

## Editorial

# Personal reflections 25 years after the International Conference on Population and Development in Cairo

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In my postgraduate training during the last years of the 80's, we had close to thirty hospital beds in a pavilion called "sépticas" (I). In Colombia, where abortion was completely penalized, the pavilion was mostly filled with women with insecure, complicated abortions. The focus we received was technical: management of intensive care; performance of hysterectomies, colostomies, bowel resection, etc. In those times, some nurses were nuns and limited themselves to interrogating the patients to get them to "confess" what they had done to themselves in order to abort. It always disturbed me that the women who left alive, left without any advice or contraceptive method. Having asked a professor of mine, he responded with disdain: "This is a third level hospital, those things are done by nurses of the first level".

Seeing so much pain and death, I decided to talk to patients, and I began to understand their decision. I still remember so many deaths with sadness, but one case in particular pains me: it was a woman close to being fifty who arrived with a uterine perforation in a state of advanced sepsis. Despite the surgery and the intensive care, she passed away. I had talked to her, and she told me she was a widow, had two adult kids and had aborted because of "embarrassment towards them" because they were going to find out that she had an active sexual life. A few days after her passing, the pathology professor called me, surprised, to tell me that the uterus we had sent for pathological

examination showed no pregnancy. She was a woman in a perimenopausal state with a pregnancy exam that gave a false positive due to the high levels of FSH/LH typical of her age. SHE WAS NOT PREGNANT!!! She didn't have menstruation because she was premenopausal and a false positive led her to an unsafe abortion. Of course, the injuries caused in the attempted abortion caused the fatal conclusion, but the real underlying cause was the social taboo in respect to sexuality.

I had to watch many adolescents and young women leave the hospital alive, but without a uterus, sometime without ovaries and with colostomies, to be looked down on by a society that blamed them for deciding to not be mothers. I had to see situation of women that arrived with their intestines protruding from their vaginas because of unsafe abortions. I saw women, who in their despair, self-inflicted injuries attempting to abort with elements such as stick, branches, onion wedges, alum bars and clothing hooks among others. Among so many deaths, it was hard not having at least one woman per day in the morgue due to an unsafe abortion.

During those time, healthcare was not handled from the biopsychosocial, but only from the technical (2); nonetheless, in the academic evaluations that were performed, when asked about the definition of health, we had to recite the text from the International Organization of Health that included these three aspects. How contradictory!

To give response to the health need of women and guarantee their right when I was already a professor, I began an obstetric contraceptive service in that third level hospital. There was resistance from the directors, but fortunately I was able to acquire international donations for the institution, which facilitated its acceptance. I decided to undertake a teaching career with the hope of being able to sensitize health professionals towards an integral focus of health and illness.

When the International Conference of Population and Development (ICPD) was held in Cairo in 1994, I had already spent various years in teaching, and when I read their Action Program, I found a name for what I was working on: *Sexual and Reproductive Rights*. I began to incorporate the tools given by this document into my professional and teaching life. I was able to sensitize people at my countries Health Ministry, and we worked together moving it to an approach of human rights in areas of sexual and reproductive health (SRH). This new viewpoint, in addition to being integral, sought to give answers to old problems like maternal mortality, adolescent pregnancy, low contraceptive prevalence, unplanned or unwanted pregnancy or violence against women. With other sensitized people, we began with these SRH issues to permeate the Colombian Society of Obstetrics and Gynecology, some universities, and university hospitals. We are still fighting in a country that despite many difficulties has improved its indicators of SRH.

With the experience of having labored in all sphere of these topics, we manage to create, with a handful of colleagues and friend at the Universidad El Bosque, a Master's Program in Sexual and Reproductive Health, open to all professions, in which we broke several paradigms. A program was initiated in which the qualitative and quantitative investigation had the same weight, and some alumni of the program are now in positions of leadership in governmental and international institutions, replicating integral models. In the Latin American Federation of Obstetrics and Gynecology (FLASOG, English acronym) and in the International Federation of Obstetrics and Gynecology (FIGO), I was able to apply my experience for many years in the SRH committees of these association to benefit women and girls in the regional and global environments.

When I think of who has inspired me in these fights, I should highlight the great feminist who have taught me and been with me in so many fights. I cannot mention them all, but I have admired the story of the life of Margaret Sanger with her persistence and visionary outlook. She fought throughout her whole life to help the women of the 20th century to be able to obtain the right to decide when and whether or not they wanted to have children (3). Of current feminist, I have had the privilege of sharing experiences with Carmen Barroso, Giselle Carino, Debora Diniz and Alejandra Meglioli, leaders of the International Planned Parenthood Federation - Western Hemisphere Region (IPPF-RHO). From my country, I want to mention my countrywoman Florence Thomas, psychologist, columnist, writer and Colombo-French feminist. She is one of the most influential and important voices in the movement for women rights in Colombia and the region. She arrived from France in the 1960's, in the years of counterculture, the Beatles, hippies, Simone de Beauvoir, and Jean-Paul Sartre, a time in which capitalism and consumer culture began to be criticized (4). It was then when

they began to talk about the female body, female sexuality and when the contraceptive pill arrived like a total revolution for women. Upon its arrival in 1967, she experimented a shock because she had just assisted in a revolution and only found a country of mothers, not women (5). That was the only destiny for a woman, to be quiet and submissive. Then she realized that this could not continue, speaking of "revolutionary vanguards" in such a patriarchal environment.

In 1986 with the North American and European feminism waves and with her academic team, they created the group "Mujer y Sociedad de la Universidad Nacional de Colombia", incubator of great initiatives and achievements for the country (6). She has led great changes with her courage, the strength of her arguments, and a simultaneously passionate and agreeable discourse. Among her multiple books, I highlight "Conversaciones con Violeta" (7), motivated by the disdain towards feminism of some young women. She writes it as a dialogue with an imaginary daughter in which, in an intimate manner, she reconstructs the history of women throughout the centuries and gives new light of the fundamental role of feminism in the life of modern women. Another book that shows her bravery is "Había que decirlo" (8), in which she narrates the experience of her own abortion at age twenty-two in sixty's France.

My work experience in the IPPF-RHO has allowed me to meet leaders of all ages in diverse countries of the region, who with great mysticism and dedication, voluntarily, work to achieve a more equal and just society. I have been particularly impressed by the appropriation of the concept of sexual and reproductive rights by young people, and this has given me great hope for the future of the planet. We continue to have an incomplete agenda of the action plan of the ICPD of Cairo but seeing how the youth bravely confront the challenges motivates me to continue ahead and give my years of experience in an intergenerational work.

In their policies and programs, the IPPF-RHO evidences great commitment for the rights and the SRH of adolescent, that are consistent with what the organization promotes, for example, 20% of the places for decision making are in hands of the young. Member organizations, that base their labor on volunteers, are true incubators of youth that will make that unassailable and necessary change of generations. In contrast to what many of us experienced, working in this complicated agenda of sexual and reproductive health without theoretical bases, today we see committed people with a solid formation to replace us. In the college of medicine at the Universidad Nacional de Colombia and the College of Nursing at the Universidad El Bosque, the new generations are more motivated and empowered, with great desire to change the strict underlying structures.

Our great worry is the onslaught of the ultra-right, a lot of times better organized than us who do support rights, that supports anti-rights group and are truly pro-life (9). Faced with this scenario, we should organize ourselves better, giving battle to guarantee the rights of women in the local, regional, and global level, aggregating the efforts of all pro-right organizations. We are now committed to the Objectives of Sustainable Development (IO), understood as those that satisfy the necessities of the current generation without jeopardizing the capacity of future generations to satisfy their own necessities. This new agenda is based on:

- The unfinished work of the Millennium Development Goals
- Pending commitments (international environmental conventions)
- The emergent topics of the three dimensions of sustainable development: social, economic, and environmental.

We now have 17 objectives of sustainable development and 169 goals (III). These goals mention "universal access to reproductive health" many times. In objective 3 of this list is included guaranteeing, before the year 2030, "universal access to sexual and reproductive health services, including those of family planning, information, and education." Likewise, objective 5, "obtain gender equality and empower all women and girls", establishes the goal of "assuring the universal access to sexual and reproductive health and reproductive rights in conformity with the action program of the International Conference on Population and Development, the Action Platform of Beijing". It cannot be forgotten that the term *universal access* to sexual and reproductive health includes *universal access* to abortion and contraception.

Currently, 830 women die every day through preventable maternal causes; of these deaths, 99% occur in developing countries, more than half in fragile environments and in humanitarian contexts (12). 216 million women cannot access modern contraception methods and the majority live in the nine poorest countries in the world and in a cultural environment proper to the decades of the seventies (13). This number only includes women from 15 to 49 years in any marital state, that is to say, the number that takes all women into account is much greater. Achieving the proposed objectives would entail preventing 67 million unwanted pregnancies and reducing maternal deaths by two thirds. We currently have a high, unsatisfied demand for modern contraceptives, with extremely low use of reversible, long term methods (intrauterine devices and subdermal implants) which are the most effect ones with best adherence (14).

There is not a single objective among the 17 Objectives of Sustainable Development where contraception does not have a prominent role: from the first one that refers to ending poverty, going through the fifth one about gender equality, the tenth of inequality reduction among countries and within the same country, until the sixteenth related with peace and justice. If we want to change the world, we should procure universal access to contraception without myths or barriers. We have the moral obligation of achieving the irradiation of extreme poverty and advancing the construction of more equal, just, and happy societies.

In emergency contraception (EC), we are very far from reaching expectations. If in reversible, long-term methods we have low prevalence, in EC the situation gets worse. Not all faculties in the region look at this topic, and where it is looked at, there is no homogeneity in content, not even within the same country. There are still myths about their real action mechanisms. There are countries, like Honduras, where it is prohibited and there is no specific medicine, the same case as in Haiti. Where it is available, access is dismal, particularly among girls, adolescents, youth, migrants, afro-descendent, and indigenous. The multiple barriers for the effective use of emergency contraceptives must be knocked down, and to work toward that we have to destroy myths and erroneous perceptions, taboos and cultural norms; achieve changes in laws and restrictive rules within countries, achieve access without barriers to the EC; work in union with other sectors; train health personnel and the community. It is necessary to transform the attitude of health personal to a service above personal opinion.

Reflecting on what has occurred after the ICPD in Cairo, their Action Program changed how we look at the dynamics of population from an emphasis on demographics to a focus on the people and human rights. The governments agreed that, in this new focus, success was the empowerment of women and the possibility of choice through expanded access to education, health, services, and employment among others. Nonetheless, there have been unequal advances and inequality persists in our region, all the goals were not met, the sexual and reproductive goals continue beyond the reach of many women (15). There is a long road ahead until women and girls of the world can claim their rights and liberty of deciding. Globally, maternal deaths have been reduced, there is more qualified assistance of births, more contraception prevalence, integral sexuality education, and access to SRH services for adolescents are now recognized rights with great advances, and additionally there have been concrete gains in terms of more favorable legal frameworks, particularly in our region; nonetheless, although it's true that the access condition have improved, the restrictive laws of the region expose the most vulnerable women to insecure abortions.

There are great challenges for governments to recognize SRH and the DSR as integral parts of health systems, there is an ample agenda against women. In that sense, access to SRH is threatened and oppressed, it requires multi-sector mobilization and litigation strategies, investigation and support for the support of women's rights as a multi-sector agenda.

Looking forward, we must make an effort to work more with youth to advance not only the Action Program of the ICPD, but also all social movements. They are one of the most vulnerable groups, and the biggest catalyzers for change. The young population still faces many challenges, especially women and girls; young girls are in particularly high risk due to lack of friendly and confidential services related with sexual and reproductive health, gender violence, and lack of access to services. In addition, access to abortion must be improved; it is the responsibility of states to guarantee the quality and security of this access. In our region there still exist countries with completely restrictive frameworks.

New technologies facilitate self-care (I6), which will allow expansion of universal access, but governments cannot detach themselves from their responsibility. Self-care is expanding in the world and can be strategic for reaching the most vulnerable populations. There are new challenges for the same problems, that require a re-interpretation of the measures necessary to guaranty the DSR of all people, in particular women, girls, and in general, marginalized and vulnerable populations. It is necessary to take into account migrations, climate change, the impact of digital media, the resurgence of hate discourse, oppression, violence, xenophobia, homo/transphobia, and other emergent problems, as SRH should be seen within a framework of justice, not isolated.

We should demand accountability of the 179 governments that participate in the ICPD 25 years ago and the 193 countries that signed the Sustainable Development Objectives. They should reaffirm their commitments and expand their agenda to topics not considered at that time. Our region has given the world an example with the Agreement of Montevideo, that becomes a blueprint for achieving the action plan of the CIPD and we should not allow retreat. This agreement puts people at the center, especially women, and includes the topic of abortion, inviting the state to consider the possibility of legalizing it, which opens the doors for all governments of the world to recognize that women have the right to choose on maternity. This agreement is much more inclusive:

Considering that the gaps in health continue to abound in the region and the average statistics hide the high levels of maternal mortality, of sexually transmitted diseases, of infection by HIV/AIDS, and the unsatisfied demand for contraception in the population that lives in poverty and rural areas, among indigenous communities, and afro-descendants and groups in conditions of vulnerability like women, adolescents and incapacitated people, it is agreed:

33. To promote, protect, and guarantee the health and the sexual and reproductive rights that contribute to the complete fulfillment of people and social justice in a society free of any form of discrimination and violence.

37. Guarantee universal access to quality sexual and reproductive health services, taking into consideration the specific needs of men and women, adolescents and young, LGBT people, older people and people with incapacity, paying particular attention to people in a condition of vulnerability and people who live in rural and remote zone, promoting citizen participation in the completing of these commitments.

42. To guarantee, in cases in which abortion is legal or decriminalized in the national legislation, the existence of safe and quality abortion for non-desired or non-accepted pregnancies and instigate the other States to consider the possibility of modifying public laws, norms, strategies, and public policy on the voluntary interruption of pregnancy to save the life and health of pregnant adolescent women, improving their quality of life and decreasing the number of abortions (I7).

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