programmes of government. Masimanyane has recently launched a national campaign with a campaign theme of " Reproductive Justice for all women and girls". The campaign will have four components to it. The first will be a review of the national strategic plan on HIV/STI'S and T.B. We will monitor the implementation of this plan from the budgets allocated to it to the roll out across the country The second element is the training of community leaders to teach women at the grassroots about their rights and how to demand these rights from their local municipalities. We will hold community meetings to teach women about all aspects of sexual and reproductive health and the rights related to that. We will provide training on sexuality including work with LGBTI communities. The final element is a postcard campaign which we are distributing at every meeting, and workshop Masimanyane and its alliance partners will run over the next 10 months. The postcards have a list of demands together with space for each person to write their personal message.

MASIMANYANE IS CONFIDENT that we are turning the tide on discrimination against women in respect of their sexual and reproductive health and rights and we will continue to reduce levels of violence against women, HIV and maternal deaths. □

"Det handler om menneskerettigheter - ikke homorettigheter"

Skvist mellom fiendtlige styresmakter og homofobe samfunn står seksuelle minoriteter i Kenya og Uganda på barrikadene.

TEKST: **ODA GILLEBERG**

Jacquiline og Pauline begikk selvmord i påsken. En av jentene ble voldtatt av sju menn nær byen Kisumu vest i Kenya. Etterpå skrev hun et brev til kjæresten sin før hun inntok en dødelig dose rottegift. Samboeren i over ti år ville ikke fortsette livet alene. Hun skrev til foreldrene sine og ba om at de to jentene skulle bli begravd i samme grav. Så spiste også hun rottegift og døde.

"Voldtekt mot lesbiske er utbredt," sier Qamunde, programkoordinator i Artists for Recognition and Acceptance (AFRA) i Kenya. "Folk i lokalsamfunnet blir fort mistenksomme og kan ty til vold mot kvinner som bor sammen slik som Jacquiline og Pauline gjorde."

Wambya, helsekoordinator i Freedom and Roam Uganda (FARUG), sier at lesbiske er utsatte voldtektsofre også i Uganda. "I tillegg mangler det tilbud om oppfølging etter voldtekt, fysisk vold og psykologisk tortur," sier hun.

I en nylig publisert rapport fra Kenya National Commission on Human Rights utredes det hvordan lesbiske, homofile, bifile, transpersoner og intersexpersoner (LHBTI) er utsatt for tilfeldige arrestasjoner, trakassering, seksuelle overgrep fra politi, religiøst motiverte angrep og vanskeligheter med å oppsøke helsetjenester.

Det er første gang at en nasjonal rapport eksplisitt adresserer brudd på LHBTI-personers seksuelle og reproduktive helserettigheter.

"Det er faktisk revolusjonært," sier Solomon, programkoordinator i Gay and Lesbian Coalition of Kenya (GALCK). "Når en statlig organisasjon diskuterer LHBTI-saker betyr det at vi blir hørt."

Men styresmaktene er trege til å handle. GALCK kjemper for å få omgjort artikkel 165 i straffeloven som kriminaliserer "handlinger mot naturens orden." "Men det vil ikke skje med det første," sier Solomon.

I Uganda kjemper aktivistene mot den såkalte Bahati-loven som foreslår dødsstraff for homofile. Lovforslaget ble trukket i mai i 2011, men den er nå tilbake på agendaen i det Ugandiske parlamentet.

"Sodomilover" nærer stigma og diskriminering og bidrar til å opprettholde barrierer som hindrer seksuelle minoriteter fra å nyte sine helserettigheter, sine menneskerettigheter.

BRYTER TAUSHETSPLIKTEN

Å få tilgang til gode helsetjenester er en av de største utfordringene for LHBTI-personer i Uganda og Kenya.

Qamunde forteller at AFRA en gang tok med seg en gruppe kvinner til klinikken for underlivsundersøkelser. "Da vi fortalte sykepleieren at vi ikke har sex med menn løp hun ut og begynte å rope at, "'lesbene er her! Kom og se!' Atten kvinner fikk panikk og stakk av. Bare to ble igjen for å bli testet," sier Qamunde.

I Uganda unngår de fleste å fortelle helsepersonell om sin seksuelle orientering på grunn av faren for å bli eksponert. "Vi lyver eller later som om vi har partnere av det motsatte kjønn," sier Wambya. "Det fører til feildiagnostisering og dårlig behandling." At helsepersonell bryter taushetsplikten kan være den første dominobrikken som faller. Avslørt seksuell orientering kan bety at en ikke får jobb, bannlysing fra religiøse grupper og utvising fra boligområder. I den nasjonale rapporten fra Kenya hevdes det at LHBTI-personer er konstant på flukt.

INGEN SNAKKER OM MENTAL HELSE

Qamunde ga nettopp ut sin første demo. Sangen How it Feels handler om "hvordan det er å bo i et land hvor du er behandlet som en 'social misfit'," forklarer hun.
Å føle seg som en annenrangs borger påvirker folks selvfølelse. "Det kalles for minoritetsstress," sier Annika Wattne Rodriguez, internasjonal rådgiver i Landsforeningen for LHBT (LLH). "For noen kan det føre til mentale helseproblemer og destruktiv adferd."

LLH har samarbeidet med LHBTI-organisasjoner i Kenya and Uganda siden 2006. Rodriguez og hennes kollegaer i Øst-Afrika etterlyser helsetjenester for mental helse.

SEKSUELLE MINORITETER i Kenya og Uganda er utsatt for ulike stressfaktorer. "Vi er bekymret for sikkerheten vår," sier Qamunde, og forteller om drittslenging, forfølgelse og trusler.
Noen blir kastet ut hjemmefra og utvist fra skolen, merket for livet av brutte familiebånd og svikefulle vennskap. Mange inngår heterofile ekteskap for å opprettholde en straight fasade, men fortsetter å ha forhold til personer av sitt eget kjønn i hemmelighet. Dobbeltlivet er ikke bare krevende mentalt sett, men flere sexpartnere på samme tid øker også faren for å bli smittet av kjønnssykdommer og HIV.
Aktivistene fremhever også at særlig lesbiske tyr til narkotiske stoffer og alkohol for trøst og flukt fra virkeligheten. "Kanskje tror de at narkotika kan hjelpe dem med å bli komfortable med hvem de er og livene de lever," sier Qamunde.

Rodriguez poengterer at lesbiske og biseksuelle kvinner støter på spesifikke utfordringer. "Fordi de er kvinner erfarer de kvinnerelaterte utfordringer som finnes i samfunnet generelt, som vold og trakassering. Dermed er det ekstra utfordrende å skulle leve ut sin seksualitet og bryte med etablerte kjønnsroller."

Likevel er mental helse et ikke-tema. "Det finnes ingen hjelpetilbud," sier Qamunde. "Ja, bortsett fra våre utblåsningssamlinger, da," ler hun. En gang i måneden arrangerer nemlig AFRA åpent hus for medlemmer som har behov for blåse ut innestengt og undertrykt frustrasjon.

PÅ BARRIKADENE

Til tross for at LHBTI-personer i Kenya og Uganda opplever grove brudd på sine helserettigheter, og fort blir skyteskiver for verbal, fysisk og seksuell trakassering, vold og trusler, kaster ikke aktivistene bort tiden med å klage.

"Voldsratene har gått ned," sier Qamunde optimistisk. "Og det hender til og med at folk stopper meg på gata og sier at de er stolte av meg for den jobben jeg gjør."

"Jeg er optimistisk," sier Wambya også. Selv om "det aldri er trygt å etablere en LHBTI-organisasjon i Uganda" har FARUG nettopp søkt om å bli registrert som en. "Vi er her og vi må kreve vår plass," sier hun.
"For det handler ikke om homorettigheter," understreker Solomon. "Det handler om menneskerettigheter. For alle." □

Qat Qamunde bruker kunst og musikk i sin menneskerettighetskamp.

FAKTA:

- **Ulike internasjonale konvensjoner, for eksempel CEDAW og ICERD, beskytter rettighetene til forskjellige grupper i samfunnet. Det finnes ingen konvensjon som tydelig beskytter rettighetene til seksuelle minoriteter.**
- **Yogyakarta-prinsippene fra 2006 danner kanskje det mest eksplisitte rammeverket for beskyttelse av seksuelle minoriteters rettigheter i internasjonal menneskerettighetslov.**
- **Kenyas menneskerettighetskommisjon anerkjenner at, "for at seksuelle minoriteters seksuelle og reproduktive helserettigheter skal kunne bli en realitet i Kenya må lovene som kriminaliserer handlinger og oppførsel bli tilbakevist og fjernet."**

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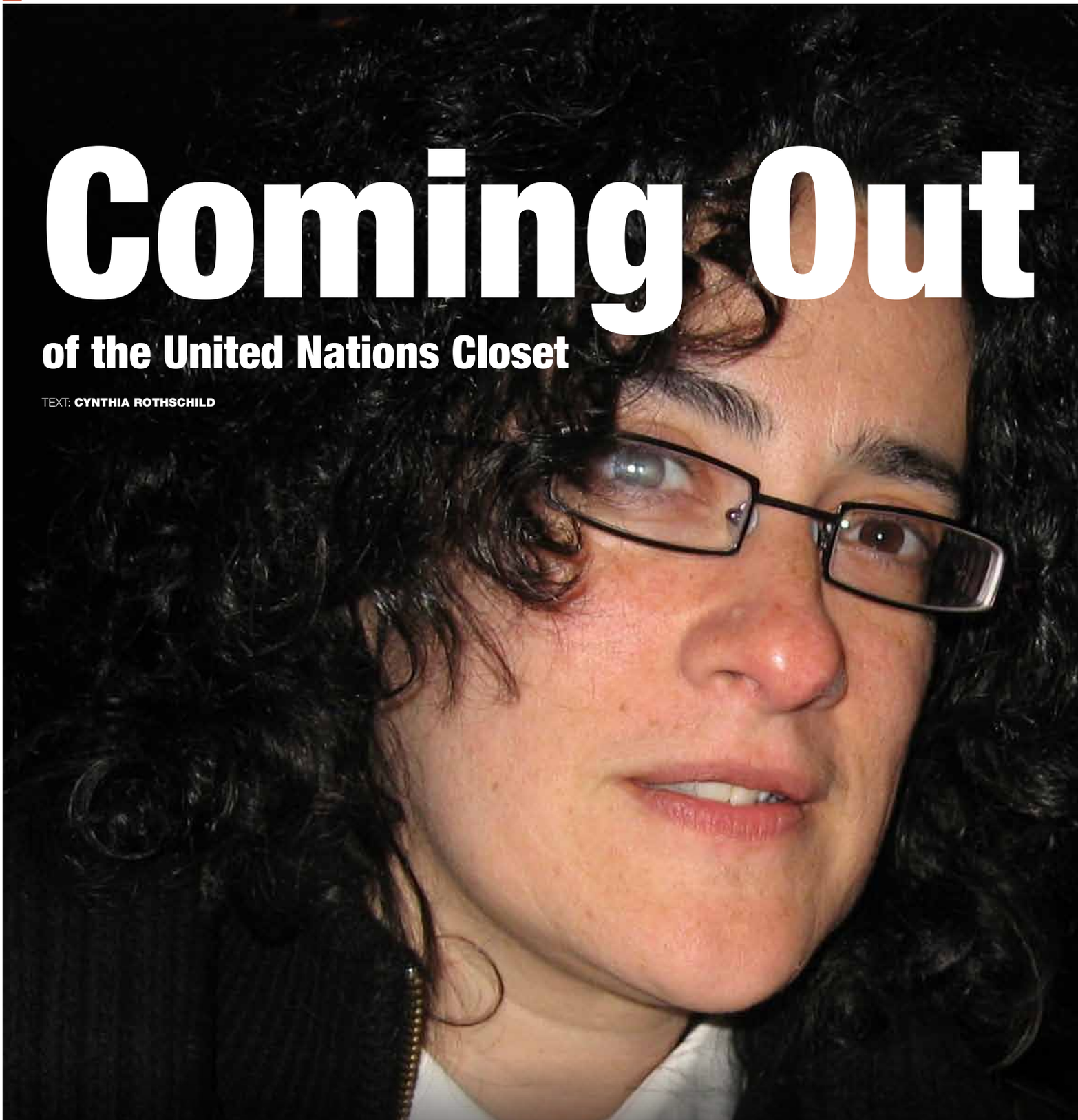
Coming Out

of the United Nations Closet

TEXT: **CYNTHIA ROTHSCHILD**



IN DECEMBER OF 2011 the Office of the High Commissioner for Human Rights released the first-ever report from the entire UN system on violence and discrimination related to real – or even perceived - sexual orientation and gender identity. This doesn't mean that the UN system hasn't ever addressed these issues – in fact quite the opposite is true: there is an 18 year trend of evolving attention from UN treaty bodies and independent experts called "special rapporteurs" that has been integrated into their other areas of focus.

BUT IN 2011, THE MAIN human rights arm of the UN (the Office of the High Commissioner for Human Rights) was tasked for the first time to conduct research and produce a report on the mounting body of evidence from around the world that shows, quite simply, that people are killed, tortured, raped, arrested and denied health care, employment and education because of who they are, who they are seen to be, or, in some instances, because of who they choose to love.

LONG OVERDUE, THE slim twenty-four page UN document [hyperlink] "Study of discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity", has its roots in a process that also was late in coming: in June of 2011, the UN Human Rights Council adopted the first-ever resolution to focus solely on violence and discrimination based on sexual orientation and gender identity (often called "SOGI"). The process was controversial, yet forward-thinking ideology prevailed as Council member states agreed to adopt a resolution put forward by South Africa that called for the research and report, and then an official follow up Council session, which took place in March 2012.

THAT GROUNDBREAKING panel was the first high level official SOGI session ever held

« **There is great need** for lesbian-specific deeper work, more consistent research, and more nuanced analysis, including on asylum issues, torture, "private" acts of violence by "non-state actors", on experiences of young lesbians (and LGBT people, generally) and discrimination lesbians face in housing, education, and health care arenas. »

by the UN system. In United Nations terms, this is breakneck speed for a set of issues deemed by some governments to be "too controversial" to be surfaced in these spaces. And, of course, advocates and ally states have long thought these issues were rendered invisible for too many years.

UN SECRETARY GENERAL Ban Ki Moon gave a very moving video introduction to the panel, and the High Commissioner for Human Rights, Navi Pillay, addressed the full house in March. With their participation, the UN human rights machinery has come out of the UN closet: there's no turning back now.

ALTHOUGH CALLING FOR a report and convening a panel seem so moderate, in the political universe of global governance, these were bold demands. In fact, they were bold enough that more conservative states used the opportunity to rebel: after opposing the June resolution that simply acknowledged that people face violence and discrimination because of sexual orientation and gender identity, some actually staged a mildly entertaining walk out of the Council panel.

THE REPORT, WHICH I made contributions to, rests on previously documented experiences of lesbians, gay men, bisexuals and transgender (LGBT) people. But the report also speaks to gender-non-conforming people who do not claim those identities or labels. It argues that people are targeted for violence as severe as torture and the death penalty and various forms of discrimination because they are not seen to fit gender norms, including those related to physical appearance.

THE STUDY MAKES such simple but powerful claims: First, LGBT people, and lesbians within that group, exist. We are targeted for various violations - sometimes those abuses are at the hands of family members or police. We experience discrimination in health care, schools and in employment. Our organizing and advocacy are interrupted through police raids on our offices, or made illegal, as in when our organizations are not officially allowed to register with the state. And, of course, LGBT activists, or "defenders" of rights, are harassed and targeted for attacks, some of which result in death.

OVERALL, THE REPORT isn't gender specific, yet much of the lesbian-specific information that UN entities have addressed is captured in it. Lesbian cases are woven throughout, as are women-specific issues, such as forced pregnancy. Abuses that more frequently occur with women as targets, such as forced marriage, and rape (including in marriage) are also highlighted.

THE REPORT NAMES sexism and gender inequality in both the global North and South as forces with great impact on people's day-to-day experience. Notably, trends of violence that are often inadequately punished include killings of lesbians, and attacks in the home. In fact, one important contribution the SOGI report makes is in the elaboration about violence perpetrated by family and community members; it's in this so-called "private" sphere where women are most at risk of abuses. The report argues that where patterns of these abuses take place, the state must be held accountable, including in preventing future attacks and punishing perpetrators.

MANY UN REPORTS rest on information that has been previously generated by bodies within the UN. This presented a circular problem for this SOGI report: although there are now many LGBT references by treaty bodies and special rapporteurs, overall, this research has been spread over regions and time, and the result of either targeted advocacy by activists or the specific support of particular individuals serving in these UN-related roles. Since the Office of the High Commissioner for Human Rights has issued this official and more comprehensive report, that gap of inconsistency and relying on personal interest is beginning to be filled.

ONE THING REMAINS true, however: the UN system has not adequately addressed lesbian experience, with recent notable exceptions including the special rapporteur on violence against women and the CEDAW Committee, which measures state compliance with the Convention on the Elimination of All Forms of Discrimination Against Women. In a few other cases, lesbian identity and experience have been noted by other rapporteurs and treaty bodies.

THERE IS GREAT NEED for lesbian-specific deeper work, more consistent research, and more nuanced analysis, including on asylum issues, torture, "private" acts of violence by "non-state actors", on experiences of young lesbians (and LGBT people, generally) and discrimination lesbians face in housing, education, and health care arenas.

THE NEXT STEPS are for UN bodies, including OHCHR, to move beyond monolithic experiences of "LGBT" communities. Lesbian experience is sometimes different from that of gay men and trans people; there are sometimes added layers of sexism and misogyny that fuel violence and discrimination against lesbians (although I would argue that homophobia has roots in these forms of gender oppression, as well) and the UN ought to be better able to recognize these realities. The good news is that the trend in UN reporting on SOGI is unequivocally moving in the right direction. But it's now the responsibility of advocates to demand more work in this area, and greater nuance from governments and the UN system itself. □

Endelig jordmor!

30. mai i 2012 har dagen endelig kommet. To års studier er forbi, og 25 jenter tar eksamen ved jordmorutdanningen i Wardak. En av dem er Rogul. Hun er 20 år, og kommer fra det sentrale Chaki distriktet, et Taliban-dominert område og et av de mest utrygge distriktene i Wardak.

TEKST: **ELINA SILÉN OG HEIDE SOFIE KVANVIG, AFGHANISTANKOMITEEN I NORGE** FOTO: **AFGHANISTANKOMITEEN I NORGE**

I AFGHANISTAN ER barne- og mødredødeligheten skyhøy. En av hovedårsakene til de grufulle tallene er at kvinner ikke får oppfølging under graviditeten, eller kvalifisert hjelp under fødselen. En av elleve kvinner dør relatert til graviditet og fødsel. Ett av sju barn dør før fylte fem år. Likevel har det blitt bedre de siste årene. Før fikk bare 14 % hjelp av en jordmor, lege eller helsearbeider under fødselen. Nå er tallet 24 %. Kvinners forventede levealder har gått opp med 5 år. Barnedødeligheten har gått ned fra 200 dødsfall per 1000 levendefødte barn, til 149. Hovedårsaken til forbedringene er utdanning av helsearbeidere generelt, og utdanning av jordmødre spesielt. I 2003 fantes 500 jordmødre i Afghanistan. I dag er det 3000, men dette er på langt nær tilstrekkelig.

ALLE ROGULS STUDIEVENNINNER kommer fra ulike distrikter i Wardak-provinsen, bare en time utenfor Kabul. Provinsen regnes for å være både usikker og konservativ og er et vanskelig utgangspunkt for en jente som ønsker utdanning.

-Jeg ble fortalt om jordmorutdanningen for litt mer enn to år siden. Ansatte i Afghanistankomiteen i Norge kom til landsbyen jeg er fra for å rekruttere studenter til skolen. Alle snakket om det, og jeg ble veldig interessert. Jeg har alltid ønsket å jobbe med mennesker. Dette var også en mulighet til å gjøre en innsats for mitt lands fremtid. Jeg kommer fra en landsby som heter Pana. Der har Taliban sterkt fotfeste. Bare måneder før hadde de stengt skolen for jenter, og det fantes ikke noe alternativ hvis du ønsket utdanning. Før Afghanistankomiteen kom på besøk, forteller Rogul.

I BEGYNNELSEN VAR familien til Rogul helt imot tanken på at hun skulle studere. -Jeg er ikke sikker på hvorfor, kanskje fordi det betydde at jeg måtte bo et annet sted i hele to år. Det er ikke vanlig at jenter forlater landsbyen for å studere forteller Rogul. Det var en av brødrene hennes som støttet henne i å søke på utdanningen. -Jeg var også heldig fordi min mann var positiv. Men det var ikke hans familie. Der var alle imot det og det var en vanskelig situasjon, medgir hun.

Rogul fikk altså støtte fra både broren og mannen sin. I tillegg jobbet Afghan-

istankomiteen med å overbevise landsbyrådet om at jordmorutdanning var en god idé. Det var viktig for landsbyrådet å få forsikringer om at det var en god utdannelse, som respekterer islam og at skolen bare er for kvinner. Til slutt fikk hun tillatelse til å dra.

ROGUL SER PÅ DE to årene ved skolen som fantastiske. -Vi har lært så mange ting som ikke bare handler om jordmoryrket, men også helse generelt. Alle lærerne har vært gode, inspirerende og støttende. For å få praksis dro vi til Malaka Mohammed Khan Hospital to ganger i uken. Dette var det beste med studiene, å få erfaring med praktisk arbeid, å jobbe med virkelige mennesker og se hvordan vi som jordmødre kan hjelpe andre, sier hun.

NÅ ER FAMILIEN TIL Rogul verken for eller imot hennes studier. De sier lite om det, forteller hun. Snart skal hun tilbake til sitt distrikt for å jobbe som jordmor. Der har de en klinikk, men ingen lege. Grunnen er sikkerhetssituasjonen. Rogul forteller at Taliban ved flere anledninger har vandalisert klinikken. Både vinduer, dører og utstyr har blitt ødelagt. Det skremmer ikke Rogul. -Jeg vet at min jobb er viktig. Som jordmor kan jeg gjøre mye for mødre og barn, sier hun.

HUN SER VIKTIGHETEN av yrket sitt i et internasjonalt perspektiv. Hun er klar over statistikkene; at Afghanistan er blant landene i verden hvor risikoen for å dø i forbindelse med svangerskap og fødsel er størst.

-Mitt ønske er at flere skal forstå hvor viktig det er å utdanne jordmødre og gi flere jenter mulighet til å studere. Hvis du har en forkjølelse og treffer en lege for å få medisin, og han gir deg feil tabletter, er ikke det så farlig. Men hvis en jordmor gjør en feil, da kan moren eller barnet bli skadet eller dø. Det er viktig å utdanne jordmødre. Det er viktig med all utdanning for kvinner. Slik kan vi selv bidra til å utvikle vårt land, og gi oss selv en lysere fremtid, avslutter Rogul. □

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B

PostAbonnement

RETURADRESSE: FOKUS
STORGT. 11, 0155 OSLO

UN Photo/Martine Perret

Dette er FOKUS

■ FOKUS - Forum for Kvinner og Utviklingsspørsmål - er et kompetanse- og ressurssenter for internasjonale kvinnespørsmål med vekt på informasjonsformidling og kvinnerettet utviklingssamarbeid.

■ FOKUS' overordnede mål er å bidra til å bedre kvinners sosiale, økonomiske og politiske situasjon internasjonalt.

■ FOKUS prioriterer følgende tema områder:
Kvinner og klima, kvinners seksuelle og reproduktive helse og rettigheter, vold mot kvinner, kvinner, fred og sikkerhet, kvinners politiske deltakelse og rettigheter og kvinners økonomiske deltakelse og rettigheter.

■ FOKUS består av 74 organisasjoner. Det omfatter ulike typer kvinneorganisasjoner, diasporaorganisasjoner og kvinneutvalg i politiske partier, fagforbund, solidaritets- og bistandsorganisasjoner.

■ FOKUS er nasjonalkomité for FNs kvinneorganisasjon UN Women.

■ FOKUS ble formelt etablert i 1995 av 41 kvinneorganisasjoner i Norge, men opprinnelsen går tilbake til 1989 da kvinneorganisasjonene innledet et samarbeid rundt TV-aksjonen "Kvinner i den 3. verden". Med midler fra TV-aksjonen ble det opprettet et sekretariat som formidlet støtte til kvinneorganisasjoner i Norge som drev prosjektvirksomhet i samarbeid med søsterorganisasjoner i Sør.

■ I 2005 fikk FOKUS igjen tildelt TV-aksjonen ("Drømmefanger") denne gangen med tema vold mot kvinner

■ FOKUS' arbeid har basis i kvinneorganisasjoner i Norge sin kunnskap, arbeidsmetoder og mål. Dette grunnlaget brukes til å bygge partnerskap med søsterorganisasjoner internasjonalt og i land i Sør for å realisere kvinners rettigheter og bedre kvinners levekår. Dette er vårt bidrag til utvikling.

■ Hennes Kongelige Høyhet Kronprinsesse Mette-Marit er beskytter for FOKUS.

FOKUS
FORUM FOR KVINNER OG UTVIKLINGSSPØRSMÅL