

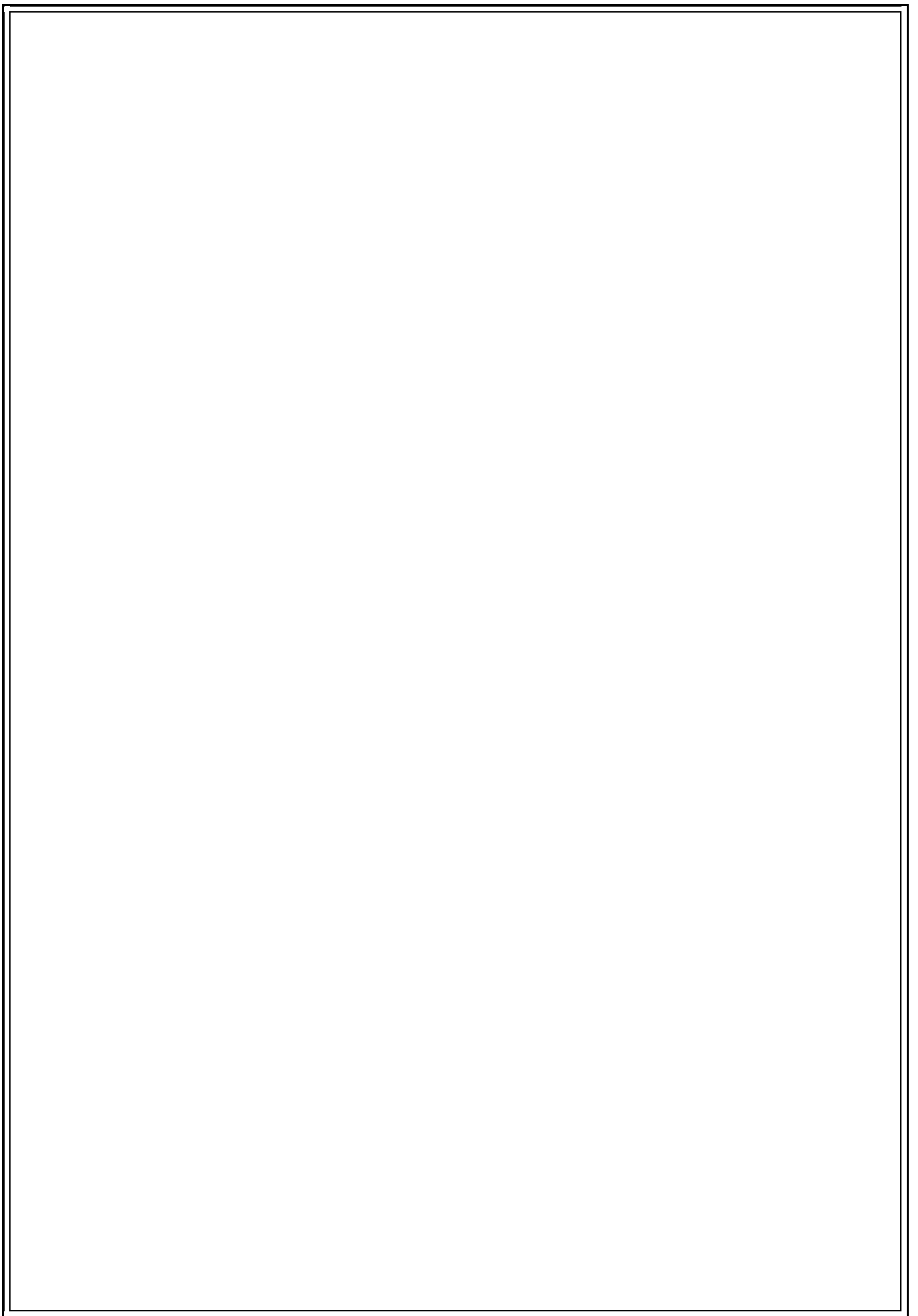
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF YOUNG PEOPLE

A Rights-Based Perspective

This Charter is the result of a Study Session, entitled
*“Improving the Health of Young People in Europe:
Towards a Sexual Health Strategy”*,
organised by YouAct, the European Youth Network for Sexual and
Reproductive Rights, in co-operation with the Directorate of Youth and
Sport of the Council of Europe, in July 2008.



This charter gives an account of various aspects of the Study Session. It has been produced by and is the responsibility of the Educational Team of the Study Session and of YouAct. It does not represent the official point of view of the Council of Europe.



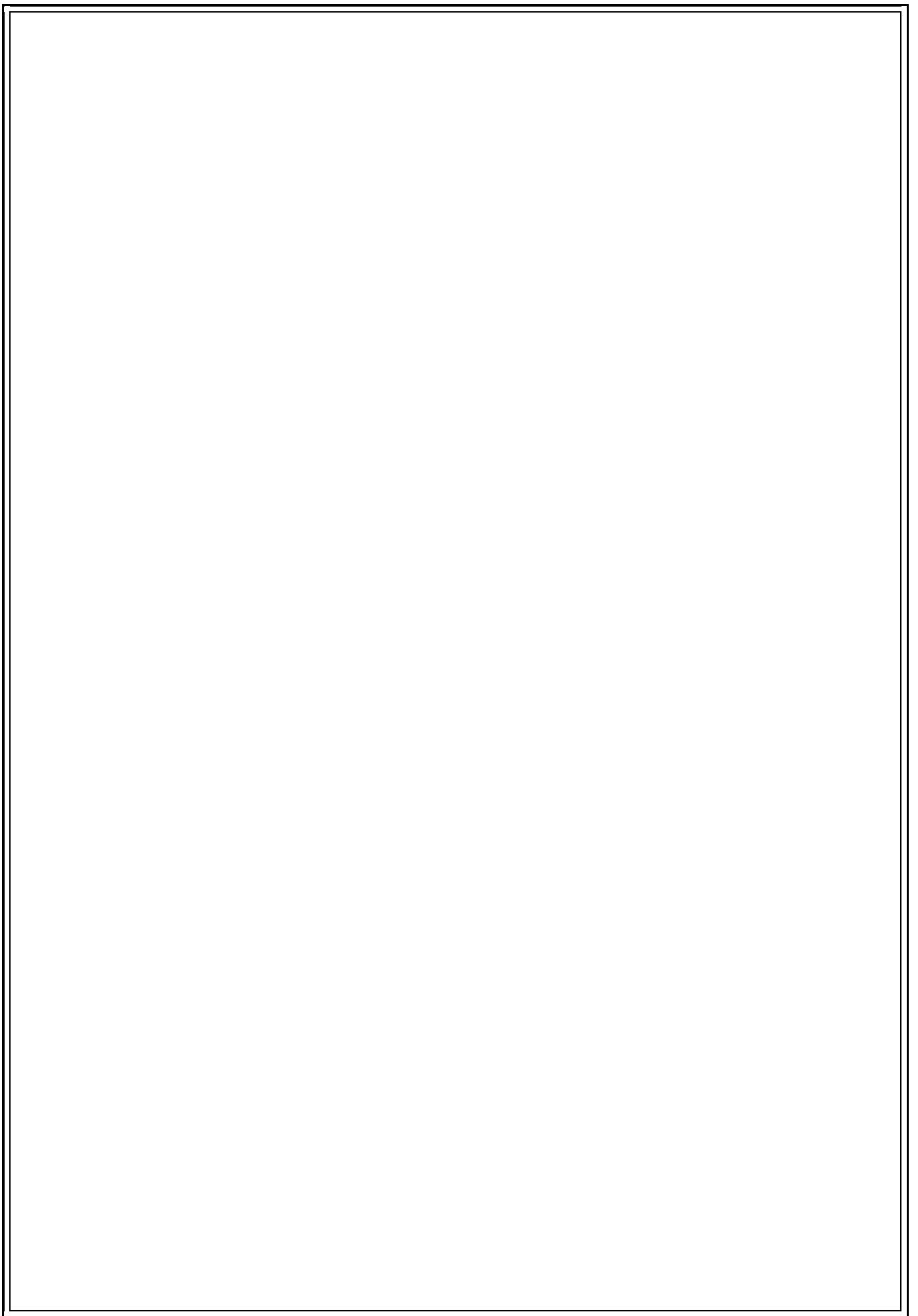
YouAct - Charter

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Introduction

The idea to host a Study Session, which served as the basis for the present Charter originated from a very successful previous YouAct Study Session held in Budapest in 2006 on “Young People’s Intercultural Dialogue on Sexuality, Politics and Human Rights”. One of the conclusions of this previous Study Session was that the linkage between sexual rights and human rights needs to be addressed, discussed and highlighted, and finally put in writing in a positive, youth friendly manner and language. Hence, the idea of a Charter for young people’s SRHR was born. The Study Session, entitled “*Improving the Health of Young People in Europe: Towards a Sexual Health Strategy*” was prepared by a team of YouAct members and the YouAct Executive Coordinator, in co-operation with the Directorate of Youth and Sport of the Council of Europe, it took place from 6-12 July 2008, in Strasbourg/France.

The main goal of this Study Session was to gather young Europeans active in the field of Sexual and Reproductive Health and Rights (SRHR), or Human Rights, and compose a Charter that depicts young Europeans’ experiences, needs, ideas and visions concerning SRHR. The objectives of the study session were:

- To explore the current instruments available on SRHR and Human Rights and discuss their usefulness for current support for SRHR
- To explore the concept of human rights and familiarise oneself with the United Nations and Council of Europe Human rights systems and the most important Human Rights instruments
- To discuss Sexual and Reproductive Health and Rights issues from a Human Rights perspective
- To share SRHR related knowledge and experience with other participants
- To discuss and set future strategies to implement the Charter based on the communications and advocacy experience of participants

Twenty seven (27) young people, including YouAct members, and other young individuals working professionally or volunteering for SRHR or human rights causes, from 15 countries of the Council of Europe took part in this Study Session. Through realization of the objectives outlined above, the young people laid the foundations for the present Charter, which was subsequently to form the unified document that you have in your hands.

This Charter will serve as an advocacy and awareness raising tool on SRHR of young people for the European community, at national, European and international levels. It is to be used by young people, NGOs, and other advocates working with SRHR in Europe.

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Executive Summary

Sexual and Reproductive Health and Rights (SRHR) are an integral part of Human Rights, and of particular importance to young people. Several human rights documents include direct or indirect references to SRHR, yet no unified document exists that addresses SRHR from a youth perspective. This Charter has been composed by young people from the Council of Europe, to reflect our common visions about SRHR, from a human rights perspective, in the context of a Study Session organised by YouAct, European Youth Network for Sexual and Reproductive Rights, and the Council of Europe Directorate of Youth and Sport.

Although we come from different countries, our vision, values, and beliefs are similar. Our common vision focuses on the promotion of well-being regarding sexuality, rather than merely on disease prevention and treatment. We call for changes within the context of each of our countries, changes that will involve the commitment and contribution of governments, non-governmental organisations (NGOs), educational and academic institutions, healthcare providers, and other stakeholders, to enable SRHR to move toward the direction of our vision. We deal with 11 specific topics in SRHR that we consider important, and give our perceived needs and long term vision, based on human rights principles.

Firstly, we stress the imperative of Meaningful Youth Participation (MYP) in Sexual and Reproductive Health and Rights, as a universal human right of young people. We consider current youth involvement to be insufficient, and call for changes to ensure that young people are involved in the design, implementation, monitoring, and evaluation of programs targeting young people. Access to comprehensive information, tools for comprehensive peer education, and treatment as equal partners in all endeavours, are required to equip young people with the power and skills necessary to shape and express their own opinions. In order for young people to be actively involved in the

fulfilment of their rights, MYP should be supported financially, and mutual trust and respect between young people and adults should be restored.

We are aware that people's understanding of gender and sexuality varies between and within cultures, and during different historical periods. Nowadays, the world encounters several forms of gender discrimination, including gender based violence, pressure to conform to traditional gender roles, restrictions on family planning choices, and discrimination based on sexual orientation. In order to ensure Gender Equality and Non-Discrimination for all, we call for an approach that aims to eliminate gender based discrimination that involves analysis of different influences such as age, class, ethnicity, sexual orientation, and other individual characteristics. All individuals should be free from all forms of gender based discrimination, SRHR for young people should be achieved through evidence based, Comprehensive Sexuality Education (CSE) and safeguarding of rights. States should provide education and encourage discussions concerning sexuality and gender equality. Sexual enjoyment and wellbeing should be emphasised in the SRHR discourse.

Gender Based Violence is a major public health and human rights issue throughout the world. Gender based violence can impair the psychological or physical health of an individual, and may lead to adverse physical or psychological outcomes. Gender based violence includes, but is not limited to, intimate partner violence, culture based violence, violence perpetrated or condoned by the State and sexual harassment. It is necessary to provide information on the different forms of gender based violence in order for people to be able to recognise them, report them and receive the required services for prevention and protection. We envision a future free from all forms of gender based violence. We call for special attention to be paid to violence resulting from harmful traditional or cultural practices. States should develop and implement a legal framework against gender based violence. We call for States to provide freely accessible trainings and workshops for all individuals in the field of gender based violence and gender equality, and to be held

accountable to safeguard the rights and safety of victims of gender based violence and individuals in marginalised groups.

Young people throughout Europe come from broad backgrounds of ethnicity, culture, economic situations, and physical abilities. This contributes to diverse sexual identities and therefore different needs and demands. Young Individuals in Marginalized Groups may include asylum seekers, refugees, people living with HIV, Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning (LGBTIQ) people, people living with physical or mental disabilities, people in imprisonment, sex workers, drug users and people in rural areas. The Universal Declaration of Human Rights (1948) states that everyone is entitled to the same human rights. Yet, in Europe, many young people do not have the same opportunities as others of the same age within their countries, or between different countries. The lower social and economic status of marginalised groups may hinder the attainment of equal rights. To achieve the same rights for all young people it is of utmost priority that young people in marginalised groups are ensured access to services, and SRHR-related information and education. We therefore encourage States to use, where necessary, special provisions such as specific funding, targeted marketing of services to ethnic minorities, special language provisions and outreach services in order to promote equality in the SRHR situation for individuals in marginalised groups.

The term LGBTIQ refers to Lesbian, Gay, Bisexual, Transgender, Intersex and Questioning individuals. Sexual orientation is different from sexual behaviour, as it refers to feelings and an individual's concept of self. LGBTIQ issues are often considered controversial; a common misconception is that LGBTIQ people claim "special" rights. On the contrary, LGBTIQ people only claim the realisation of equal rights as those given to heterosexual people. Many States and societies do not recognise LGBTIQ sexual activity as morally equal to heterosexual sexual activity. Nowadays LGBTIQ people often experience prejudice and discrimination both from States and from individual persons or groups. This stigma and discrimination may lead to stress and mental health problems. Many common misconceptions about LGBTIQ

people contribute to prejudice, and need to be dispelled. Whereas LGBTIQ people desire and have committed relationships, and whereas empirical research evidence shows that LGBTIQ people are as likely as heterosexual parents to be good parents, the right to form a family remains one of the several rights of LGBTIQ people that are not respected in many European States. Treatment should ensure full protection of human rights for all individuals regardless of age or sexuality.

Families, Partnership and Childcare constitute organisations of society where gender roles are often clearly defined, ranging from traditional forms to more modern and diverse forms. Young men and women may face unequal opportunities and practices during the development of their sexuality and their opportunities reaching the related information. Young people need to receive comprehensive, evidence-based education regarding childcare, contraception and family planning issues, and sexuality. Comprehensive information and education in issues pertaining to partnership, marriage, families and parenthood should be available to individuals at an early age, starting from childhood, to empower choice and awareness while individuals are adopting their roles and status in the society.

The sexual and reproductive lives of young people should also be respected in the context of Employment. Young people often lack access to adequate information regarding their employment rights, and therefore might face difficulties in their daily working life. Women still have unequal access to employment and career advancement compared to men. For example, employers may exclude women, or discriminate against them, on the mere assumption or expectation of childbearing and motherhood. Discrimination can be both direct and indirect and varies between countries. Stereotypes, sexual and gender based harassment, and the creation of hostile environments for women also restrict the realisation of gender equality in the workplace. We envision a future where every workplace is free from any direct or indirect discrimination, including any form of sexual or gender related harassment. We call for equal rights to parental leave for women as well as

for men and, for adequate access to pre-natal and post-natal medical care for all employees.

Sexually Transmitted Infections (STIs) including HIV/AIDS appear to be on the rise in several parts of the world, and disproportionately affect young people. STIs can lead to further, often lifelong, complications, including infertility and cancers, and exacerbate the burden – economic, physical and psychological – on individuals as well as health care systems. A comprehensive, effective approach to dealing with STIs should respect the individual's fundamental rights to health, education, privacy and confidentiality, and non-discrimination, as well as the right to labour. The provision of comprehensive sexuality education, peer-to-peer education, by trained providers, is imperative, and States should be considered accountable for the provision of such education. Professional and confidential STI-related clinical and counselling services should be provided free of charge without requirement for parental consent, and be accessible to all young people, in a youth-friendly manner. States should ensure access to free provider-initiated and client-initiated HIV testing, and provide pre- and post- test counselling, and support groups, with appropriate follow ups. The involvement of young people, and people living with HIV/AIDS is necessary at all stages. At the same time, the necessary financial commitments and legal protections should be in place to ensure that services are available and of the highest quality for all. Data collection should be mandatory for all health and service providers, in a manner that ensures anonymity and confidentiality, but at the same time ensures adequate epidemiological monitoring for STIs. Our vision in relation to dealing with STIs is for everyone to have access to comprehensive information and education on sexuality, so as to be able to make informed choices about their sexuality, free from any cultural, social, or other bias; for everyone to have free access to all preventative measures, including contraceptive technologies, diagnosis, treatment options, and vaccination, including the Human Papilloma Virus (HPV) vaccine. We envision a future that is free from stigma and discrimination, and where young people can enjoy equal rights to employment, education, and sexuality, irrespective of STI or HIV status.

SRHR services and Contraception should be available to all individuals, not only married couples, as is often the case in several countries. Earlier sexual debut in combination with lack of credible and comprehensive information on SRHR for young people often result in increases in unsafe sexual practices and STIs. We envision a future where non-directive sexuality counselling is available and accessible to all young people, without any discrimination based on race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity, disability or other characteristic. The rights of marginalised or vulnerable groups should be protected through additional efforts to ensure that access to information and services reaches such groups. Contraceptive options provided should be comprehensive, and include barrier methods, including condoms and femidoms, and emergency contraception without requiring medical prescription. Information, education, and services, should be provided in a manner that is professional, confidential, and value-free, free from any coercion or pressure, and is comprehensive, including demonstrations of proper use of contraceptive methods.

Although the effectiveness of Comprehensive Sexuality Education (CSE) in reducing risky behaviour and STI transmission has been repeatedly demonstrated in numerous scientifically rigorous, peer-reviewed published studies, many young people do not receive any sexuality education, or receive sexuality education that is inadequate, or biased, rather than comprehensive. Contrary to CSE, such approaches to sexuality education, particularly abstinence-based approaches, have received little or no evidence with regards to their effectiveness. We envision a future where CSE is provided to all young people by trained professionals through both formal and informal venues, addresses all issues pertaining to puberty, sexuality, available contraception options, and SRHR, and empowers young people to gain knowledge, develop negotiation skills, life skills, and make informed choices. Young people, along with experts, NGOs, educators, and policy-makers should be involved in the process of designing such programmes, while adequate monitoring and evaluation should be warranted.

Unwanted pregnancies often result from lack of CSE, inadequate contraceptive and sexual health services, and often relate to restrictive regulations or social norms. Comprehensive provision of high quality services is essential for prevention of unwanted pregnancies. In order to guarantee women's right to reproductive choice, and minimise the risks women over the world face on a daily basis by unsafe and illegal abortions, States should provide access to safe, legal, affordable, appropriate, and acceptable abortion-related services for all women. Such services should be provided with complete confidentiality, and in cases of underage women, confidentiality should also cover the disclosure of such information to guardians or partners. Abortion-related counselling services should be available and accessible in a non-directive manner, respecting the right to self-determination, and taking into account the particular needs of young people. We envision a future where access to high quality abortion-related services is universal, free of charge, for all women, including youth, students, immigrants, minorities, or marginalised groups.

Many issues pertaining to SRHR, including those addressed in the present Charter, are, in several societies, considered controversial or even taboo. We urge for increased discourse on these issues, in order to enable effective communication of the needs of all people, including young people, and the implementations of steps that will enhance well-being in relation to sexual and reproductive health, and respect the sexual and reproductive rights of all people. We call for the collaboration between all stakeholders, including young people, the civil society, decision-makers, educators, and health care providers, in order to enable movement toward the realisation of our vision. We want to see equal realisation of all the rights delineated in this Charter for all groups and individuals.

The Executive Summary was prepared by Margarita Kapsou & Constantina Panayi

“Sometimes young people are ashamed to talk about sexuality or sex, but they are not ashamed to practise it. I would like to change that.”

Peer educator, Youth Centre “In Corpore”, Lithuania.

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Foreword

This Charter was prepared and developed by 27 young people from 15 countries from the Council of Europe. This took place during a study session organised by YouAct, European Youth Network for Sexual and Reproductive Rights, and the Directorate of Youth and Sport of the Council of Europe, between the 6th and the 12th of July 2008.

This Charter outlines the current situation of Sexual and Reproductive Health and Rights throughout Europe. It also establishes a common vision for this field, and guidelines to achieve this vision.

The Chapters below use a rights-based approach emphasising the universality of Human Rights specifically in the field of sexual health. The implementation of these guidelines will contribute to the enhancement of the sexual wellbeing of young people throughout Europe and increasingly enable them to take informed decisions with regards to their sexuality. We call upon the States and Civil Societies to seriously consider including the suggestions we present here when designing and implementing their policies.

This Charter also constitutes a common tool that will help unify the various efforts of young activists working on youth participation, public health, non-discrimination and other related issues. Its use will facilitate progress in attaining this common vision. We encourage young people throughout Europe to use of this document and help make a difference.

**SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
OF YOUNG PEOPLE**

A Rights-Based Perspective

**PART I.
INTRODUCTION
& KEY DEFINITIONS**

1. INTRODUCTION

We have today the largest generation of young people ever in the world, with a number that reaches 1.5 billion¹. Many of these young people are deprived of their human right to access health services concerning sexuality and reproduction. [Sexual and Reproductive Health and Rights](#) (SRHR) are an integral part of human rights and of particular importance to young people.

This Charter has been developed by 27 young people from 15 different European countries^a who work and volunteer in the field of SRHR, and who came together during the Study Session: *“Improving the Health of Young People in Europe: Towards a Sexual Health Strategy”*, between the 6th and the 12th of July 2008, in Strasbourg, France. The Study Session was organised by [YouAct](#), [European Network for Sexual and Reproductive Health and Rights](#), in cooperation with the [Directorate of Youth and Sport of the Council of Europe](#). This Charter aims to address the SRHR needs of young people in Europe.

Recent research indicates substantial differences among European countries on issues pertaining to SRHR. For instance, there are differences between countries concerning the availability of legal and freely accessible [abortions](#), as well as considerable variations between countries in the availability and access to SRHR information and services. Furthermore, 10 out of 26 Western and Central European countries apply restrictions to the availability of abortion services². Additionally, almost half of the European Union member states have not officially adopted minimum standards for sexuality education in schools. It should also be noted that the age at which a child or adolescent is exposed to sexuality education varies from 5 to 14³.

^a The 15 countries represented by the participants of the Study Session were the following (in alphabetical order): Armenia, Azerbaijan, Bulgaria, Cyprus, Czech Republic, Finland, Former Yugoslavian Republic of Macedonia (FYROM), Georgia, Lithuania, Malta, Norway, Sweden, The Netherlands, Turkey, The United Kingdom.

At the same time, young people across Europe share a common concern for the universality of SRHR, including some of its most sensitive issues. This Charter emphasises a human rights-based approach, which stresses the universality of human rights for all young people, and calls for the respect and safeguarding of these rights throughout Europe.

Previous international agreements have addressed important aspects of SRHR as human rights. Our aim here is to expand on these efforts, and fill gaps in the documentation, by providing a document that adds to the existing ones by using language that is more progressive, by including explicit references to the needs of youth as perceived by young people themselves, and by articulating the vision of young people living in the European region, for societies that fully meet the SRHR of all individuals. Unlike previous documents, this Charter aims to address sexual well-being and enjoyment, not merely, or primarily, the elimination of ill-health, disease, or injustice regarding sexuality. In order to achieve this, it is necessary to address norms restricting sexual life as fully as possible. This is something that we, young Europeans working on this Charter, feel has not been sufficiently realised in previous documents. At the same time, we as young people are aware and worried about the limited access to [Comprehensive Sexuality Education](#) (CSE) and youth-friendly services, which inhibits young people's abilities to make informed decisions in regards to their sexual lives and health.

This Charter therefore clearly lists the rights, needs, interests and vision on a number of issues that we consider key to SRHR, namely: [Meaningful Youth Participation](#), [Gender Equality & Discrimination](#), [Gender Based Violence](#), [Young Individuals in Marginalised Groups](#), [LGTBIQ issues](#), [Families](#), [Partnership & Childcare](#), [Employment](#), [HIV/AIDS and Sexually Transmitted Infections](#), [SRHR Services and Contraception](#), [Comprehensive Sexuality Education](#), and [Abortion](#).

Coming from different countries, but with similar vision, values, and beliefs we call for changes within the context of each participating country. At the same time, we are striving to ensure the commitment - political, social, and financial

- by governments and other stakeholders, including inter-governmental and non-governmental organisations, potential donors, educational establishments and healthcare providers, to address the specific needs concerning SRHR are fully realised. Our aim is that this Charter be used as an advocacy tool to ensure the fulfilment of sexual and reproductive rights for young people.

The following section of this document addresses definitions of SRHR and young people as a target group. This is followed by chapters dealing with the rights and needs regarding the particular issues and themes mentioned before. The Charter is supplemented with an [Appendix](#) which defines key terms and references.

2. DEFINING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

We believe that it is necessary to define key terms that relate to [Sexual and Reproductive Health and Rights](#) (SRHR) from the perspective of young people in Europe. Several definitions for terms such as sexuality, sexual health, reproductive health and rights, have been proposed by various organisations and sources, including, among others, the [World Health Organisation](#) (WHO)⁴, the [United Nations](#) (UN)⁵, the [Programme of Action of the International Conference on Population and Development](#) (ICPD - PoA)⁶. In the present section, we use the WHO and ICPD definitions on key terms of SRHR as a background for discussing young people's perspective on SRHR. Our intent is to provide comprehensive definitions that reflect young people's conception of key terms in SRHR.

We are aware that various definitions have been proposed for what constitutes young people. For the purposes of the present Charter, we define young people as all individuals between 12 and 30 years of age.

Defining Sexual and Reproductive Health

Sexuality

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.”

(WHO working definition, 2002)⁷.

Sexual Health

“A state of physical, emotional, and mental well-being related to sexuality: not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

(WHO, working definition, 2002)⁸

Reproductive Health

“A state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of **family planning** of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.”

(WHO, working definition, 2002)⁸

Our views as young people

We believe that well-being in relation to sexuality is an essential component of any definition of sexual and reproductive health. It is therefore an important element in the definitions. Addressing the mere absence of disease or infirmity is not sufficient for ensuring sexual and reproductive health; however the achievement of satisfaction and well-being regarding sexuality is essential in order to achieve a complete state of health. Despite this emphasis on the positive framing and well-being dimension related to sexuality in the WHO definition, we argue that in practice there is not enough attention being paid to

the positive conceptualization of sexuality and the right of pleasure towards sexual life.

We endorse the WHO working definitions of sexual and reproductive health. In addition, we also call for more emphasis to be placed when setting any future goals related to promoting sexual and reproductive health and guiding practices and policies in the direction of promoting the positive, pleasurable elements of sexuality, including enjoyment and fulfilment.

We believe that the achievement of high quality sexual and reproductive health among individuals is necessary to one's overall well-being. We also emphasise the necessity of securing sexual and reproductive rights as a precondition to the full attainment of sexual and reproductive health. In order for these rights to be fully attained for all, adequate funding that ensures provision of [Comprehensive Sexuality Education](#) (CSE) and access to high quality services is required. These are human rights that belong to all individuals.

Defining Sexual and Reproductive Rights

Sexual Rights

“Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other international agreements. These include the right of all persons, free of coercion, discrimination and violence, to:

the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services, to seek and impart information in relation to sexuality, sexuality education, respect of bodily integrity, choice of partner, decide to be sexually active or not, consensual sexual relations, consensual marriage, decide whether or not and when to have children, pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.”

*(WHO, working definition 2002)*⁸

Reproductive Rights

Reproductive Rights embrace certain human rights that are already recognised in national laws, international human rights documents and other Reproductive Rights consensus documents. These rights rest on the recognition of the basic right for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so and the right to the highest attainable standard of sexual and reproductive health. They also include their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

(UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, Para 7.2)

Our views as young people:

In addition to the components of the definitions proposed by WHO and UN ICPD PoA on sexual rights and reproductive rights, we believe that these definitions should also include the rights of individuals to make informed choices regarding their sexual and reproductive lives. We therefore believe that sexual rights include the right to comprehensive, evidence-based sexuality education, as well as the right to decide not only whether or not and when to have children but also with whom.

Sexual and reproductive rights are closely interconnected and should be treated as such, in order to ensure the full attainment of the well-being of individuals. Sexual and reproductive rights are both considered as basic human rights.

Sexual and Reproductive Rights as Human Rights

Many important international rights declarations and conventions do not refer specifically to sexuality. However, the [*Universal Declaration of Human Rights \(1948\)*](#)¹¹ and the agreed treaties establish that human rights apply to everyone and that no one should be excluded⁹.

Considering that sexual rights are not explicitly stated in official documents and international agreements, we call upon the explicit inclusion of sexual rights in all official legal documents in the national and international level. We strongly argue that the inclusion of sexual rights is necessary in order to ensure the well-being of individuals.

Defining the Rights-Based Approach

“A rights-based approach shifts the focus and role of young people in programs from *recipients to actors*, empowering them to participate in decisions that affect their lives and emphasises the importance of choice and non-discrimination. A rights-based approach within programs would include efforts to:

- Address sexual violence and coercion, especially as it relates to restricting young women’s choices, and exposing young women to morbidity and mortality.
- Incorporate communication and behavioural change interventions, encourage the prevention of disease, the practice of [safe sex](#) and change of social norms that encourage equitable partnerships.
- Incorporate multi-source SRHR education strategies and empower young people to demand their rights.
- Establish means of ensuring that programs are accountable to the people they serve and means of addressing violation of rights.”

*International Planned Parenthood Federation (IPPF)*¹⁰

Sexual and Reproductive Rights are Human Rights

SRHR are recognised as a part of human rights throughout International Agreements. Therefore, in this Charter a rights-based approach is utilised. We identify that SRHR entail not only the absence of reproductive or sexual illnesses, but also the full enjoyment and well-being of sexual health.

SRHR, as part of human rights, have the following principles of human rights described in the [Universal Declaration of Human Rights \(1948\)](#)¹¹, and outlined by the [United Nations Population Fund \(UNFPA\)](#):

- **Universality:** They apply equally to all persons and they are the rights of every individual, there are no exceptions.
-

- **Inalienability:** This means that you can never lose your rights. You have them, from the moment you are born, because you are human.
- **Indivisibility:** No right is more important than another right, they are all connected and you cannot have one without the other. Denial of one right impedes the enjoyment of the other rights.
- **Interdependency and interrelation:** The fulfilment of one right may depend in part or in whole on the fulfilment of other rights.

In order for these rights to be fully attained, it is necessary to ensure *Meaningful Youth Participation* and keeping our governments accountable to their commitments in realising SRHR in policy-making and funding. We as young Europeans envision a future for all young people based on a comprehensive, rights-based approach to SRHR, closely linked to the well-being of individuals and gender equality.

PART II.
ISSUES IN SEXUAL AND
REPRODUCTIVE HEALTH AND RIGHTS

1. MEANINGFUL YOUTH PARTICIPATION IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

“No one is born a good citizen; no nation is born a democracy. Rather, both are processes that continue to evolve over a lifetime. Young people must be included from birth. A society that cuts off from its youth severs its lifeline.”¹²

Kofi Annan,

1st World Conference of Ministers Responsible for Youth,

Lisbon, Portugal, 1998

1.1. Introduction

Meaningful Youth Participation (MYP) is a right to which every young person must have access. Nearly half of the world's population is under the age of 25¹³. Therefore, young people should be involved, young people want to be involved and young people can be involved, not only because they are the future but because they are also the present.

Youth participation is the active and meaningful involvement of young people in all areas which affect them, especially SRHR. This is important because MYP is a human right, a key element of youth empowerment, an ethical responsibility and way to build life-skills and self-esteem.

1.2. The current situation:

- Youth involvement is insufficient in decision-making processes on levels such as designing, implementing, monitoring and evaluating programs related to youth [Sexual and Reproductive Health and Rights](#);
 - The need for knowing and understanding young people's needs are rarely prioritized or heard;
 - As a direct result of certain norms, as well as restrictive cultural tendencies, young people's participation in decision-making processes is hindered; [Comprehensive Sexuality Education](#) programs are not taken into consideration, and access to youth-friendly sexual and reproductive health services remains inadequate;
 - Lack of time and funding allocation toward youth organisations and young people results in young people not receiving training, preparation, and coaching which adults would receive in similar situations;
 - Inadequate organisational capacities in knowledge management result in youth organisations that are not always stable over time.
-

This makes it harder for these organisations to remain active and be effective in their goals.

1.3. Rights

MYP is not a luxury but a universal right which many different countries, including Council of Europe countries, have agreed on already. Some universal rights which are in connection with MYP are listed in the box below.

[Universal Declaration of Human rights \(1948\)](#)¹¹

Article 20

Everyone has the right to freedom of peaceful assembly and association.

Article 21

Everyone has the right to take part in the government of his/her country, directly or through freely chosen representatives.

[Millennium Development Goals \(2000\)](#)¹⁴

MDG 8

Develop a global partnership for development.

Target 16

In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.

[UN Convention on the Rights of the Child \(1989\)](#)¹⁵

Article 12

1. State's Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

1.4. Needs and interests

Young people themselves are the best advocates in addressing obstacles they face in their daily life. Although young people are often seen as a passive group, they have remarkable capacities for being active and contributing to bringing about social changes. Youth-led organisations advocating for SRHR are the key to generating change toward the societies that respect and promote these human rights.

The following box presents a negative example of youth participation:

Youth Participation can happen in a lot of various ways. When young people are invited to an event in which they are supposed to be involved but end up only giving a short speech which isn't even heard by the other participants and is called "sweet", then you are talking about tokenism and not about youth participation.

When talking about MYP it is important to stress that youth participation exists at several levels that range from being informed about decisions taken by adults to youth-initiated adult-youth partnership. We would like to see MYP implemented by all the various stakeholders such as governments, schools, non-governmental organisations (NGOs) and other organisations.

To be able to ensure MYP young people need the following:

- To make sure that the rights of young people can be put into practice. This addresses the imminent need for change in priorities.
 - That the content of programs targeting young people are designed, implemented, monitored and evaluated by young people in partnership with adults.
 - That we, young people, have access to tools needed for comprehensive peer education.
 - That we, young people, are treated as equal partners without being stereotyped, in order to be included in decision-making processes.
 - That we, young people, are involved in decision-making organisations and policy-making, without being held back by bureaucracy or lack of funding.
-

- That we, young people, are encouraged to advocate on the issues that are relevant to us.
- That we, young people, have information of how to assemble ourselves, for example in a youth organisation, youth group as well as in society in general to empower ourselves.
- That we, young people, are ensured that we are not used for matters of decoration, manipulation or tokenism. This could be done by involving young people in all levels of the decision-making processes.

The boxes that follow give just a few examples of good practices in MYP.

In September 2007, an advertising agency in the Former Yugoslavian Republic of Macedonia (FYROM) made a short film and designed posters for World AIDS Day. A group of young people were invited to participate in evaluating this project. The agency handed out posters with HIV/AIDS related content to the young people in order to see if they agreed with its message and were they were also invited to make comments about the film. The project was very successful, because young people genuinely contributed to how the message was communicated.

"I started my voluntary work when I was 15. Then, the group of young volunteers belonged to big, national, adult-led organisation in Lithuania. We, young people, felt that we were used as decoration in that organisation. Our voices were not heard if we disagreed with the content of programs created for young people. We didn't want to continue being decorations. So we, all group of young people, decided to leave adult-led organisation and establish our own, youth-led organisation. Today it has been working for four years. I am happy that we've made a choice in order to have meaningful youth participation."

Peer educator, Youth Centre "In Corpore", Lithuania

Youth Organisation **CHOICE** (Netherlands) works for youth and sexuality and has members starting from the age of 16 up until 28. They promote SRHR for young people, both at national and international level.

CHOICE does this work by participating in National Events but also in High Level Events and International Conferences. During these conferences they advocate for the SRHR of youth and are part of the decision-making processes at different levels.

Another important part of the work of **CHOICE** is that they train and support young people and youth organisations in developing countries.

By being able to be active in a youth organisation such as **CHOICE** the Dutch youth gets an opportunity to meaningfully participate at national and international level.

1.5. Vision

Young people are important actors within the subject of SRHR. The States and Civil Society have the responsibility to provide young people with the means and tools to behave in a responsible way. Young people should be respected and given the opportunity to shape and express their own opinions. Therefore, young people should be actively involved in the fulfilment of these rights. We call for the following to be recognised as crucial for the implementation of successful participation of young people:

- That programs for young people on SRHR are designed, implemented, monitored and evaluated by youth, including youth-adult partnerships;
 - That young people are heard, taken more seriously and no longer stereotyped;
 - That MYP is supported financially and that there is mutual trust and respect between young people and adults;
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Important steps to be implemented for the attainment of our vision are:

- The acknowledgement and support of young people and youth organisations as indispensable partners in decision-making processes and development, for decisions that affect them directly and indirectly;
 - To commit and involve NGOs and governmental institutions in processes of youth inclusion;
 - To ensure that young people are represented in all policy-making bodies. It is therefore important that young people are included in regional and national policy-making and in the national delegations during conferences and events on a European and international level.
 - To increase available funding for SRHR programs designed by young people and youth-led organisations. This must be done by the state but also by the different stakeholders including NGOs, schools, clubs, youth centres and hospitals.
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2. GENDER EQUALITY & NON-DISCRIMINATION

“Gender equality means an equal visibility, empowerment and participation of both sexes in all spheres of public and private life. Gender equality is the opposite of gender inequality, not of gender difference.”¹⁶

Council of Europe Human Rights and Legal Affairs.

2.1. Introduction

We are aware that people's understanding of [gender](#) and [sexuality](#) varies between and within cultures during different historical periods.

We treat our understanding of [gender](#) and [sexuality](#) as being based in objectivity. However, in reality, much of what we understand by gender norms and sexuality are socially constructed through a variety of influences such as tradition, politics and religion. [Gender roles](#) and [stereotypes](#) affect how women and men are expected to act and practise sex. It is important to identify these influences, in order to confront the obstacles young people face.

2.2. Current situation

Young people in Europe and the world encounter several forms of [gender discrimination](#), including [gender based violence](#), fulfilling traditional [gender roles](#), restrictions on [family planning](#) choices, discrimination based on [sexual orientation](#), or limited opportunities for [marginalised groups](#) to exercise human rights such as the right of [freedom of choice](#).

Our understandings and conceptions of [sexuality](#) change and evolve as we acquire more knowledge and insight. For example, even though same-sex sexual behaviour has always existed, it is only recently that we developed the idea that same-sex sexual behaviour is usually not isolated to being a sexual act, but entails a sexual orientation and identity. So the understanding of same-sex sexual behaviour has varied over history and is still subject to different levels of acceptance depending on culture and context.

Today the right to pleasure and enjoyment is often omitted in the human rights discourse. Sexual rights are mostly discussed in negative terms with a specific focus on problems such as lack of comprehensive sexual education, diseases and insufficient sexual health care. Sex is an enjoyable experience and must

be highlighted as part of young people's sexual rights. With the existing traditional gender and social norms it is difficult for young people to find their own way to pleasure, since many of them do not fit into these expected roles. Women are especially limited by these norms, as they are not only expected to take on a passive approach to sexuality, but can be criticised, reprimanded, and even disciplined if they exercise the same freedoms in sexual behaviour as men.

In order to have equal possibilities for all persons to enjoy their bodies these norms have to be challenged.

More and more young people have unlimited access to the Internet and this is where they usually first encounter sexual images. Pornography can be both a source of inspiration and pleasure and information, as well misleading and a source of degradation. Our concern is that certain types of sexual activity are usually more represented than others, thus depicting stereotypical images of women and men¹⁷.

2.3. Rights

[International Planned Parenthood Federation \(IPPF\) Charter on Sexual and Reproductive Rights \(1996\)](#)¹⁸

5.3 All persons have the right to be free from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.

[Millennium Development Goals \(2000\)](#)¹⁴

Goal 3: Promote gender equality and empower women.

Declaration of Sexual Rights (1999)¹⁹

1. The Right to Sexual Freedom. Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situation in life.

5. The Right to Sexual Pleasure. Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well-being.

6. The Right to Emotional Sexual Expression. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.

World Association for Sexual Health

2.4. Needs and interests

Categorising societies and individuals within those societies is a basic strategy we use for rationalising the world around us. However, this intrinsic sorting mechanism is often based upon, and leads to, prejudice.

Even though **stereotypes** are subject to change, they are often taken to be the natural and stable idea. An example of such a stereotype is the common conviction that there exists a female passive sexuality and a male active sexuality. Beliefs such as these are often reproduced through gendered language and stereotypical images in various aspects of the media. These often result in compromising freedom of expression and freedom of choice.

We believe that young people should be free to pursue their **sexuality** on the basis of consenting individuals without suffering any stigma. For example, in many parts of Europe double standards prevail, such that women who have several sex partners would be labelled as promiscuous, while men would be

praised for the same behaviour. Young people need to be freed from these gendered limitations and restrictive interpretations.

The [Swedish Association of Sexuality Education \(RFSU\)](#) works with the emphasis on three freedoms:

- The freedom to choose.
- The freedom to enjoy.
- The freedom to be oneself.

These freedoms are the rights of each individual, with the pre-condition that it does not compromise the freedom of another²⁰.

Therefore, young people need:

- Diversity in terms of influences such as gendered images, language use and role models.
- Empowering tools to exercise their freedom of choice concerning sexuality and [gender roles](#) by being able to adopt a critical approach to stereotypes.
- To have an emphasis on pleasure and wellbeing in the [Sexual and Reproductive Health and Rights](#) discourse.
- Discussions about [sexuality](#) and [gender roles](#) in relation to different contexts including different types of media such as the Internet.

2.5. Vision

We call for an approach that aims to eliminate [gender based discrimination](#) and that involves analysis of different influences such as age, class, ethnicity, sexual orientation, and other individual characteristics.

- All individuals should be free from all forms of [gender based discrimination](#).
-

- SRHR for young people should challenge stereotypes and gender norms. One way of achieving this is through discussing the fact that they are, to a large extent, socially constructed.
 - SRHR for young people should be achieved through evidence-based, [Comprehensive Sexuality Education](#) and safeguarding of rights.
 - SRHR for young people should actively involve men in the pursuit of [gender equality](#).
 - States should provide education and encourage discussions concerning sexuality and [gender equality](#).
 - Sexual enjoyment and well-being should be emphasised in the SRHR discourse.
-

3. GENDER BASED VIOLENCE

This type of violence is frequently invisible since it happens behind closed doors, and effectively, when legal systems and cultural norms do not treat it as a crime, but rather as a "private" family matter, or a normal part of life.

World Health Organisation on Gender Based Violence²¹

3.1. Introduction

Gender based violence encompasses all the various documented types of violence. It can be, amongst others, physical, sexual, psychological, economic or socio-cultural violence.

Gender based violence can impair the psychological or physical health of an individual, leading to stunted development. Although it affects both sexes, 89% of those experiencing domestic violence are women²². Men whose behaviours do not conform to expected traditional, heterosexual behaviour are also at risk of gender based violence.

One can experience gender based violence in different contexts. However, it is most common for the perpetrator to be someone close to the victim or at least an acquaintance. This includes spouses, friends or colleagues²³.

It is commonly argued that many forms of gender based violence are about power, rather than about sex. One source of such forms of gender based violence relates directly to the powerlessness of the individuals targeted. This powerlessness can be seen in several spheres, including organisational power, financial power, gender power, socio-cultural power, and sexual power.

3.2. Current situation

Gender based violence includes different types of violence:

3.2.1. Intimate partner violence

The most common form of gender based violence is intimate partner violence including domestic violence or spousal abuse. This could include physical abuse, psychological abuse, emotional abuse, sexual abuse and economic abuse. Statistics show that over 70% of female homicide victims are killed by their male partners²⁴.

3.2.2. Domestic violence

Statistics show that 12-15% of women in Europe face violence in the home on a daily basis²⁵. Twenty nine percent (29%) of women in Romania, 22% in Russia and 21% in Ukraine reported experience of spousal physical abuse. Over 42% of all married or cohabiting women in Lithuania reported that they have been victims of physical/sexual violence or threats of violence by their present partner. Only 10.6% of the Lithuanian respondents reported these incidents to the police²⁶. The problem of under-reporting to police or other authorities is substantial; therefore the actual rates of domestic violence are probably much greater than what is suggested by reports.

Myths surrounding domestic violence remain common in the general population. Persons of any culture, religion, [sexual orientation](#), marital status, age, and sex can be victims or perpetrators of domestic violence. Domestic violence should not be perceived as a private problem simply because it tends to occur behind closed doors, but rather a social and public issue that requires urgent attention.

The fact that a victim of domestic violence does not abandon the situation should, under no circumstance, be taken to mean that the individual is at ease with being abused. This is only one of the many myths surrounding gender based violence. In most circumstances, victims are held back by fear or have no information on who to turn to and thus remain trapped in a reality of abuse²⁷.

3.2.3. Culture based violence

Harmful traditional practices include, but are not limited to, female infanticide and prenatal sex selection, early marriage, [female genital mutilation](#), 'honour' [crimes](#) and maltreatment of widows, including inciting widows to commit suicide.

3.2.4. Violence in the community

Physical, sexual and psychological violence can be a daily feature of interactions in neighbourhoods, on public transport, in workplaces, schools,

sports clubs, colleges, hospitals, and in religious or other social institutions. Violence in the community includes, but is not limited to, gender based killing, rape, date rape, [sexual harassment](#), gender based harassment, human trafficking, and forced prostitution.

3.2.5. Violence perpetrated or condoned by the State

Custodial violence against women and men in police cells, prisons, social welfare institutions, detention centres and other state institutions constitutes violence perpetrated by the State. Violence by the State can also include the use of sterilisation to control the reproductive behaviour, violence in armed conflict and multiple discrimination²⁸.

3.2.6. Sexual harassment

In the European Union the percentage of female employees who have received unwanted sexual proposals is estimated between 40%-50%²⁹.

Sexual harassment transcends gender, occupational and professional categories, age groups, educational backgrounds, racial groups and ethnic groups.

Men are less likely to experience sexual harassment than women. This could be due to the different cultural and social influences that dictate different behaviours, or different expected behaviours of the sexes.

Most young people are reluctant to talk about experiences of having been sexually harassed, when asked about such experiences directly. However, research shows that a high percentage of young people respond in the affirmative when the question is put in a different context.

[Sexual harassment](#) includes uninvited sexual remarks, uninvited suggestive looks, uninvited pressure for dates, unprovoked deliberate touching, pressure for sexual favours/letters/calls and actual or attempted rape or assault³⁰. In recent times, internet-based sexual harassment is also experienced by many young people. Examples include unwanted spread of pictures and videos of suggestive content.

Definition of sexual harassment

Although there is no universal definition of what constitutes sexual harassment, many agree that the two main forms are: quid pro quo harassment and hostile environment sexual harassment.

“Quid pro quo harassment generally occurs when a person with more authority exerts power over a subordinate or person of less power by making sexual advances, requesting sexual favours, or by engaging in other conduct of a sexual nature.”

“The second and more common type of sexual harassment is hostile environment sexual harassment. This type occurs between or among individuals of equal power.”³¹

3.3. Rights

[International Planned Parenthood Federation \(IPPF\) Charter on Sexual and Reproductive Rights \(1996\)](#)¹⁸

12.4. All civilians have the right to be protected from degrading treatment and violence in relation to their sexuality and reproduction, especially during times of armed conflict.

12.5. All persons have the right to protection from rape, sexual assault, sexual abuse and sexual harassment.

2.3. All women have the right to be free from all forms of genital mutilation.

[Convention on the Elimination of all forms of Discrimination Against Women \(CEDAW, 1979\)](#)³²

All individuals have the right to protection from trafficking and coercion into prostitution or other forced sexual practices.

3.4. Needs and interests

Every young person needs to be informed about different forms of gender based violence to be able to recognise them, report them and receive the required services for prevention and protection.

Every young person should have access to capacity building training and the development of life skills in the field. Support groups, helplines and other support systems should be readily available and easy to access for all young people who require these services.

3.5. Vision

- Elimination of all forms of gender based violence. Special attention should be paid to violence resulting from harmful traditional or cultural practices³³.
 - States should develop and implement a legal framework against gender based violence.
 - States should be held accountable for the development of methods to prevent and address gender based violence, such as helplines, shelters, support groups and consulting services for people exposed to sexual violence.
 - States and Courts of Justice should ensure that the verdict given to the perpetrator of gender based violence is proportional to the extent of the crime.
 - States should provide free counselling for both the perpetrator and the victim.
 - Encouragement of further discussion and action on topics as prostitution, domestic violence, sexual harassment, rape and other forms of gender based violence.
-

- States should prohibit degrading practices such as forced marriages and forced labour³⁴, human trafficking and coercion into prostitution.
 - States should be held accountable to safeguard the rights and safety of victims of gender based violence and individuals in marginalised groups³⁵.
 - There should be specific and precise data collection in the field of gender based violence so as to be better equipped with targeting the situation.
 - States should provide freely accessible trainings and workshops for all individuals in the field of gender based violence and [gender equality](#).
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4. YOUNG INDIVIDUALS IN MARGINALISED GROUPS

4.1. Introduction

Marginalised groups may include, but are not limited to: asylum seekers; refugees; people living with HIV; Lesbian, Gay, Bisexual, Intersex and Questioning (LGBTIQ) people; people living with physical or mental disabilities; people in imprisonment; sex workers; drug users; and people in rural areas. Young people in Europe come from broad backgrounds of ethnicity, culture, economic situations, and physical abilities. This contributes to diverse sexual identities and therefore different needs and demands.

4.2. Current situation

Even though the [Universal Declaration of Human Rights \(1948\)](#)¹¹ states that everyone is entitled to all the rights, independent of background, many young people in Europe do not have the same opportunities as others of the same age within the same countries, as well as between different countries. The reason for this is often that marginalised groups have lower social and economic status.

4.3. Rights

[Universal Declaration of Human Rights \(1948\)](#)¹¹

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

4.4. Needs and interests

Young people in [marginalised groups](#) have the same rights as everyone else. These rights are not always met; the needs of the individuals in marginalised groups can often be different from others. To achieve the same rights for all young people, it is of highest priority that young people in marginalised groups are ensured the same access to services, and [Sexual and Reproductive Health and Rights](#) SRHR information and education. This often requires the provision of services, resources and education which are targeted towards particular groups, and are sensitive to their unique needs. It is also important that young people from marginalised groups are involved in the processes of decision making, in order to be able to address and achieve the changes required for the individuals in each group.

As an example of marginalised groups, refugees can be mentioned. This is an often under-prioritised group that frequently have unmet health needs. Problems that refugees can face are for example rape, sexual abuse, harassment and abduction (UNHCR *Ensuring Gender Sensitivity in the Context of Refugee Status Determination and Resettlement*, page 16). It is important for all refugees and asylum seekers, including young people, to be ensured equal access to health care and treatment enjoyed by other residents. Since refugees and asylum seekers often have special needs, resulting from language barriers and particular health requirements, extra services may be necessary. It is therefore important that refugees and asylum seekers are entitled to use the health services without charge and that their needs are met. For example, in the UK, persons with an outstanding application for refuge in the UK are entitled to use National Health Services without charge, like other UK residents, and a recent judicial ruling (11 April 08) extended this to include many failed asylum seekers also³⁶.

Department of Health, UK

4.5. Vision

- We want to see equal realisation of all rights in this Charter for all groups and individuals.
 - All countries, stakeholders etc. should recognise their own marginalised groups and their issues in order to be able to protect the SRHR of the individuals in these groups.
 - States should promote and call attention to SRHR, and provide SRHR services to individuals within marginalised groups.
 - When needed, we encourage States to use special provisions such as specific funding, targeted marketing of services to ethnic minorities, special language provisions and outreach services in order to promote equality in the SRHR situation for individuals in marginalised groups.
 - All SRHR information and services should be accessible to all individuals independent of language, disability and other possible causes for limited opportunities to accessibility.
 - States should create inclusion programs to facilitate inclusion for those young people in marginalised groups who wish it.
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5. LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX, & QUESTIONING (LGBTIQ) ISSUES

5.1. Introduction

LGBTIQ people are Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning. These terms refer to [sexual orientation](#). Sexual orientation is different from sexual behaviour, because it refers to feelings and an individual's concept of self.

For instance, some people have same-sex sexual relations (male-male, or female-female) but do not self-identify with any of the terms included in LGBTIQ. All the rights, needs and the vision in this section apply to these individuals also.

LGBTIQ people do not claim any 'special' or additional rights, only the realisation of equal rights as those given to heterosexual people.

5.2. Current situation

LGBTIQ people often experience prejudice and discrimination both from States and from individual persons or groups. This stigma and discrimination may lead to stress and mental health problems³⁷ and must be addressed.

There are many common misconceptions about LGBTIQ people that contribute to prejudice and need to be dispelled.

Many rights of LGBTIQ people are not respected, including:

- The right to form a family, despite the fact that LGBTIQ people desire and have committed relationships, and research showing that LGBTIQ people are as likely as heterosexual parents to be good parents³⁷.
 - The right to physical and mental health due to discriminatory policies and practices, some physicians' [homophobia](#) and the lack of adequate training for health care personnel regarding sexual orientation issues.
-

- LGBTIQ students may not enjoy the right to education because of an unsafe climate created by peers or educators in schools.

Examples:

Misconception: “People choose their sexuality.”

Fact: Human beings cannot choose to be either gay or straight³⁷.

Misconception: “LGBTIQ people make bad parents”

Facts: Gay men and lesbians desire and have committed relationships, and are as likely as heterosexual parents to provide healthy and supportive environments for their children.

Fears about children of lesbian and gay parents being excluded by peers or isolated in single-sex lesbian or gay communities have received no scientific support³⁷.

We recognise that many aspects of LGBTIQ rights, particularly [adoption](#), are controversial in some countries for reasons including cultural traditions and certain religious beliefs. Part of the vision listed at the end of this document may be aspirational long-term goals for these countries.

5.3. Rights

Many important international rights declarations and conventions do not refer specifically to sexuality. However, the [Universal Declaration of Human Rights \(1948\)](#)¹¹ and the agreed treaties establish that human rights apply to everyone and that no one should be excluded¹¹.

The rights set out in the declaration include:

- The right to marry and found a family (article 16)
 - Access to adequate health care (article 25)
 - The right to education (article 26); including ‘Education shall be directed to the full development of the human personality and to
-

the strengthening of respect for human rights and fundamental freedoms.’

Article 2: Everyone is entitled to their rights and freedoms set forth in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

[The International Covenant on Economic, Social and Cultural Rights \(UN GA 1966\)](#)³⁸.

In 1994 the Human Rights Committee decided that the references to “sex” in certain articles should be taken to include sexual orientation:

Article 2: Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognised in the present Covenant, without distinction of any kind, such as race, colour, sex sexual orientation, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 26: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex sexual orientation, language, religion, political or other opinion, national or social origin, property, birth or other status.

5.4. Needs and interests

- Young people have equal rights with people of any age and sexuality.
 - Sexual orientation emerges for most people in early **adolescence** prior to any sexual experience³⁷.
-

- Adolescence is often a difficult, even traumatic time for young people, and the common feelings of insecurity and isolation may be magnified for LGBTIQ people.
- Issues such as coming out (openly declaring your LGBTIQ sexuality) to family and friends, work colleagues etc., and obtaining LGBTIQ-specific SRHR information, are often difficult for young people.

5.5. Vision

5.5.1. Recognition of LGBTIQ:

- States and educators should recognise that there should be no stigma attached to any sexuality.
- States should ensure that LGBTIQ people have equal rights to heterosexual people, and ensure that they are not subject to discrimination due to sexual orientation or lifestyle, neither from the state, nor from individuals within the State.
- States should work with stakeholders and civil society to achieve the vision laid out in this section.

5.5.2. Equal rights:

LGBTIQ and heterosexual people should enjoy the same rights. These include, but are not limited to, the following:

Protection from discrimination

This includes protection from discrimination by the State (through fair legislation and policies), and protection from individuals within the State (through making discrimination a criminal offence, and ensuring effective policing of such offences).

Access to services

- This includes services provided by the State, such as health services, and commercial services provided by individuals or individual companies. Service providers should be open-minded, non-judgemental and use progressive language³⁹.

Example: Two men go to a nice hotel. It's a weekend break for them and someone recommended this place. It's lovely.

"Can you make sure it's a double bed?" says one of the men to the receptionist.

"I'm sorry, we don't actually do that here," says the receptionist. "We don't allow two men to share a double bed. You can have two separate beds or I can recommend another hotel if you'd like..."⁴⁰

Gay marriage, civil partnerships and families

- Same-sex couples should be able to marry or have a [civil partnership](#), which is equal to marriage before the law, including inheritance, effects on taxation and social services.
 - Same-sex couples that choose not to marry or undergo a civil partnership should have the same rights as non-married heterosexual couples.
 - LGBTIQ parents and families should have equal rights as heterosexual parents and families.
 - As with heterosexual families, domestic (relationship) violence can occur, including many of the issues discussed in the section 'gender based violence'⁴¹. LGBTIQ-appropriate legislation and services should be available to combat this, as for all families. This should include marriage counselling and access to shelters for people subject to violence.
-

Adoption and reproductive services

Example

Two women go along to their very first antenatal clinic (birth and child-care workshop). This is their first child and they are very excited and want to do everything properly.

“These classes are actually for pregnant women and their partners,” says someone checking names off a list. “Not friends.”

“Oh, that’s alright,” says the pregnant woman, “this isn’t a friend, it’s my partner. We’re having this baby together.”

“We mean male partner,” says the nurse with the list. “As in ‘father’. If we start letting anyone in...”⁴¹.

- LGBTIQ people should have the same opportunities to adopt and foster children as heterosexual people, and the same legal status as guardians. This includes LGBTIQ couples, single people and should ensure rights to parental leave.
- Reproductive services (such as *in vitro* fertilisation and any other assistance to a woman in becoming pregnant) should be provided to LGBTIQ women and couples as equally as to heterosexual women.

Specific needs of young LGBTIQ people:

- Young LGBTIQ people should have access to LGBTIQ-friendly youth services, which can be in the form of LGBTIQ youth centres, counselling and support groups to gain advice and information, as well as meeting their peers who are in a similar situation.
 - Sexual health services for young people should be appropriate for LGBTIQ people, including use of non-heteronormative language⁴².
 - These services should extend to the parents or guardians and families of LGBTIQ people, to encourage their support.
 - Services for children and young people such as schools, education systems and public libraries often promote heterosexual behaviour without discussion of LGBTIQ issues. For example, very few children’s
-

books or teenage fiction in libraries in the UK feature same-sex couples. Teachers, care-givers and all others involved in working with children and young people should be trained in LGBTIQ issues and be careful not to promote particular sexualities, or discriminate against others. Issues such as bullying or discrimination by peers should also be addressed.

- LGBTIQ issues should be included in the comprehensive sexual health education provided by schools and higher education institutes, and included in other school curricula (such as reading/literature, current affairs, etc.)

Sexual activity

- LGBTIQ sexual activity should be recognised as being morally equal to heterosexual activity. This should include having the same age of consent for LGBTIQ sexual acts as heterosexual acts, and legalising LGBTIQ sexual acts (in countries where currently illegal).
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6. FAMILIES^b, PARTNERSHIP & CHILDCARE

^b The word “families” includes different forms of relations other than just a nuclear family. The definition can include, among other types, heterosexual or same-sex couples, rainbow families, extended families etc.

6.1. Introduction

Partnership, marriage, and families constitute organisations of society where [gender roles](#) are often clearly defined, ranging from traditional forms to more modern and diverse forms. Young men and women are facing unequal opportunities and practices during the development of their sexuality and their opportunities reaching the related information. Traditional [gender roles](#) often dictate that women's roles essentially involve the undertaking of childcare and related responsibilities. These dictated responsibilities and expectations may affect women's reproductive choices and sexual freedoms. By the same token, men are often expected to take on specific roles and responsibilities within the families, while they are specifically excluded from other roles.

Beyond this, in many traditional societies young women are at risk of forced early marriage. Illiteracy and lack of education or lack of access of education contribute to the exacerbation of these problems and inequalities⁴³.

6.2. Current situation

In some parts of Central and Eastern Europe, early marriage is still practised; notably among the Roma people and in the Former Yugoslavian Republic of Macedonia (FYROM) where 27% of the women who married in 1994 were aged between 15 and 19. In most of Eastern Europe and the Commonwealth of Independent States (CIS), the average age at marriage is in the low to mid-20s, with a significant proportion in their teens (in the Kyrgyz Republic, 11.5%)⁴⁴.

It is estimated that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services. That means some 175,000 women each year could be saved, and many more could avoid severe or long-lasting injuries⁴⁵. However, in many countries, funding⁴⁶ for [family planning](#) has been curtailed, and many low-income countries find themselves without adequate supplies of contraceptives⁴⁷.

Forced early marriage of young girls or adolescents is another practice that can cause lifelong psychological as well as physical problems, especially those resulting from early childbearing.

As conflicts among ethnic groups rage, women and girls have increasingly become victims of war, and continue to experience rape and forced pregnancies.

At the same time, culture related practices including [Female Genital Mutilation](#) and Female Genital Cutting, coerced sex and early marriage are also factors in the spread of [HIV](#) amongst women.

Forced and early marriage is not unique to developing countries. In developed countries, young girls, adolescent and young women, from minorities and marginalised groups are especially at risk for forced and early marriage.

“In Switzerland there are some 17,000 early or forced marriages each year. Most of these are from immigrant communities, or their residency situation is unstable or precarious.”

Jacqueline Thibault, president of the Surgir Foundation, 2007⁴⁸

Male Dowry/bride price is a cultural practice in some European countries that is an obstacle for young people to have a free choice for marriage. Young women are forced to live with any man who gives the best price!

6.3. Rights

[Convention on the Elimination of All Forms of Discrimination Against Women \(CEDAW, 1979\)](#)³²

Article 16

- (a) The same right to enter into marriage;
 - (b) The same right to freely choose a spouse and to enter into marriage only with their free and full consent;
 - (c) The same rights and responsibilities during marriage and at its dissolution;
 - (d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;
 - (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;
 - (f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;
 - (g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation.
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[International Planned Parenthood Federation \(IPPF\) Charter on Sexual and Reproductive Rights \(1996\)](#)¹⁸

Article 7

7. The right to choose whether or not to marry and to found and plan a family.

7.1. All persons have the right to protection against a requirement to marry without that person's full, free and informed consent.

6.4. Needs and interests

- Young people need to be empowered to be able to make informed choices free from any imposed social or cultural beliefs, traditions, customs, or practices.
 - Young people need to receive comprehensive, evidence-based education regarding childcare, [contraception](#) and [family planning](#) issues, and sexuality. Comprehensive information and education in issues pertaining to partnership, marriage, families and parenthood should be available to individuals from early ages, starting from childhood, to empower choice and awareness while individuals are adopting their roles and status in the society.
 - State based institutions and stakeholders need to develop policies to ensure that young people can realise their own choices regarding the formation or dissolution of partnerships or marriage, regardless of their social and financial situation. Poverty and financial challenges severely limit the ability of young women, in particular, to choose whether to remain in or to break from a partnership, marriage, or other family commitment. This is a fact that needs to be seriously considered through policies and services that relate to partnership, marriage, and families.
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6.5. Vision

- Legal sanctions should be enforced in response to violations of the minimum age of marriage, as well as forced marriage at any age.
 - Continuing education for young women and men should be guaranteed by the state, in order to empower young women to resist family pressures to accept early marriage and traditional [gender roles](#).
 - Forced birth control practices, including forced sterilisation and forced [abortion](#), are often used as a tool or weapon against certain ethnic, cultural, religious groups, or other minorities. The forcing of any kind of birth control practice should be prohibited and penalised through legislation and State policies (to eliminate the risk of using it against certain groups).
 - Social security should be guaranteed for all individuals, irrespective of family or marital status.
-

7. EMPLOYMENT

7.1. Introduction

Young people often lack access to adequate information regarding their employment rights, and therefore might face difficulties in their daily working life. For example, many young people are disproportionately discriminated against in regards to issues pertaining to parental leave, especially during the period of childcare. Women still have unequal access to employment and career advancement. Despite reductions in the salary gaps in the past decades, gender disparities continue to exist in most European countries. The “glass ceiling” refers to a ceiling based on attitudinal or organisational bias in the work force that prevents minorities and women from advancing to leadership positions⁴⁹, and is a prime example of direct gender based restrictions on salaries and promotions.

7.2. Current situation

In Europe, average salaries for women are 20 to 50% lower compared to average salaries for men⁵⁰. The ratio of estimated female to male income for 2005 was 0.56 in Croatia, Former Yugoslavian Republic of Macedonia, and Albania, 0.46 in Bosnia and Herzegovina and 0.65 in Moldova. In countries where gender inequalities are considered to be less robust, and where positive actions and steps have been implemented in order to reduce the gap in salaries, disparities are lower, but still exist. For example, in Norway the ratio of estimated female to male income for 2005 was 0.75⁵¹.

UNDP Human Development Report, 2005

Employers often exclude women, or discriminate against them, on the mere assumption or expectation of childbearing and motherhood. Discrimination can be both direct and indirect and varies between countries. Inadequate access to childcare services can severely impair a person’s options to employment and career advancement. Stereotypes, sexual and gender based harassment, and the creation of hostile environments for women also restrict the realisation of [gender equality](#) in the workplace.

7.3. Rights

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979)³²

Part III, Article 11, Para. 2

In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

- (a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
- (b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
- (c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of childcare facilities;
- (d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

7.4. Needs and interests

- Legislation that prohibits discrimination and penalises any form of gender based discrimination or harassment, direct or indirect.
- Sexual harassment and gender based harassment need to be acknowledged as serious obstacles in the reduction of gaps in salaries and promotions. In addition, sexual and gender based harassment need to be acknowledged as obstacles to achieving equal opportunities of employment and advancement for women and men.
- Young parents need comprehensive information about their rights concerning employment.
- Young people need to be secured access to sufficient and affordable childcare services, to ensure that their employment opportunities are not compromised.
- Many young people who are parents need childcare services to be provided in a youth-friendly manner.
- Young parents need affordable access to sexual and reproductive health care.

7.5. Vision

- Equal access and opportunities to employment and advancement regardless of gender, [sexual orientation](#), marital status, or family situation.
 - Workplaces to be free of direct or indirect discrimination, and all forms of sexual or gender related harassment.
 - Equal rights to parental leave for women as well as for men.
 - All women should be ensured adequate access to pre-natal and post-natal medical care.
 - States and employers should encourage the possibility to combine professional and family life of parents, by providing flexible working hours and conditions, child care that can be youth-friendly and not restrict advancement opportunities for women and men that have returned to work following parental leave.
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8. SEXUALLY TRANSMITTED INFECTIONS (STIs) INCLUDING HIV/AIDS

8.1. Introduction

Sexually Transmitted Infections (STIs) are infections that spread primarily through sexual contact (oral, vaginal, anal or other genital contact). There are approximately 30 documented transmissible STIs. Even though they are termed sexually transmitted, many are also transmissible through blood-to-blood contact (ex. needle-stick injuries, needle sharing) and vertical transmission from mother to child during labour and/or breastfeeding.

8.2. Current situation

The number of people currently infected with STIs appears to be on the rise^{52 53}. **HIV/AIDS** is claiming lives, destroying families and breaking down social structures as we speak.

The need for immediate action becomes more urgent with every life that fades in the dawn of the rising HIV/AIDS epidemic, and with every young person that becomes infected with an STI, or finds themselves infertile as a result of symptom-less, prolonged infection.

HIV/AIDS infection increases the susceptibility of infection with other STIs. Similarly, infection with other STIs increases susceptibility to HIV.

HIV/AIDS and Tuberculosis (TB) co-infection has also become a major health issue in both developed and developing countries⁵⁴.

8.2.1. STIs

The **World Health Organisation's** (WHO) global estimates show that around 340 million new infections of curable STIs occur per year in the 15-49 age group⁵⁵.

Infection with STIs can lead to further complications and health problems such as Pelvic Inflammatory Disease, **infertility** and cancers of the reproductive system.

This causes physical and psychological distress as well as increased financial burden on healthcare systems.

Given the social, demographic and migratory trends, the population at risk of STIs will continue to grow dramatically⁵⁶.

8.2.2. HIV

The number of HIV infections is still on the rise despite efforts from various NGOs, national and international alike. This calls for immediate and comprehensive action from all stakeholders to turn the tide.

The current global estimate of people living with HIV/AIDS is 33.2 million. These trends are presented in Figure 1 below⁵⁷.

There are around 5 million new HIV infections every year and over 2 million of these are amongst young people. Approximately 3 million deaths occur worldwide from HIV/AIDS every year, leading to a total death toll of 28 million people since the first recorded cases, and 15 000 children orphaned as a result of HIV/AIDS⁵⁸.

It is estimated that if the current trends in HIV/AIDS transmission continue, at least 52 million people will have died by 2010, and 58 million will be infected and still alive⁵⁹.

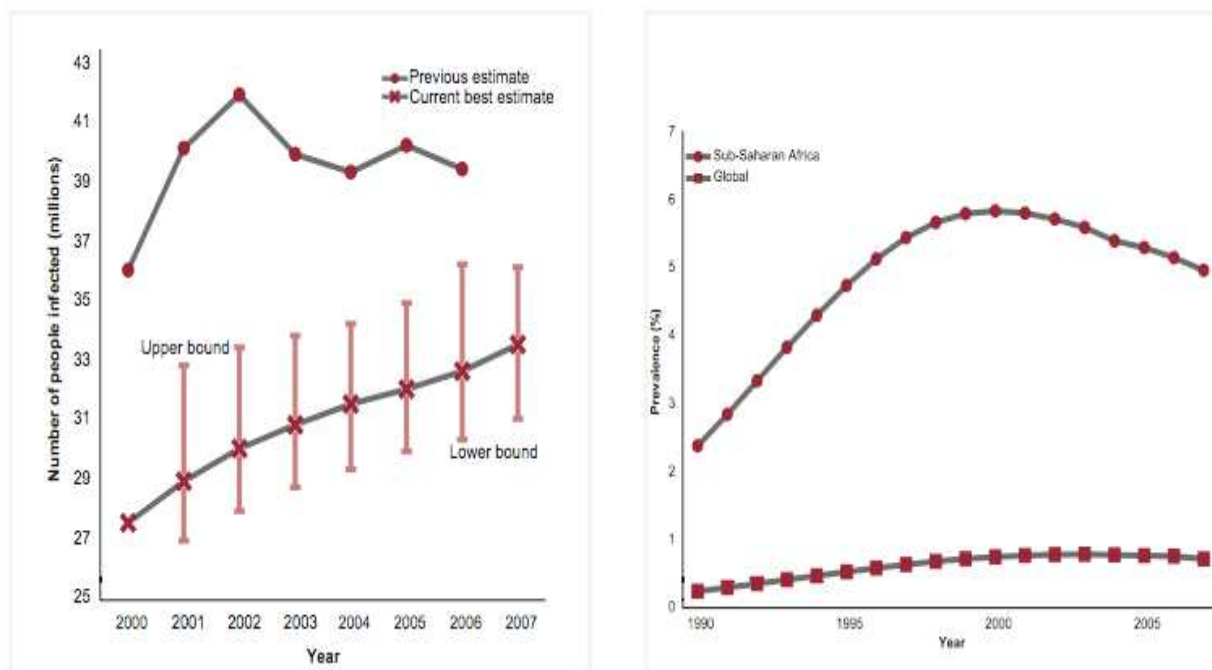


Figure 1. Global trends of HIV / AIDS infection.

8.2.3. HIV in Europe

1. Eastern Europe and Central Asia

Nearly 90% of all newly reported HIV cases for 2007 in Eastern Europe and Central Asia were in two countries – Ukraine (21%) and the Russian Federation (66%)⁶⁰.

Around two thirds of new cases in women in both Ukraine and the Russian Federation can be attributed to intravenous drug use.

New HIV infections are also rising in Azerbaijan, Georgia and Republic of Moldova.

Overall, in Eastern Europe and Central Asia, 35% of HIV-positive women acquired HIV from intravenous drug use and a further 50% acquired it from partners who make use of intravenous drugs⁶⁰.

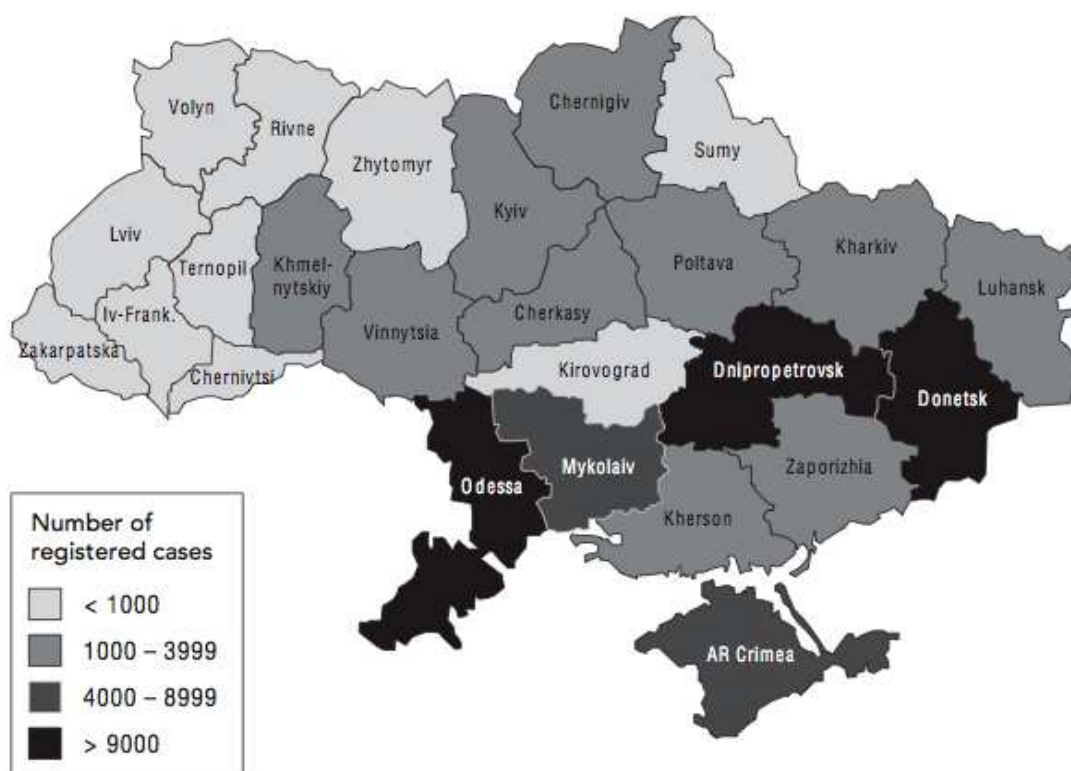


Figure 2: HIV infection in Ukraine Regions, 2007⁶¹

2. Western Europe

HIV infections acquired through heterosexual sex, most of which were in immigrant and migrant populations, formed the largest group (42%) of new HIV infections diagnosed in Western Europe in 2006⁶².

A significant percentage (29%) of newly diagnosed HIV infections were attributed to unsafe sex between men while 6% were attributed to intravenous drug use⁶².

In Western Europe, the United Kingdom continues to have a large HIV epidemic together with France, Italy and Spain⁶².

The annual report of newly diagnosed HIV cases has more than doubled in the United Kingdom from 2006 to 2007⁶².

8.3. Rights

8.3.1. Right to Health

1.1 The Committee on Economic, Social and Cultural Rights speaks of the right of men and women to the enjoyment of the highest attainable standard of health, as articulated in Article 12 of the Covenant⁶³.

1.2 We recognise that the right to health is a basic human right and that it entails free access to preventative measures from disease, free access to diagnostic measures and free access to treatment of all STIs including anti-retroviral therapy.

1.3 The right to health includes the right to the enjoyment of a sexual life in full health.

8.3.2. Right to Education

2.1 We believe that young people have the right to Comprehensive Sexual Education.

2.2 The Committee on the Rights of the Child recognises that children living with HIV/AIDS are discriminated against in both formal and informal educational settings⁶⁴.

8.3.3. Right to Privacy and Confidentiality

3.1 As young people in the European Region, we believe in the basic human right to privacy and [confidentiality](#). This applies to the provision of youth-friendly clinics, provider-initiated testing clinics, counselling facilities and other services.

3.2 Young people should have the right to give individual consent for STI testing, including testing for HIV. (i.e. without the need for parental consent).

3.3 Concerning the right to privacy, it is in violation of this right for third parties to have access to information in the clinical file of the young person in question under any circumstance.

3.4 We also recognise that this right touches upon the subject of disclosure of HIV/STI status to employers and consenting sexual partners. We recognise this as an issue to be highlighted in future debate.

8.3.4. Right to Non-Discrimination

Very few ailments have been stigmatised to the degree that STIs have been, especially HIV/AIDS.

4.1 Discrimination, including gender inequality, has led to inadequate information and a general lack of access to services amongst the individuals in marginalised groups.

4.2 We recognise the need for a legal structure that protects against stigmatisation and against the criminalisation of people living with STIs including HIV/AIDS, though recognise that the duty of an HIV-positive person to safeguard the health of sexual partners is a controversial issue.

4.3 HIV-positive women should be protected against criminalisation in the event of vertical transmission from mother to child during labour and/or breastfeeding. The [CEDAW](#) committee recognises that women and adolescent girls lack adequate access to information and services necessary to ensure sexual health, including HIV/AIDS prevention and treatment⁶⁵. Sex workers, trafficked women, and adolescents are particularly vulnerable groups⁶⁶.

4.4 The right to life should not be violated with respect to real or perceived HIV status. Children must not suffer deprivation of a family life as a result of their HIV status⁶⁷.

4.5 Various tribal people and other ethnic minorities are discriminated against and lack adequate access to most, if not all, SRHR services provided. It is noted that the spread of STIs, including HIV/AIDS, disproportionately affects indigenous and tribal peoples, and it is recommended that plans of action to combat the pandemic are developed and implemented⁶⁸.

8.3.5. Right to Labour

All individuals should have the right to labour and equal access to employment opportunities and salary with respect to equal qualifications. This right has been violated with respect to people living with HIV/AIDS. The rights of people living with HIV/AIDS (PLWHA) should be safeguarded by the legal framework⁶⁹.

8.4. Needs and interests

8.4.1. Education

- [Comprehensive Sexuality Education](#) (CSE) is a necessity.
- [Peer-to-peer education](#). Most young people obtain knowledge from their peers, therefore peer-to-peer education exploits this normal behaviour for the benefit of the benefactors and the beneficiaries.
- CSE should be provided in the native language of the beneficiaries.
- Capacity building and adequate training for the people providing CSE is a necessity.
- [Accountability](#) of the State should be in place for the provision of CSE, as well as adequate monitoring and evaluation of the program to ensure that levels are maintained, as well as to assess effectiveness.

8.4.2. Services

- Access to free and confidential counselling by adequately trained non-judgmental healthcare professionals in [youth-friendly](#) clinics, home-based visits and schools.
 - Access to free and [confidential](#) STI testing for all young people without the requirement for parental consent.
 - Access to free treatment for all STIs, including access to [anti-retroviral therapy](#) (ART), and any consequential infections such as TB and HIV/AIDS co-infection.
 - Access to free pre- and post-test counselling.
 - Access to both [provider-initiated](#) and [client-initiated HIV testing](#) services.
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- The involvement of people living with HIV/AIDS at all stages of the counselling and testing process should be put in place.
- The involvement of young people and the participation of the whole community in question is essential for these services to be youth-friendly and also as a method of raising awareness as well as reducing stigmatisation.
- Follow-up with people should be ensured, irrespective of outcome of the test.
- Access to support groups should be provided free of charge to people who test HIV-positive.
- Access to post-exposure prophylaxis for the period of one month on an individual case assessment should be available.

8.4.3. Other services

- Allocating financial budget for the attainment of the best available services and the highest quality of treatment for all.
 - [Accountability](#) of the State for the assurance of good health for all members of the population including marginalised individuals.
 - [Accountability](#) of the State for the safeguarding of sex workers who are at a higher risk of coercion and of acquiring STIs including HIV/AIDS.
 - Detailed and precise data collection in both the public and private sector. This should be taken to mean that gender, age, requested test and test results only should be clearly documented. The presence of codes, names, addresses, identity (I.D.) numbers and other possible methods of tracing the individual shall be considered a breach of the Right to Privacy and [Confidentiality](#).
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8.5. Vision

When dealing with STIs including HIV/AIDS, young people in Europe have the following vision:

- Access to [Comprehensive Sexuality Education](#) for everyone including young people in marginalised groups.
- Ability to make informed decisions about their sexuality without cultural and social bias.
- Free access to preventative measures (including barrier contraception), diagnostic facilities and treatment options for all young people.
- Free access to the Human Papilloma Virus (HPV) vaccine for all youth prior to becoming sexually active. HPV infection is implicated in the development of cervical/penile cancer. Hence, the HPV vaccine will drastically decrease the prevalence of these conditions in young people.
- A future that is free from stigma and discrimination, re-enforced by a legal framework that criminalises discrimination.
- Equal rights to employment, education, enjoyment of a sexual life and enjoyment of a family life irrespective of real or perceived HIV status.
- A future that is free from HIV/AIDS and other STIs.

States should establish effective frameworks for their response to HIV/AIDS, which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and program responsibilities across all branches of government⁷⁰.

9. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES AND CONTRACEPTION

9.1. Introduction

[Sexual and Reproductive Health and Rights](#) (SRHR) services for young people are given unequal attention amongst different European countries. Such services are, in some cases, restricted to married couples, though access to these services must also be ensured for a broader level of possible service users, irrespective of their social or family status.

[Youth-friendly SRHR services](#) are based on a good understanding of the needs and desires of young people in relation to services. These targeted services are often most successful at attracting young people, responding to their needs, and retaining them in continuing care. Due to a change in social trends there is a heightened need for these specific services to be put into action immediately.

9.2. Current situation

Approximately 1.25 million teenagers become pregnant each year in the 28 [OECD](#) (Organisation for Economic Co-operation and Development) nations. Of these, about half a million pregnancies will be terminated and approximately three quarters of a million teenagers will become mothers⁷¹. Unwanted pregnancies among teenagers are often associated with a numerous complications, health problems, and social difficulties.

The need for SRHR services is also highlighted by the fact that in many countries young people are engaging in earlier sexual debut than they previously did. For example, in the 1960s, in France the median age at first sexual intercourse for women, i.e. the age at which half of all women had experienced their sexual debut, was 20.6, two years later than it was for men. Women's age at first intercourse has fallen sharply since then, approximating to 17.6 for women and of 17.2 for men in 2000^{72 73}.

Earlier sexual debut, in combination with a lack of credible and comprehensive information and resources on SRHR for teenagers, contributes to the rise in STIs and risky sexual behaviours among young people in many parts of the world. [Youth-friendly SRHR services](#) thereby are based on an understanding of and respect for the realities of young people's diverse sexual and reproductive health and lives.

9.3. Rights

[International Planned Parenthood Federation \(IPPF\) Charter on Sexual and Reproductive Rights \(1996\)](#)¹⁸

Right 3.2: All the persons have the right to equal access to education and information to ensure their health and wellbeing, including access to information, advice and services relating to their SRHR.

Right 3.8: No person shall be discriminated against in their access to information, health care, or services related to their SRHR.

Right 4.1: All sexual and reproductive health care services, including information and counselling, should provide clients with privacy and ensure that personal information given will remain confidential.

Right 4.4: All sexual and reproductive health care services, including information and counselling services, should be made available to all individuals and couples, especially young people, on a basis which respects their right to privacy and confidentiality.

Right 6.3: All persons have the right to full information as to the relative benefits, risks and effectiveness of all methods of fertility regulation and the prevention of unplanned pregnancies.

Right 8.2: All persons have the right of access to the widest possible range of safe, effective and acceptable methods of fertility regulation.

Right 9.1: All persons have the right to the highest possible quality in health care including all care related to their sexual and reproductive health.

Right 9.5: All persons have the right to sexual and reproductive health care services as part of primary health care, which are comprehensive, accessible – both financially and geographically, private and confidential and, which pay due regard to the dignity and comfort of that person.

Right 10.1: All persons shall have the benefit of and access to available reproductive health care technology, including that related to infertility, contraception and abortion, where to withhold access to such technology would have harmful effects on health and wellbeing.

[Universal Declaration of Human Rights \(1948\)](#)¹¹

Article 21:

Equal access to public services.

The right to access to contraceptive services is ensured by various international agreements. Among others:

[Convention on the Elimination of all forms of Discrimination Against Women \(CEDAW, 1979\)](#)³²

[UN Convention on the Rights of a Child \(1989\)](#)¹⁵

[International Covenant on Civil and Political Rights \(1966\)](#)⁷⁴

9.4. Needs and interests

Youth-friendly SRHR services must be established to ensure that young people can easily gain the information and services they need regarding their sexuality.

9.4.1. Services

In many countries, young people lack high-quality, youth-friendly services due to the following:

- Reproductive health and contraceptive services are often targeted towards married couples, ignoring or underestimating the needs unmarried couples or individuals.
- **Comprehensive Sexuality Education (CSE)** is generally ignored in the education system.
- Sexuality related information is a taboo in many societies.
- Health care practitioners are not aware or adequately trained in the basic principles of counselling appropriate to young people.

9.4.2. Contraception

- In some societies, young people are too shy or inhibited to buy contraceptives as a result of cultural stigmatisation and lack of CSE, and/or are afraid of the potential side effects from using them.
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- Young people need accurate information on available services, [contraception](#), and access to contraception.
- Young people often have limited money to pay for contraceptives, as well as for access to services.

9.5. Vision

- All healthcare institutions and facilities should utilise a [youth-friendly](#) approach. This applies even to those institutions that are not officially designated as youth-friendly clinics.
 - Youth clinics should offer non-directive [sexuality counselling](#) and emphasise sexuality as a positive and important aspect of young people's lives.
 - Accessibility and credibility of services without prejudice and parental control. This requires:
 - Equal access to services irrespective of race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity, disability or any other status.
 - Up-to-date counselling, where the young people are provided with up-to-date information.
 - Healthcare providers to allocate adequate time for [contraception](#) counselling.
 - That the rights of marginalised young people are secured, including ethnic minorities, sexual minorities, and other minorities are respected by providing information and facilitating access to SRHR services for these groups.
 - That States and Civil Society organisations should establish telephone helplines, web and phone consultations for young people in need, as well as pay more attention to young people's SRHR in the media and internet.
 - Affordability of services, including [contraception](#) and counselling:
 - Particular attention must be paid to unemployed young people and young people with fewer resources, who cannot afford contraception and services. These contraception and services
-

should be provided free of charge to young people applying for those services.

- [Emergency contraception](#) should be provided without prescription.
 - Ensure full access to condoms and femidoms (female condoms) as a main available contraception for men and women, as well as information on how to use them.
 - Regular funding from the government to ensure the provision of youth-friendly clinics, which cover contraception, diagnosis and treatment of STIs.
 - Access to contraception and SRHR services should be included in the basic benefit packages in compulsory insurance schemes, and therefore granted by States.
 - States should eliminate taxation of contraception.
 - Young people must have access to the latest scientific advancements with respect to services, including diagnostic and treatment facilities and contraceptive methods.
 - Recognising and ensuring the right of young people to privacy and [confidentiality](#), to help them feel secure when accessing services and contraception, welcomed, and treated with dignity and respect:
 - To ensure a private environment during counselling and services.
 - No coercion or pressure: young people should be encouraged and able to make their own decisions.
 - Require and ensure accurate data collection for purposes of record keeping and monitoring at a national level, for both public and private service providers. The information to be provided for those institutions from SRHR clinics should include age, sex, requested services and the result of those services, but should not disclose any personal information.
 - Possibility of online consultations and information.
 - Information and education:
 - Enhance health care practitioner's skills to provide appropriate, non-directive counselling and accurate information to young people.
 - Provide SRHR information and orientation lectures and workshops for young people, to raise awareness among young people who are
-

sexually active and build partnerships within the youth community and gain credibility for services.

- All young people should be provided with unbiased information about SRHR and equal access to available and affordable contraception. Young people should receive training on the proper use of contraceptives. These two points are especially relevant to adolescents, who are more likely to have their sexual debut during this age.
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10. COMPREHENSIVE SEXUALITY EDUCATION (CSE)

“I believe young people can have a safe sexual and reproductive health and make their choices if they access comprehensive sexuality education. I mean access to accurate information which can include data, figures, drawings and narratives, but also skills and empowerment to reflect and choose.”⁷⁵

*J. Almeida, YouAct,
Hearing at the European Parliament, 12th February 2008.*

10.1. Introduction

Young people need accurate and comprehensive education regarding sexuality in order to be able make informed choices, enjoy life, practise safe sexual behaviour and avoid the unwanted outcomes of unsafe behaviour.

Numerous scientifically rigorous, peer reviewed studies provide robust evidence for the efficacy of [Comprehensive Sexuality Education \(CSE\)](#) programs in reducing risky behaviour and [HIV](#) transmission⁷⁶. The efficacy of CSE programs in decreasing the likelihood of unprotected sexual intercourse at the time of the first intercourse^{77 78 79} and reducing risky sexual behaviours has also been demonstrated in numerous empirical studies^{80 81}. On the other hand, [abstinence-based sexuality education](#) has received little or no evidence in regards to its effectiveness, and has repeatedly been demonstrated to be no more effective or even less effective than no sexuality education at all⁸². Indeed, in several studies, adolescents who received CSE had lower risk of pregnancy than adolescents who received abstinence-only sex education, or who did not receive any sex education⁸³. Furthermore, CSE programs conducted by peers have greater influence on youth attitude and behaviour than adult or professionals led programs^{84 85}. Contrary to common myth, CSE programs that discuss the appropriate use of condoms do not result in an earlier age of first sexual intercourse^{86 87} but do decrease pregnancy rates⁸⁸. The majority of parents also support the provision of CSE programs for their children^{89 90}.

10.2. Current situation

Due to a lack of, or inadequate, knowledge and skills, young people may engage in risky behaviours related to [sexuality](#) such as: unsafe sex (which can lead to unwanted pregnancies and STIs), [sexual harassment](#), peer pressure and [unsafe abortions](#). Research repeatedly indicates that the majority of sexually active adolescents do not use condoms consistently⁹¹. Although young people are concerned about HIV/AIDS, many of them do not perceive themselves to be personally at risk and lack accurate information about circumstances that place

them at increased risk for HIV infection⁹². Data provided by WHO indicate that nearly one million people acquire an STI, including HIV, every day⁹⁰.

In order to address these problems it is necessary that States provide CSE to young people.

10.3. Rights

The [ICPD Programme of Action \(1994\)](#)⁶, Article 7.37, states that:

“Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child.”

“Educational efforts should begin within the family unit, in the community and in the schools at an appropriate age, but must also reach adults, in particular men, through non-formal education and a variety of community-based efforts”.

The [Universal Declaration of Human Rights \(1948\)](#)¹¹, [European Convention of Human Rights \(1950\)](#)⁹³, [International Covenant on Economical, Social and Cultural Rights \(1966\)](#)⁷⁴ and the [Convention on the Rights of the Child \(1989\)](#)¹⁵ state that everyone has the right to education.

The [Convention on the Rights of the Child \(1990\)](#)¹⁵ states that the child has the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

The [Convention on the Elimination of all forms of Discrimination Against Women \(CEDAW, 1979\)](#)³², Article 10, declares that states parties shall take all appropriate measures to ensure access to specific educational information to help ensure the health and wellbeing of families, including information and advice on family planning.

The [Beijing Declaration \(1995\)](#)⁹⁴, Article 30, states that equal access to and equal treatment of women and men should be ensured in education and health care and enhance women's sexual and reproductive health as well as education.

10.4. Needs and interests

- Young people need to receive adequate information on puberty, [sexuality](#), [contraception](#) methods, services, and other topics in SRHR.
 - Young people need to develop adequate skills on how to make responsible decisions, how to use contraception (particularly barrier methods such as condoms and femidoms), how to negotiate the use of contraception with sexual partners, and how to protect themselves from unwanted pregnancy and [STIs](#) including [HIV](#).
 - Young people need CSE with a broad scope of approaches in order to be enabled to make informed choices.
 - CSE should be provided for everyone starting at childhood (at 6 years) throughout schooling and education.
 - Young people should receive CSE with content including the following topics:
 - Anatomy and development in [adolescence](#)
 - Feelings and emotions
 - [Gender roles](#) and [stereotypes](#)
 - Well-being, relationships, and the positive aspects of sexuality
 - Decision making
 - Sexuality, including LGBTIQ issues
 - Raising awareness on STIs, including HIV/AIDS
 - Raising awareness on substance abuse
 - Healthy lifestyles
 - Prevention of violence
-

“I would like to see Comprehensive Sexuality Education in schools equally as important as maths for example”

Milan, youth activist, Former Yugoslavian Republic of Macedonia.

10.5. Vision

- Providing CSE is the responsibility of the State and it should be included in school curricula throughout all levels of schooling.
- Programs of CSE should be designed by young people together with NGOs, experts, teachers and policy makers.
- CSE should be implemented in schools by trained professionals (e.g. teachers, health professionals) and trained peer educators. In order to guarantee the quality of CSE programs teachers should receive proper training on SRHR issues and on how to work with young people on these issues. Also, additional trainings and courses should be provided to teachers and non-formal educators on a regular basis.
- States should ensure that adequate monitoring and evaluation systems programs are in place for CSE, to measure the impact and ensure the high quality of these programs. Young people and professionals should be involved in the monitoring and evaluation processes of CSE programs.
- States, NGOs and other stakeholders should ensure that non-formal CSE is provided for young people through youth centres and clubs in order to reach all young people, including young people from minorities and [marginalised groups](#), and LGBTIQ people.
- Every young person should be equipped with life skills for the field of SRHR.

[The International Conference for Population and Development 5 year Review ICPD+5 \(1999\)](#)⁹⁵, Paragraph 53, states that Governments, with assistance from UNAIDS and donors should ensure that by 2010 at least 95 % of young men and women aged 15-24 have access to information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.

Parliamentary Assembly, Resolution 1394 (2004) on “The involvement of men, especially young men, in reproductive health” calls upon member states to provide age- and gender-appropriate, comprehensive sexual and reproductive information and education⁹⁶.

Examples:

“Sometimes young people are ashamed to talk about sexuality or sex, but they are not ashamed to practise it. I would like to change that.”

Peer educator, Youth Centre “In Corpore”, Lithuania.

Every young person has the right to CSE. Every day young people are confronted with numerous confusing messages about SRHR. CSE can facilitate their understanding of these messages, in order to enable them to have a healthy and pleasurable sexual life. Every young person should be equipped with life skills in the field of SRHR when leaving school.

It is often asserted that CSE enables young people to make informed choices about sexual relationships and to protect their sexual health. There is now strong international evidence that school-based education can be effective in reducing sexual risk behaviour and is not associated with increased sexual activity or increased sexual risk.

The majority of reviewed [CSE](#) programs have been demonstrated to either delay sex or reduce the number of sexual partners among young people. CSE also has empirically demonstrated benefits on increasing the knowledge and awareness of risk, values and attitudes, efficacy to negotiate sex and to use condoms, and communication with partners. All of the above have been shown to be effective steps in promoting healthy behaviour^{78 97}.

11. ABORTION

11.1. Introduction

This section concerns access to safe, legal, affordable, appropriate and acceptable [abortion](#).

All women have the right to be and feel in charge of their own body. It is, consequently, important for young women to know how to be in charge of their own body, their own feelings, and their own [sexuality](#). Young women have to be able to make informed decisions regarding their sexuality, when and with whom to have sex, when to have children, with whom to have children, or if to have children at all. Young women tend to delay in seeking [abortion](#) services; either because of fear of stigma, not having recognised that they are in fact pregnant, lack of money or fear of discrimination or a combination of these. Unwanted pregnancies could be a serious threat to a young woman's life and her future in terms of access to education and access to the employment market, which could have repercussions on the availability of needed finances for both herself and her child.

11.2. Current situation

Young women often have different needs to adult women, such as being more fertile, or having less experience in using contraception. This often puts them at greater risks of unwanted pregnancy compared to older women, as well as at risk of more adverse implications such as health complications and social effects from pregnancy. Unfortunately, due to lack of access to [CSE](#), [youth-friendly services](#), to [contraception](#), and often, because of restrictive national legislation young women are not always able to act upon their right to decide over their own body⁹⁸.

Since young women are less likely to have access to legal and safe abortion than their older counterparts, they are estimated to account for 14% of all [unsafe abortions](#) globally⁹⁹. It is estimated that up to four million adolescents a year have unsafe abortions¹⁰⁰. If there are complications as a result of unwanted pregnancy or unsafe abortion, young people are more likely to delay seeking care. In some countries where access to modern contraception

is very limited, abortion levels are high. A ban on abortion is often introduced with the intention to decrease the number of abortions within the nation that adopts this policy. However, it has been shown that as a result of such policies abortion is forced underground leading to an increase in the number of unsafe abortions and recently a trend in abortion tourism.

It is not possible to completely eliminate all unwanted pregnancies because of all factors and causes involved. We all need to acknowledge the fact that all methods of contraception can fail.

Unsafe abortion methods constitute a serious threat to a woman's freedom of choice, her health and even her life¹⁰¹.

11.3. Rights

[International Planned Parenthood Federation \(IPPF\) Charter on Sexual and Reproductive Rights \(1996\)](#)¹⁸

8.1. All women have the right to information, education and services necessary for the protection of reproductive health, [safe motherhood](#) and safe abortion, and for these to be accessible, affordable, acceptable and convenient for all users.

[UN Convention on the Rights of the Child \(1989\)](#)¹⁵

Article 16.1, 16.2.
No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation. The child has the right to the protection of the law against such interference or attacks.

Council of Europe, Resolution 1607 (2008)¹⁰²

The Assembly affirms the right of all human beings, women included, to respect for their physical integrity and to freedom to control their own bodies. In this context, the ultimate decision on whether or not to have an abortion should be a matter for the woman concerned, and she should have the means of exercising this right in an effective way.

Convention on the Elimination of all forms of Discrimination Against Women (CEDAW, 1979)³²

Article 16e

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

11.4. Needs and interests

- Young women need privacy when they are about to undertake an abortion. **Confidentiality** is the key factor in improving access to abortion for young women. Young women and girls need to be sure that physicians, nurses, and other health practitioners will not disclose the abortion to third parties, including their parents, and also that their identity will not be included in data collection for purposes of monitoring and record keeping.
 - Provision of young women with a broad range of contraceptive options, is paramount in the attempt to reduce high levels of abortion.
 - Abortion cannot be restricted to cases where the young girl's health is in danger. The right to choose and decide over own body must prevail.
 - Young women seeking abortions need to receive accurate information and non-directive counselling about abortion services. The woman's right to self-determination must always be of highest priority.
-

- Young people have specific needs concerning counselling; they may be at risk of emotional stress due to lack of support from partner, friends, or parents.
- In cases where physicians refuse to perform abortions on grounds of conscientious objections, women need to be ensured the right to be further referred and in order to be provided with abortion services.

11.5. Vision

- Access to abortion services for women should be universal, in the sense that no woman shall be denied access. It must be accessible for all women, including exchange and international students, legal or illegal immigrants, asylum seekers and other marginalised groups. The abortion service should consist of: choice, access and high-quality medical and counselling services in a stigma-free environment.
 - No young woman should be criticised or punished after having undergone an abortion.
 - Access to abortion services should be provided free of charge, including pre- and post-abortion counselling, hospital-care and medical procedure.
 - The feelings of the partner or spouse, when present, of the woman seeking abortion should be acknowledged. Counselling should be available for both the women and their partners, in partnership or individually, to help them deal with emotional issues.
 - In case of conscientious objection by a medical doctor, the woman should be immediately referred in order to ensure her access to the appropriate service.
 - Women should have the right to decide whether they want to have children, how many, when, how, and with whom. Ideally, decisions should be made in consultation with their partners, in cases of couples, but can never be limited by the partners, parents, health care professionals or the State.
 - Abortion should not be used as a method of contraception. Women need the freedom of choice when they are in need of this service.
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PART III.
FINAL WORDS

FINAL WORDS

This Charter was developed in order to introduce steps toward advancement in the [Sexual and Reproductive Health and Rights](#) (SRHR) situation of young people in Europe. It is intended to be used as an advocacy tool to address both imminent and long-term SRHR issues for young people in Europe. We call for this Charter to be used as a tool for knowledge, advocacy and decision-making with regards to SRHR issues in Council of Europe countries. This document is also intended to highlight the importance of SRHR in relation to the human rights discourse and other central socio-political issues.

We want to encourage further discussion on topics raised in this Charter. Partnerships, [adoption](#) policies, abortion, cultural issues such as honour-related violence and [female genital mutilation](#) are amongst the subjects that often spark heated debate. These subjects are often avoided as they elicit divergent opinions, however it is our view that for this very reason, it is essential for them to be discussed.

As young activists committed to the cause of human rights we will utilise this Charter, amongst our other efforts, towards improving the status of SRHR of young people. Our efforts will always be directed by our common vision of a world where everybody is able to reach maximal well-being with regards to their sexuality. Joint efforts through effective youth-adult partnerships will pave the way towards our vision.

APPENDIX

Definitions

A

Abortion

An abortion can occur either spontaneously, when it is called a spontaneous abortion or miscarriage, or it can be brought about by deliberate intervention, when it is called an induced abortion. The stage at which a foetus is considered viable varies according to different legislations and recommendations.

From: [International Planned Parenthood Federation \(IPPF\) glossary](#), online 2008¹⁰³.

Accountability

An obligation or willingness to accept responsibility or to account for one's actions.

From: [Merriam-Webster online dictionary](#), online 2008¹⁰⁴

Adolescence

According to World Health Organization, adolescence is the period of life between 10 to 19 years old.

Early adolescence (10-13) is characterized by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.

In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective.

In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions.

These changes take place at a different rate for each individual.

From: [World Health Organization](#), 2002¹⁰⁵

Adoption

The official transfer through the court system of all of the parental rights that a biological parent has to a child, along with an assumption by the adopting parent of all of the parental rights of the biological parents that are being terminated and are assumed in their entirety by the adoptive parents, including the responsibility for the care and supervision of the child, its nurturing and training, its physical and emotional health, and its financial support.

From: [Adoption glossary](#), online 2008¹⁰⁶

AIDS

Acquired immunodeficiency syndrome. The late stage of infection caused by the Human Immunodeficiency Virus (HIV). HIV steadily weakens the body's defence (immune) system until it can no longer fight off life-threatening illnesses. These include infections such as pneumonia and certain cancers

From: [IPPF glossary](#), online 2008¹⁰³.

Antiretroviral Therapy (ART)

The name given to treatment regimens recommended by leading HIV experts to aggressively suppress viral replication and progress of HIV disease.

From: [IPPF glossary](#), online 2008¹⁰³.

C

Civil Union/Civil Partnership

Legal recognition of the committed, marriage-like partnership of two individuals. Typically, the civil registration of their commitment provides the couple with legal benefits that approach or are equivalent to those of marriage, such as rights of inheritance, hospital visitation, medical decision-making, differential taxation, adoption and artificial insemination, and employee benefits for partners and dependents.

From: [Encyclopaedia Britannica](#), online 2008¹⁰⁷

Client-initiated HIV testing and counselling (also called Voluntary Counselling and Testing, or VCT)

Involves individuals actively seeking HIV testing and counselling at a facility that offers these services. Client-initiated HIV testing and counselling usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. Client-initiated HIV testing and counselling is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in people's homes.

From: [WHO & UNAIDS](#), 2007¹⁰⁸

Confidentiality

The ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure.

From: The American Heritage Stedman's Medical Dictionary, 1995¹⁰⁹.

Contraception

Contraception, also known as birth control, is designed to prevent pregnancy.

There are several general methods of birth control, including (but not limited to):

Barrier methods, such as condoms, the diaphragm, and the cervical cap, designed to prevent the sperm from entering the uterus.

Intrauterine device, or IUD, is a small device that is inserted into the uterus by a health care provider. The IUD is more than 99 percent effective at preventing pregnancy. An IUD can stay in the uterus for up to 10 years until it is removed by a health care provider.

Hormonal birth control, such as birth control pills, injections, skin patches, vaginal rings, and implants release hormones into a woman's body that interfere with fertility by preventing ovulation.

Sterilization is a method that permanently prevents a woman from getting pregnant or a man from being able to get a woman pregnant. Sterilization involves surgical procedures that must be done by a health care provider and usually cannot be reversed.

The choice of birth control depends on factors such as a person's overall health, age, frequency of sexual activity, number of sexual partners, desire to have children in the future, and family history of certain diseases. A woman should talk to her health care provider about her choice of birth control method.

It is important to remember that even though all these methods can prevent [pregnancy](#), condoms are the only method that can protect against [sexually transmitted diseases](#) or [HIV](#).

From: [National Institute of Child Health and Human Development \(NICHD\)](#), online 2008¹¹⁰

D

Domestic violence

A general term for violence directed against children in a family, i.e., child abuse; against a spouse or partner; against a dependent older person, i.e., elder abuse; or against some other household member.

From: A Dictionary of Public Health, 2007¹¹¹

E

Emergency Contraception (EC)

Method of contraception used to avoid pregnancy after a single act of sexual intercourse that was unprotected due to lack of use or failure of a contraceptive. Emergency contraceptive pills (ECPs) are thought to prevent ovulation, fertilization, and/or implantation. ECPs are not effective once the process of implantation has begun, and do not cause abortion.

From: [IPPF glossary](#), online 2008¹⁰³.

F

Family planning (FP)

The conscious effort of couples or individuals to plan for and attain their desired number of children and to regulate the spacing and timing of their births. Family planning is achieved through contraception and through the treatment of involuntary infertility.

From: [IPPF glossary](#), online 2008¹⁰³.

Female genital mutilation (FGM)

(Also Female genital cutting).

A traditional practice that involves cutting away parts of the female external genitalia, or other injury to the female genitals, for cultural or other non-therapeutic reasons, rendering

intercourse and childbirth painful and potentially hazardous. It is usually carried out by traditional practitioners under unhygienic conditions.

Also referred to as female genital mutilation or female circumcision.

The World Health Organisation has classified female genital cutting into four main groupings:

Type I clitoridectomy involves the removal of the prepuce (clitoral hood), sometimes together with part or all of the clitoris. This is what is commonly referred to as 'Sunna circumcision'.

Type II involves excision, where both the clitoris and part or all of the labia minora (inner vaginal lips) are removed.

Type III (infibulation) is where the clitoris is removed, some or all of the labia minora are amputated and incisions are made on the labia majora (outer lips) to create a raw surface.

These raw surfaces are either stitched together and/or kept in contact until they seal as a 'hood of skin' covering the urethra and most of the vaginal opening. A small opening is created to allow the flow of urine and menstrual blood.

Type IV is an unclassified category that includes other operations on the external genitalia including introcision, piercing or incising the clitoris and/or labia, cauterization, scraping and/or cutting of the vagina, introduction of corrosive substances and herbs into the vagina and similar practices.

From: [IPPF glossary](#), online 2008¹⁰³.

G

Gender

Refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women.

The distinct roles and behaviour may give rise to gender inequalities, i.e. differences between men and women that systematically favour one group. In turn, such inequalities can lead to inequities between men and women in both health status and access to health care.

From: [World Health Organization](#) (WHO, 2001)¹¹²

Gender based violence

Gender based violence (GBV) encompasses a range of acts of violence. The United Nations General Assembly in 1993 adopted the definition of violence against women as "any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It encompasses, but is not limited to: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital cutting and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."

From: [IPPF glossary](#), online 2008¹⁰³.

Gender discrimination

Gender discrimination refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms which prevents a person from enjoying full human rights.

From: [World Health Organization](#) (WHO, 2001)¹¹².

Gender equality

The equal valuing of the roles of women and men leading to both sexes being able to equally contribute to and benefit from economic, social, cultural and political developments within society.

From: [Global education glossary](#), online 2008¹¹³

Gender Identity

The psychological sense of the self as masculine or feminine. This is not always the same as gonadal sex. A few individuals who are genetically members of one sex feel and act as though they are members the other sex.

From: A Dictionary of Public Health, 2007¹¹⁴

Gender roles

Gender roles are learned behaviours in a given society/community, or other special group, that condition which activities, tasks and responsibilities are perceived as male and female.

From: [United Nations Development Program](#), UNDP, 2001¹¹⁵

H**HIV**

Human immunodeficiency virus. The virus that causes AIDS. Two types of HIV are currently known: HIV-1 and HIV-2. Worldwide, the predominant virus is HIV-1. Both types of the virus may be transmitted by sexual contact, through blood, and from mother to child (either before or during birth, or through breast feeding), and they appear to cause clinically indistinguishable AIDS. However, HIV-2 is less easily transmitted, and the period between initial infection and illness is longer in the case of HIV-2. While some individuals experience mild HIV-related disease soon after initial infection, nearly all then remain well for years. As the virus gradually damages their immune system, they begin to develop opportunistic infections of increasing severity, including diarrhoea, fever, tuberculosis, pneumonia, lymphoma and Kaposi's sarcoma.

From: [IPPF glossary](#), online 2008¹⁰³

Homophobia

Irrational fear of, aversion to, or discrimination against, homosexuality or homosexuals.

From: [Merriam- Webster online dictionary](#), online 2008¹¹⁶

I**Infertility**

Infertility is the inability to become pregnant after 12 months of unprotected sex (intercourse).

Primary infertility is the term used to describe a couple that has never been able to achieve a pregnancy after at least one year of unprotected sex.

Secondary infertility describes couples who have been pregnant at least once, but have not been able to achieve a pregnancy again.

From: [Medical Encyclopaedia](#), online 2008¹¹⁷

P

Provider-initiated HIV testing and counselling (PIHTC)

Refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status.

In the case of persons presenting to health facilities *with symptoms or signs of illness that could be attributable to HIV*, it is a basic responsibility of health care providers to recommend HIV testing and counselling as part of the patient's routine clinical management. This includes recommending HIV testing and counselling to tuberculosis patients and persons suspected of having tuberculosis.

Provider-initiated HIV testing and counselling also aims to identify unrecognised or unsuspected HIV infection in persons attending health facilities. Health care providers may therefore recommend HIV testing and counselling to patients in some settings even if they *do not have obvious HIV-related symptoms or signs*. Such patients may nevertheless have HIV and may benefit from knowing their HIV-positive status in order to receive specific preventive and/or therapeutic services. In such circumstances, HIV testing and counselling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in the health facility.

It is emphasised that, as in the case of client-initiated HIV testing and counselling, provider initiated HIV testing and counselling is voluntary and the "three C's" – informed consent, counselling and confidentiality – must be observed.

From: [World Health Organization & UNAIDS](#), 2007¹¹⁸

S

Safe motherhood

Pregnancy and childbirth with low risk of death or ill health. In order to make motherhood safer, women need regular antenatal advice and care, a good diet during pregnancy, to be attended by trained personnel at delivery, and to have access to treatment for obstetric emergencies. Reducing high rates of maternal mortality and morbidity also depends on reducing the likelihood of women experiencing an unwanted high risk pregnancy, which necessitates the availability of family planning and safe abortion services.

From: [IPPF glossary](#), online 2008¹⁰³.

Safe sex

Any sexual practice that aims to reduce the risk of unwanted pregnancy and of passing HIV (and other sexually transmitted infections) from one person to another. Examples are non-penetrative sex or vaginal intercourse with a condom. During unsafe sex, fluids that can transmit HIV and other STIs (semen, vaginal fluid or blood) may be introduced into the body of the sex partner.

From: [IPPF glossary](#), online 2008¹⁰³.

Sexual orientation

Sexual orientation refers to the primary sexual attraction to the same sex, opposite sex or both sexes. It should be emphasised that it is not a choice to be heterosexual.

From: [IPPF glossary](#), online 2008¹⁰³.

Sexuality counselling

Counselling on issues of sexuality with the aim of creating a climate here clients can express themselves and their concerns relating to sexual relationships and intimacy without fear of discrimination.

From: [IPPF glossary](#), online 2008¹⁰³.

Sexuality Education, Abstinence-based

Abstinence-based sexuality education is an approach of promoting the decision to avoid certain sexual activities or behaviours. Different people have different definitions of sexual abstinence. For some, it may mean no sexual contact. For others, it may mean no penetration (oral, anal, vaginal) or only 'lower-risk' behaviours.

From: [IPPF glossary](#), online 2008¹⁰³.

Sexuality Education, Comprehensive (CSE)

Education that encompasses and refers to all kind of information relating to SRHR, reproductive processes, puberty, sexual behaviour, etc. Comprehensive Sexuality education may include other information, for example about contraception, protection from sexually transmitted infections and parenthood.

From: [IPPF glossary](#), online 2008¹⁰³.

Sexually Transmitted Infections (STIs)/Sexually Transmitted Diseases (STDs)

Sexually transmitted infections (STIs) are infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites.

Several, in particular HIV and syphilis, can also be transmitted from mother-to-child during pregnancy and childbirth, and through blood products and tissue transfer.

From: WHO, [Sexually Transmitted Infections](#), online 2008¹¹⁹

U**Unsafe abortion**

An induced abortion conducted either by persons lacking the necessary skills or in an environment lacking the minimal medical and hygienic standards, or both. Although the majority of the world's women live in countries where laws permit an induced abortion if a woman requests one and if there are health or social grounds for allowing it, a quarter of women live in countries where there is no access to legal abortion. Even in countries where abortion is legal, women may not be able to obtain abortions easily for reasons of bureaucracy, availability or accessibility. In these circumstances women with unwanted pregnancies frequently resort to unsafe abortion.

From: [IPPF glossary](#), online 2008¹⁰³.

Y**Youth-Friendly Services**

Youth-friendly sexual and reproductive health services are those that attract young people, respond to their needs and retain young clients for continuing care. Youth-friendly services are based on a comprehensive understanding of what young people in a given society or community want, and on respect for the realities of their diverse sexual and reproductive lives. The aim is to provide all young people with services they trust and which they feel are intended for them.

All clients of Sexual and Reproductive Health services have the right to information about the benefits and availability of services and to access these services, regardless of their race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability. They have a right to protect themselves from unwanted pregnancy, disease and violence and to decide freely whether and how to control their fertility and other aspects of their sexual health. Service providers should treat all young people with dignity and respect, assure confidentiality, offer a comfortable and relaxed environment and provide services for as long as needed.

Optimum youth-friendly services offer an integrated range of different services, or a good referral system to high-quality specialist services, and should include:

- Sexuality information
- Counselling
- Pregnancy testing
- Safe abortion
- Testing and treatment for sexually transmitted infections (STIs) and HIV and
- Services for those who experience emotional or physical (domestic) violence, rape, gender based violence, trafficking or female genital mutilation.

From: [IPPF EN, Fact Sheet on Youth – Friendly Services](#), online 2008¹²⁰

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