

*Sexual and reproductive rights
in Central America*

Towards an agenda for action

Systematisation: Michael Clulow



LAS DIGNAS



Las Melidas



Grupo Venancia is a feminist popular education collective based in Matagalpa, Nicaragua where it has worked for over 13 years. The group's principal objectives are: the strengthening of collective and individual leadership of women of all ages; the transformation of discriminatory beliefs, attitudes and practices; and the promotion of a culture of equity, diversity and creativity.



The Women's Association for Dignity and Life "Las Dignas" was founded in El Salvador in 1990. Since then Las Dignas have sought to contribute to the struggle of the

women's movement through four principal areas of action: anti-sexist education; the improvement of women's economic conditions; gender violence; and political participation and leadership.



The Mélida Anaya Montes Women's Association (Las Mélidas)

celebrated its tenth anniversary in July 2002. During those

ten years, this Salvadorian organisation has been active in widely varying areas of work including: feminist education; political participation and citizens' initiatives; health; domestic and gender-based violence; socio-economic development; and workers' rights.



The Women's Support Centre, Tierra Viva was created in Guatemala in 1989 with the

mission to confront the inequality, subordination and discrimination of women. The group seeks to influence political decision-making; support the creation and growth of local women's organisations; and to contribute to raising the awareness of all Guatemalans about women's rights.



The Women's Study Centre-Honduras (CEM-H) has worked

for 16 years to promote: women's human rights; participation and leadership; the eradication of violence; and sexual and reproductive health. The centre's principal strategies are lobbying, public mobilisation and the strengthening of the women's movement.



One World Action works for a world free from poverty and oppression in which strong democracies safeguard the

rights of all people. To this end, it provides money, expertise and practical help to organisations committed to strengthening the democratic process and improving people's lives in poor and developing countries. One World Action also helps its partners to forge closer links with decision makers in Britain and the European Union, and influence them.

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Introduction

Sexual rights and reproductive rights (SRRR) are of crucial importance for women. Nevertheless, in Central America, the full exercise of those rights is severely obstructed with serious consequences for women's well-being and independence. This is not only a matter of urgent problems such as maternal mortality, HIV AIDS or sexual trafficking; the denial of women's SRRR also undermines the exercise of women's citizenship. To quote the Latin American and Caribbean Committee for the Defence of Women's Rights (CLADEM): "We are citizens... we can determine the destiny of our nations, shouldn't we also determine the destiny of our bodies?"

During 2003, the five feminist organisations that participate in the project "Building Women's Citizenship and Governance in Central America" prepared national studies that analysed the reality of women in El Salvador, Guatemala, Honduras and Nicaragua in relation to their SRRR.¹ These studies analysed a range of important issues—health, maternity, abortion, sexual exploitation, sex education, contraception, sexual orientation and others—but were not limited to a description of indicators and tendencies in women's situation. Rather, they also analysed the State's treatment of these rights—through laws, programmes and other actions—as well as exploring the approach of the women's movement. Each study concluded with a set of proposals, which, in the first place, were aimed at the women's movement but also provided ideas to guide the action of other sections of civil society, as well as governments and donors.

The present document seeks to systematise those studies, adding in some additional material from other sources, so as to present a regional overview and proposals. The marked similarities between the four countries make the construction of such an overview meaningful and give validity to the development of common strategies through which women in each country may achieve greater access to these rights. It is our hope that the document will make a contribution to improving understanding of the issues dealt with by the studies, both in government and in civil society, within the region and abroad. Most importantly, we hope that it contributes to the design of actions to promote sexual rights and reproductive rights in Central America and elsewhere, and to the increased prioritisation of this area by the women's movement, international aid agencies and the global social movement.

Author's notes

Most of the information sources quoted in this document refer to additional information not included in the national studies. Generally speaking, sources already cited in those studies have not been referenced.

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Executive summary

Demands and reality

By demanding their sexual rights and reproductive rights (SRRR), Central American women are reclaiming the autonomy of their bodies from a patriarchal culture which views them as dependent on men and predestined to motherhood. They declare their right to the power and resources that will allow them to take effective decisions and enjoy health in all aspects of their sexuality and reproduction. However, the reality of the region's women is that they are very far from being able to exercise those rights:

- ◆ Men tend to take the decisions on all aspects of women's sexuality. Many believe that they have the right to impose their will, and frequently feel justified in using violence.
- ◆ Only heterosexual relations are viewed as acceptable by society.
- ◆ Motherhood is practically an obligation.
- ◆ Women are exposed to high levels of violence.
- ◆ Globalisation is leading to increasing commercial sexual exploitation.
- ◆ Access to education and information on sexuality and reproduction is limited.
- ◆ State services in sexual and reproductive health are very limited in coverage and quality. In addition, health service personnel frequently mistreat women because of personal prejudices.
- ◆ Contraceptive use is blocked by many obstacles including: male opposition; limited provision of state services; limited education; and poverty.
- ◆ Abortion is completely illegal or severely restricted. These prohibitions reinforce cultural attitudes that make abortion a taboo.

The denial of SRRR has many serious impacts, including the following effects on health and reproduction:

- ◆ The rates of teenage pregnancy are among the highest in the world and include a high proportion of unplanned and unwanted pregnancies.
- ◆ Maternal mortality is one of the most important causes of women's death, due to factors that include unsafe abortions and premature pregnancies.
- ◆ The HIV/AIDS epidemic is rapidly growing and becoming feminised. The numbers of deaths of women of reproductive age due to AIDS are reaching alarming levels.

Official action and inaction

The governments of Central America have signed international agreements recognising SRRR, however their actual level of commitment is weak:

- ◆ The majority of members of governments and legislatures share the ideas of traditional culture. Consequently they neither recognise women's SRRR nor prioritise their health.
- ◆ Although the Central American states are formally secular, the church exercises considerable influence on public policy.
- ◆ The dominant neoliberal model blocks any increases in social spending which are needed to allow the exercise of SRRR.

The area of greatest legal progress is sexual violence while, in relation to commercial sexual exploitation, the procuring of prostitutes is penalised. In addition, state bodies in Honduras and Nicaragua are working together with civil society organisations to better typify crimes in this area. Recently, diverse policies and laws on sexual and reproductive health have been passed in Honduras and Guatemala, and all the countries have enacted laws related to HIV/AIDS.

Unfortunately, implementation of these measures is very limited. Frequently, little or no funding is assigned while many public officials oppose the new laws and policies. In cases of violence and sexual exploitation, the police and the courts tend to act in a patriarchal fashion, revictimising women and harassing commercial sex workers.

In addition, various policies block women's access to their SRRR, for example the prohibition of abortion. This prohibition condemns many poor women to death. Because of their poverty, they have no access to good quality services which become very expensive so they use high-risk procedures instead. At the same time, contraceptive services and information are directed almost exclusively to women, there are distortions in the promotion and availability of the different methods, and teenagers' access to contraceptives is obstructed. In relation to sex education, there is no official programme whatsoever in Guatemala while attempts to publish sex education manuals in El Salvador, Honduras and Nicaragua have all failed due to the opposition of the Catholic Church. Finally, in Nicaragua, the penal code includes sodomy as an offence, discriminating against gays and lesbians or anyone who promotes or publicises homosexuality. The other countries of the region do not have such laws but they are equally opposed to the recognition of gay and lesbian rights.

An agenda for action

The promotion of SRRR should be a priority for the women's movement. As a first step, wide-ranging discussion and debate is needed so as to develop a common agenda. At the same time, it is very important that alliances be built, promoting support by other sectors in as far as that is possible, but without sacrificing the radical nature of the movement's own agenda. Issues suggested as priorities include:

- ◆ **Cultural attitudes.** Changes that should be promoted include a positive vision of sexuality, the understanding of motherhood as an option rather than destiny, and acceptance and respect for lesbians and other people whose sexual orientation is not heterosexual.
- ◆ **Defence of the Secular State.** By persuading the region's governments to stop following the dictates of the most conservative sectors of the church, one of the principal obstacles to more progressive laws and policies would be removed.
- ◆ **Globalisation.** The relationship between neoliberalism and the negation of women's SRRR should be made clear.
- ◆ **Information.** It is crucial that young and adult women gain better access to education and information on sexuality, contraception and sexual and reproductive health.
- ◆ **Health.** The region's governments should stop relegating sexual and reproductive health behind other supposed priorities, giving it appropriate attention and resources.
- ◆ **Contraception.** Women and teenagers require improved access to contraceptives and quality advice in this area, while programmes for men should be promoted.
- ◆ **Abortion.** The right of each woman to take decisions about her own body should be a fundamental aspect of advocacy on this issue, in addition to arguments for decriminalisation based on public health and social justice. This includes the possibility of seeking that, in the first place, therapeutic abortion be decriminalised in those places where it is prohibited and that women are guaranteed access to this procedure where it is still legal.

1 A feminist vision of sexual rights and reproductive rights (SRRR)

1.1 Rights, autonomy and citizenship

Despite the changes in Central American society that have occurred during the last forty years, women are still conceived of in traditional terms. They are seen as being dependent on men and submissive to their fathers, husbands or partners. They are destined to be self-sacrificing mothers taking care of their families and homes. In their sex lives, they should be pure and faithful.

In this culture, women's bodies are not their own, rather they are at the service of others. This is the basis of women's subordination and it is reinforced through laws and state institutions. Thus, a profound contradiction has been created: for several decades women have enjoyed formal citizenship yet they are still not granted full control of their bodies even though this is the basis of citizenship.

The promotion of women's sexual rights and reproductive rights (SSSR) directly challenges this culture as the affirmation of their right to make decisions concerning their sexuality and maternity implies the autonomy of their bodies. Women need to demand this autonomy in two spheres: the personal sphere, by asserting ownership of their bodies, regardless of the restrictions placed by culture and laws; and in the political sphere, by advocating that states, rather than being characterised by patriarchal attitudes, should enact laws and policies that contest such attitudes and contribute to cultural transformation.

1.2 SRRR and sexuality

The fundamental principle underlying the demand for women's sexual rights and reproductive rights is that they have the right to the power and the resources necessary for them to be able to take effective decisions regarding all aspects of their sexuality and reproduction. However, it is not possible to understand or exercise this right without an adequate understanding of sexuality. Without this, sexual rights tend to be overlooked or considered as a sub-set of reproductive rights when, in fact they are related but distinct. In reality, sexual rights ought to be prioritised since if they are not respected, it is almost impossible for women to exercise their reproductive rights.

In Central American culture, sexuality tends to be equated with heterosexuality, marriage and reproduction. The churches, especially the Catholic Church, teach that sexuality is something bad, that it should only be exercised in limited circumstances, and that it must be related to reproduction. This position is reinforced in sex education programmes that only teach about biological reproduction. Women are taught to equate the exercise of sexuality with love and with reproduction, and even to believe that 'sexuality is something dirty and impure, only allowed for men, not for we women who should be clean and pure'.² Women, but not men are obliged to accept a formula in which love = sexuality = reproduction = the maximum expression of love. Pleasure has no place in this equation.

This vision should be challenged by affirming the value of sexuality as a basic facet of human nature that is essential for our development and happiness, as much for women as for men. Reproduction is an aspect of our sexuality, but it is only a possibility; it is not the most important reason or expression of sexuality, much less its only reason or legitimate expression. Reproduction is limited to a particular period of women's lives, but sexuality is a dimension of their being from birth to death. With such a vision, sexual rights become a central element of human rights.

1.3 Defining SRRR

1.3.1 Sexual rights

Sexual rights are based on this understanding of sexuality and on the right to self-determination of one's body. They are directly related to the ability to derive pleasure through the exercise of sexuality and to society's tolerance of diverse sexual orientations. They signify that women may enjoy freedom in the intimate aspects of their lives; that they can decide free from pressure whether, with whom, how and when to have sexual relations. An indispensable corollary is the right of access to reliable information and the resources necessary to exercise one's sexuality freely and responsibly. These rights also imply that sexual relations and practices should be free from violence, aggression and exploitation.

Sexual rights also include the right to sexual health, which includes freedom from diseases, disorders and risks that limit the possibility of enjoying a satisfactory sex life. Similarly, sexual health includes 'the absence of feelings of shame and guilt, of unfounded beliefs and of other

psychological factors which inhibit sexual activity or disrupt sexual relations'.³

1.3.2 Reproductive rights

The principal reproductive right of women is that they can freely choose whether to procreate, when, with whom and how often. Implicit in this, is the right to information on fertility and family planning and access to safe, effective and acceptable methods of contraception. Another very important aspect of reproductive rights is the right to reproductive health understood as a state of integral physical, mental and social well-being in all respects related to the reproductive system, its functions and processes. To enjoy this right, women require information and access to high quality, dignified and efficient medical attention so as to be able to enjoy maternity without risks or to terminate an unwanted pregnancy safely, as well as for the prevention and treatment of infertility.

2 Living without rights: the experience of Central American women today

2.1 Women's practical access to their SRRR

2.1.1 Sexual experience

The concept of sexual rights is very far removed from the reality of most Central American women. Popular culture, church teaching, laws and state institutions act together to control and channel women's sexuality to the extent that it virtually only exists in relation to the interests of men and the state, regulated by laws covering the family, population, maternity and others. In most cases, it is the men who decide when and how to have sexual relations, frequently using coercion and violence. Men decide if they will use condoms, have sexual health checks or advise their partners about the results. Men decide if they will let their partners attend health centres or use contraceptives.

The effects of this culture were clearly seen in focus groups of Salvadorian women from urban and rural areas, which were conducted in 2003. These women tended to relate their bodies to feelings of shame and guilt and had very little understanding of either their own bodies or those of their partners. They entered into their first intimate relationships expecting that their sexual partners would have the information that they lacked but discovered that the men were equally ill informed. On reflection, they recognised that they became pregnant against their will through their first sexual encounters. Most of their sexual relations were without pleasure, and for several of the focus group members were

characterised by fear because of the violence of their partners. From their earliest sexual experiences, they submitted to the control and domination by men.

2.1.2 Heterosexuality as an obligation

Given that women's sexuality is seen as something to be exercised for men's satisfaction and for reproduction, it is no surprise that lesbianism is not viewed as a legitimate option. Only heterosexual relations fit into this model and are presented as the only way of conceiving sexuality. Heterosexuality is said to be "natural" and the family is exalted as the basis of society. However the family is defined in strictly limited terms—family = marriage = human reproduction—thus excluding lesbian couples, even if they have children.

Those women who break with this model and seek to live their sexuality openly expose themselves to outright hatred. Both lesbians and gays are actively marginalised and accused of being a danger to society. In a feat of moral acrobatics, reality is turned on its head as lesbians and gays are accused of trying to impose their values and preferences on the rest of society.

2.1.3 The imposition of motherhood

For Central American women, motherhood isn't just one of many possible life choices, it is practically the only option. Women continue to be equated with mothers in such a way that motherhood becomes the defining characteristic of a women's

identity. In contrast to the general disregard in which women are held, mothers are idealised, always assuming that they live according to the dominant model of service and self-sacrifice.

This social pressure, combined with pressure from their partner, leads to women not taking precautions to avoid or space pregnancies and to accept high-risk pregnancies. For many young women, who see few opportunities to give meaning to their lives, the idealisation of motherhood is one factor that leads them to view it as a means of fulfilment. At the same time, the lack of sex education, information and adequate sexual and reproductive health services make family planning difficult, a situation that is further compounded by the prohibition of abortion. On top of all this, there are many cases of rape that lead to pregnancy.

2.1.4 Sexual violence

The high incidence of sexual violence is demonstrated by its prominence in criminal statistics. In El Salvador, sexual violence is one of the three most common reasons for imprisonment. In the case of Nicaragua, out of all offences against the person reported during 2001, 11% were of a sexual nature.

It is important to note that, contrary to the impression created by the media, most rapists and abusers belong to the victim's family. The earliest sexual experiences of many young women are rape or sexual abuse by their fathers, other relatives or family friends. According to the 1998 National Health Survey in Nicaragua, more than 30% of all adolescent girls had been sexually abused by a member of the family or a family acquaintance. Other Nicaraguan data indicated that in 53% of cases of child sex abuse the aggressor was a family

member, while in 27% of cases it was an acquaintance.

Young girls and teenagers are especially vulnerable to sexual violence. According to a report from El Salvador, there were 60 cases of rape and sexual abuse for every 100,000 girls between 0 and 14 years old, compared to a rate of 51 rapes for every 100,000 women between the ages of 15 and 44. Data from Nicaragua showed that 65% of rapes were made against young girls and adolescents.

Despite the magnitude of these figures, they only represent part of the true situation. The real figures are considerably higher due to the great number of assaults that are never reported and due to the fact that most aggressors who are processed by the courts walk free, supposedly because of a lack of evidence. As the women who participated in the Salvadorian focal groups reported, sexual violence is part of their common experience. It should also be emphasised that violence is not always physical; there are also many types of psychological violence.

Thanks to insistent campaigning by the women's movement and the positive response of some aid agencies, those social attitudes that have justified, minimized and hidden sexual violence are beginning to change. Nevertheless, many men continue to believe that they have the right to impose themselves with violence, the condemnation of society in general lacks consistency and force, and impunity is the rule rather than the exception. There is a tendency to justify rapists and blame women. When the victim is a girl, the mother is blamed. When the victim is a young woman or adult, she is held responsible because of her behaviour, dress, activities or anything else that could make it seem that she "incited" or

“provoked” the assault. As Nicaraguan Ana Ara commented ‘the question of violence has been covered up by the whole social system... it has been hidden by the church, politicians, the social structure, laws... a mountain of sayings and songs reinforce this attitude... it’s seen as normal’.

2.1.5 Commercial sexual exploitation

The causes of sexual exploitation are complex but are clearly related to economic, social, gender and age-related inequalities. In addition, common cultural conceptions of sexuality continue to allow men to use women, girls and boys as objects to satisfy them sexually.

Even though this a structural problem, the magnitude of which is difficult to determine, it is clear that it is worsening due to various aspects of globalisation, especially increased international tourism and travel and the growth of the Internet. The growth in tourism is leading to increased sex tourism that exploits not only adult women, but teenagers, girls and boys as well. Similarly, the opening of frontiers to trade has facilitated the transnationalisation of people trafficking networks while thousands of women, girls and boys are exploited along the international transport routes.

It should be added that not all types of sexual exploitation are commercial. Young women in poor rural and urban areas face a very serious type of exploitation in which they are kidnapped and forced into sexual and domestic slavery. It is frequently said that the women participate willingly in these relationships but in fact they are threatened with violence that sometimes leads to murder if they try to escape or report the situation. Many older men kidnap adolescents, rape and exploit them, then sell them or send them back to their homes.

2.1.6 Access to information

For women to be able to exercise their rights, it is crucial that they have access to information about their bodies, sexuality, sexual and reproductive health, contraceptive methods, national legislation and other issues. Given this, sex education is of vital importance, nevertheless very little is provided (*see section 3.3.2*) and that which is available is biologically and religiously focused, failing to promote analysis and reflection. Sexuality is almost never mentioned either in school sex education or in public information campaigns. When it is dealt with, it tends to be in terms of promoting sexual abstinence by young people and in messages that aim to frighten them about the risks of sexual activity.

According to official statistics from El Salvador, the majority of young women interviewed in 1998 professed knowledge about these issues; especially those from urban areas. Nevertheless, their knowledge tended to be very limited. For example, only 40% of women under 20 years old and 59% of women over 34 knew about reproductive risks and spacing of pregnancies. While 91% of women between 15 and 49 had heard of AIDS, only 54 and 51% respectively had heard of syphilis and gonorrhoea and even fewer knew about other sexually transmitted diseases (STDs). In addition, some women believe dangerous misconceptions. For example, one in six Salvadorian women believe that there is a cure for AIDS. The situation in the other countries of the region is no better. In Honduras, according to data from the National Survey of Epidemiology and Family Health, 54% of women interviewed had never received any sex education, a figure that rose to around 66% among rural women between the ages of 15 and 24.

2.1.7 Access to sexual and reproductive health services

Three types of factors combine to block Central American women's access to these services: limited provision, low quality and factors that limit or delay the use of available services. Consequently, a high proportion of women do not use formal services even for such basic matters as pre-natal care, birth or post-natal check-ups. Some 42% of all births in El Salvador occur outside hospital while in rural areas the proportion rises to 57%. In Guatemala, 59% of women give birth at home with the assistance of a traditional birth attendant, friend or relative; this is not necessarily negative but it does demonstrate the limited coverage of formal services and the low level of confidence that the public have in them.

Limited provision⁴

The health systems of the region are very limited. Most people have to use services in hospitals and clinics with insufficient, under-paid staff and limited availability of equipment and medicines. These facilities tend to be located far from the majority of users, especially for those resident in rural areas. In Nicaragua, the annual per capita funding of the public health system in 2003 was only \$22 while in Guatemala it was even less, on average not even reaching \$15 over the last few years. The proportions of these meagre amounts that are assigned for the specific needs of women are very small; in the case of Guatemala in 2001 it was less than 5% of the total.

The limited provision of services is also due to the concepts underlying their design and implementation. Primary health care is not directed to the needs of women but to mothers and children with the consequence that women's health is attended in so far as it relates to the needs of foetuses and

young children. Policy makers are resistant to the provision of adequate sexual and reproductive health services for adolescents, preferring instead to trust in the effectiveness of abstinence promotion. Women with HIV AIDS are less likely than men to receive medicines from state and private services, as these prioritise men as the supposed breadwinners for their families. In Honduras, pregnant women infected by HIV are treated inhumanely by the health services: they receive retroviral treatment while pregnant, but after they give birth it is withdrawn.

Low quality

Low quality is a defining characteristic of the services received by poor women, with inhumane treatment being one of the problems mentioned most often by urban women who participated in a focus group in Honduras. Several of these women gave examples of the undignified treatment, discrimination and abuse that they had suffered. Salvadorian women in a similar focus group claimed that health professionals treated them with prejudice, blaming them for their problems, and frequently failing to explain their decisions.

Underlying this situation there is a lack of staff training and motivation as well as an absence of national plans and policies that effectively guide sexual and reproductive health care. In this vacuum, service providers are guided by their personal beliefs and opinions, which frequently means their prejudices. This is so even when there is a formal policy framework, as in the cases of Guatemala and Honduras.

Limited or late use of services

The poor quality of available services combines with women's lack of information and knowledge and with the feelings of shame and guilt caused by their upbringing, leading many of them to be frightened of

seeking medical attention. They tend to seek gynaecological assistance only in extremely urgent circumstances, generally when they are about to give birth or in the case of bleeding when professional help can no longer be avoided. Even those women with high-risk pregnancies only seek support when they are already in labour.

Relatives and partners can also be responsible for women not using health services. Salvadorian women related the difficulty they faced due to the complete lack of understanding of their partners of decisions made by health care professionals. In extreme cases, women's partners and relatives effectively decide whether they should live or die: when faced by pregnancies, deliveries or abortions with complications, the decision as to whether to take the woman to receive health care is frequently taken by her partner or family.

On top of all these factors, there is the impact of poverty. Poor women and their families may be unable to pay for medical attention or medicines or for rapid transport to a health centre. At the same time, they are affected by the generalised poverty of rural areas, which are lacking in services, are far from health centres and where the transport infrastructure is totally inadequate for emergency situations.

2.1.8 Access to contraception

The vast majority of women have some information about contraceptive methods, for example it has been reported that 99.9% of Honduran women in stable relationships have information about at least some type of contraception. However, this does not mean that this information is complete or even that it is reliable. Apart from myths and misunderstandings, there is

disinformation, such as that spread by the Catholic Church alleging that condoms do not provide protection against pregnancy or HIV AIDS⁵ or that emergency contraception causes abortions. At the same time, the information on contraceptives that is provided by public services tends to be incomplete or biased (*see section 3.3.3*).

Even with adequate information, a series of factors limit women's ability to put their knowledge into practice. One of the most important of these factors is their limited ability to negotiate with their partners who may be opposed to the use of contraceptives, especially condoms; for example 37% of Salvadorian women reported that they did not use condoms because their partners did not like them. Other factors include:

- ◆ **Educational level and place of residence.** Women with higher levels of education or who live in urban areas are more likely to use contraceptives.
- ◆ **Beliefs and cultural attitudes.** Contraceptive use is conditioned by women's perception of sexuality and motherhood, and by the church's influence.
- ◆ **Poverty.** Poor women's use of contraceptives – except for "natural" methods – is limited by their cost, unless they are provided free of charge by an official or private programme.
- ◆ **Bureaucratic obstacles.** For example, women from the Cruz Roja neighbourhood of Tegucigalpa, Honduras reported that staff of the local health centre conditioned the provision of oral contraceptives on their attendance for health checks every 21 days.
- ◆ **Health personnel's attitudes.** Officials that believe that emergency oral contraceptives (EOC) cause abortions sometimes refuse to provide them. Nevertheless, the same

individuals are sometimes capable of sterilising a poor peasant woman with many children without obtaining her informed consent.

The result of this set of factors is that many women do not use contraceptive methods. In Guatemala, only 60% of married women and women with partners use some type of contraceptive method, and the proportion is much lower among indigenous women. Information from Honduras and Nicaragua shows that the women who least often use contraceptives are young women between 15 and 19 years old. In Honduras, only 41% of women in this age group use contraceptives compared with approximately 60% in other age ranges. The proportion of women who use contraceptives from the beginning of their sexual experience is even lower. Only 10% of Salvadorian women between 15 and 24 years old with sexual experience had used contraceptives during their first sexual relation.

Another cause for concern is the fact that the most frequently used methods are the most aggressive, for example sterilisation, and the least effective, such as “natural” methods. In contrast, condom use is very low even though this method is economical, not aggressive and provides protection against STDs. It should be noted that the choice of methods is strongly affected by which methods are offered and promoted by the health services. Poor women, especially those living in rural areas, are obliged to use the methods offered by official programmes supported by aid agencies such as the United States Agency for International Development (USAID) and the United Nations Fund for Population Activities (UNFPA). The predominance of aggressive methods and the limited use of condoms suggest that these programmes give women little chance to make informed choices about the types

of contraceptives that are most appropriate for their health.⁶

Finally, it is important to observe that, despite all the barriers which limit women’s use of contraception, family planning is still seen principally as their concern while men fail to assume their responsibility. A statistic from Honduras demonstrates this reality: the ratio of women who have been sterilised to men who have had vasectomies is 125 to 1.⁷

2.1.9 Access to abortion

Abortion is completely illegal in El Salvador and Honduras and very strictly limited in Guatemala and Nicaragua (*see section 3.3.4*). Consequently, any woman wishing to terminate a pregnancy and, in this way, exercise her right to ‘have control over and decide freely and responsibly on matters related to (her) sexuality, including sexual and reproductive health’⁸ faces considerable obstacles, even if her life is endangered by the pregnancy. These prohibitions are based on and reinforce the cultural barriers to abortion.

The most influential factor on Central American culture in this area is the condemnation of the church, especially that of the hierarchy of the Catholic Church. The media frequently reinforce this view, characterising women who have abortions as selfish and promiscuous. In addition, those organisations and individuals that favour the decriminalisation of abortion tend to be stigmatised. As a result, anyone having an abortion risks social condemnation as well as a penal sentence, and the matter is treated like a taboo.

It should be emphasised that the church’s opposition to abortion is not only due to its much trumpeted position that life begins with conception but also derives from its

vision of motherhood as the destiny of all women. This vision is taken up and repeated by the media. For example, during a period of much debate on therapeutic abortion in Nicaragua, an editorial in the influential newspaper *La Prensa* proclaimed that ‘The dignity and originality of women springs from their generative and nutritive powers’.⁹

Finally, poverty limits the access of most women to safe abortions. Because abortion is illegal, there are few providers of high quality service and their prices are high. The great majority of women cannot afford these services so they use high-risk methods instead. In this context, the decriminalisation of abortion can be seen as a matter of social and economic justice.

2.2 The impacts on women’s health and reproduction caused by the denial of their SRRR

It would be a mistake to think that physical health and reproductive indicators are the most important expressions of the denial of women’s sexual rights and reproductive rights. Nevertheless, they provide an important way of demonstrating the magnitude of its impact. In addition, these indicators are of strategic importance for government lobbying given that most of the data originate from official bodies.

2.2.1 Unwanted and premature pregnancies

Data from Honduras show that around 25% of births in that country are unwanted. Among women without formal education the proportion rises to 39%, while for women with six or more children or who are older than 40 the proportions are 56 and 57%, respectively.

According to a report by the NGO Save the Children,¹⁰ Nicaragua has the tenth highest rate of teenage pregnancies in the world with 135 births for every 1,000 women between 15 and 19 years old. The rates for Guatemala and El Salvador are 111 and 87 per 1,000 respectively, which also place them among the 25 countries with the highest rates. Other data suggest that the rate in Honduras is similar to that of El Salvador, while 60% of young Hondurans who have been pregnant at least once became pregnant for the first time before they were 17. The 2001 census for Nicaragua reported that 27% of women between 15 and 19 were either pregnant or had given birth to more than one child, while the percentage was double among women of these ages without formal education. It is clear that many of these pregnancies are unwanted given that 26% of abortions are conducted on women younger than 19. Similarly, among the approximately 42% of Salvadorian women aged between 15 and 24 who had been pregnant at least once, 65% reported that they had become pregnant against their wishes on one or more of those occasions.

Motherhood is a very difficult situation for young women. As Save the Children affirm ‘Adolescent mothers tend to be marginalised. In great measure, their health and educational needs tend not to be attended and they themselves lack sufficient preparation to face the challenges to them and their children.’ In the case of El Salvador, only 27% of young women that stopped studying during their first pregnancy later returned to their studies.

2.2.2 Maternal Mortality

Maternal mortality is one of the main causes of death of the region’s women. It mostly affects women in rural areas and tends to be due to preventable causes. In

Guatemala, the National Reproductive Health Programme describes the profile of women most likely to be affected as ‘indigenous women, with limited education, housewives who have given birth several times’.

According to data from the health ministries of the four countries, their maternal mortality rates are: 93 deaths per 100,000 live births in Nicaragua; 108 in Honduras; 120 in El Salvador; and 153 in Guatemala. However, these statistics are problematic, starting with the fact that they are often generated using inappropriate methodologies. This situation was made very clear in Nicaragua in 2001 when different official sources published totally contradictory data. While the health ministry affirmed the rate as 93 deaths per 100,000 live births, the office of the president set the goal of reducing the rate from 148 to 129.

According to the WHO, UNICEF and UNFPA,¹¹ the best estimates for the year 2000 are higher in each case: 230 per 100,000 live births in Nicaragua; 110 in Honduras; 150 in El Salvador; and 240 in Guatemala. However, these rates are lower than the previous estimates (1995), which contrasts favourably with the lack of improvement in the Latin American and global averages.

There is a close relationship between maternal mortality and unsafe abortions. In 1996, the then president of Nicaragua, Violeta Chamorro, recognised that 24% of all cases of maternal mortality in her country were related to abortion. Data published by the Pan-American and World Health Organisations (PAHO/WHO) that same year indicated that unsafe abortions were the principal cause of maternal mortality in Guatemala (based on data from 1989), the second most important

in Nicaragua (1993–96) and the third in El Salvador (1992) and Honduras (1990). Both in Honduras and Guatemala, it was reported that 10% of cases of maternal mortality were related to abortion. This percentage remained unchanged in Honduras in 1997.¹² It should be added that the true number of deaths due to this cause is probably much higher. As Emma Chirix from Guatemala commented, there is a culture of silence around abortion and its effects. ‘In rural towns and villages... when a woman dies due to abortion complications, people say “a young woman died” or “she died of a fever”, and the matter goes no further’.

There is also a close relationship between premature pregnancy and maternal mortality. According to the Save the Children report, women between 15 and 19 years old run twice the risk of dying due to pregnancy and birth related causes than older women; the risk for younger girls is even higher. Data from Nicaragua show that 30% of women dying through maternal mortality during 2002 were adolescents.

2.2.3 HIV AIDS

According to a recent World Bank report, four of the six countries with the highest incidence of infection in Latin America are in Central America—Belize, Honduras, Panama and Guatemala.¹³ It reported that the epidemic in the region is ‘serious and getting worse and... is becoming generalised in some countries’. Other data show that, in El Salvador, the rate of infection increased from 2.4 per 100,000 people in 1991 to 17.3 in 2001.

The virus is mainly spread now through heterosexual contact, with this accounting for 76% of cases in El Salvador and 84% in Honduras, in this way contributing to the

feminisation of the epidemic. Ten years ago in Guatemala there was one woman infected for every eight men; the current proportion is one in three. In Honduras, the proportion of AIDS cases among women has reached 41%. The frequency of AIDS among Salvadorian and Nicaraguan women is lower but there are indications that it is increasing, especially among young women.¹⁴ Between 1991 and 2002 in El Salvador, women constituted 20% of AIDS cases but 29% of people who were HIV positive; among children and teenagers from 10 to 19, 37% of those infected by the virus were girls. Nicaraguan data from December 2002 showed that 25% of all HIV positive people were women, but among adolescents between 15 and 19 years old the proportion was 44%.

The growth of the epidemic among women is reflected in the deaths of women of reproductive age. Between 1990 and 1997 the proportion of these deaths due to AIDS in Honduras increased five-fold from slightly under 3% to 17%, becoming the principal cause of death for women of reproductive age. In El Salvador, AIDS is now the fifth most common cause of death in hospital for women between 20 and 59, and the third most common in women between 30 and 49.

3 Public policies in Central America: do they promote or block the exercise of sexual rights and reproductive rights?

3.1 International agreements

Through the lobbying of women's organisations in many countries, an international concept of SRRR has been developed over the course of the last 25 years. As a result, a number of international political agreements and procedures have been used to establish important women's rights in this area.

The most important agreements include the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Programme for Action of the International Conference on Population and Development held in Cairo in 1994 (ICPD), and the Platform for Action of 1995's Fourth World Conference on Women held in Beijing. The text which most clearly summarises the international understanding of SRRR is paragraph 97 of the Beijing Platform, the first sentence of which reads, 'The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence'.

These internationally recognised rights can be grouped according to three aspects of women's sexuality and reproduction:

- ◆ **Autonomy.** Freedom to take decisions regarding all aspects of sexuality and reproduction: if, with whom, when and how.
- ◆ **Health.** Access free from discrimination to the means necessary to achieve 'a

general state of physical, mental and social well being... in all aspects related to the reproductive system and its functions and processes'¹⁵ including family planning.

- ◆ **Protection.** Against exploitation, violence and mutilation. Also defence of the rights of pregnant women workers, including adequate consideration of their health.

International agreements have tended to emphasise reproductive rights while the term "sexual rights" has not been included in official texts. Nevertheless, sexual rights are implicitly included in various international agreements. For example, the ICPD definition of reproductive health recognises that this 'entails the capacity to enjoy a satisfactory sex life without risks and to reproduce, and the liberty to decide whether or not to do so, when and how frequently'.

It should be noted that these agreements do not include protection against discrimination based on sexual orientation. Recently, there have been attempts to approve a resolution of this type in the Human Rights Commission of the United Nations in Geneva but progress has been blocked by fundamentalist and conservative delegations. Nevertheless, this right does figure in some documents of the United Nations system.¹⁶

By signing all the major international agreements on SRRR, the countries of Central America have committed themselves to promote the respect of these rights.

While it true that the Central American delegations to the Cairo and Beijing conferences formally reserved their position on some points, they did so principally to make clear that they did not sanction abortion or accept the establishment of rights for the families of gay and lesbian couples, issues which in reality were barely addressed in those conferences. They supported the majority of the other points without reservation.¹⁷ In addition, they are participants in various agreements and instruments of the Inter-American system that promote the fulfilment of the international agreements.¹⁸

3.2 Globalisation and fundamentalisms

Despite the formal recognition of SRRR, the globalisation of the neoliberal model and the parallel growth of fundamentalist and other conservative religious sectors are impacting negatively on the exercise of these rights.

Under neoliberal policies, the privatisation of basic services and the reduction of social spending have reduced health service provision and increased its cost. For example, health centres in Honduras and El Salvador have become dependent on service charges and community support. As a result, the coverage and quality of the services have been reduced with direct effects on the health of poor women. At the same time, the decentralisation of health services is being promoted without due consideration of its effects. A 1998 study found that decentralisation was having negative effects on sexual and reproductive health services.¹⁹ According to this, it was frequently the case that neither the ICPD agenda nor national policies were implemented at local level, either due to lack of funding or because of opposition

from local staff. This was particularly common in relation to sexual health services for adolescents and the treatment of incomplete abortions.

Other effects of neoliberal policies include the transnationalisation of people trafficking networks facilitated by the easing of restrictions on international movements (*see section 2.1.5*), and the abuse of women's rights in export processing zones. According to a Salvadorian study published by Las Mélicas in 2001, 70% of women working in factories in these zones reported that they had been obliged to take a pregnancy test before being hired. A 2002 study in Honduras found that violence and sexual exploitation had increased in those areas where there were the highest levels of transnational investment, in export processing zone factories and in tourist areas.²⁰

Turning to the effects of religious fundamentalists and conservatives, their influence in international political forums has significantly increased. An important example of their success is how pressure from the Vatican and a small number of conservative governments led to the elimination from the Millennium Development Goals of a goal that would have established that 'all people of appropriate age should have access to reproductive health services by the year 2015 at the latest' even though it was supported by the World Bank and the International Monetary Fund and had been adopted in 1996 by the 21 governments that participate in the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD).²¹

The influence of these sectors has increased since George W. Bush assumed the presidency of the United States in January

2001. He has reaffirmed and widened the application of conservative principles in international aid policies and ensured their more thorough implementation, for example through his signature of the “gag rule”²² on his first day in office, and later through significant cuts in official funding of UNFPA.²³ Similarly, in international forums, his government has signalled its wish to turn back progress made during the 1990s. For example, during 2004 it exerted pressure on Latin American governments in the context of the meeting of the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) Population and Development Committee to monitor progress on implementation of the ICPD accords. The Bush administration sent letters in which it affirmed that it would not renew its support for the ICPD Programme of Action and that it considered that the level of the delegations was insufficient to permit approval of the declaration ratifying commitment to the Cairo accords.²⁴

3.3 The integration of SRRR into national laws and policies

Despite the fact that the governments of the region have, in general terms, approved international agreements on SRRR, legislation and public policies provide little support for the exercise of women’s rights in this area. Some aspects of the international agreements have been translated into legislation and action plans but implementation is weak.

In part, this situation is due to a lack of resources but it is also caused by a lack of political will. On the one hand, members of government do not see women’s health and lives as priorities. On the other hand, to make profound changes would require that they confront church hierarchies, something that they are unwilling to do. In addition,

the expansion of services that would be required to support the exercise of SRRR runs counter to the strictures of neoliberal policy.

Recently, some progress has been made. During the last five years in Honduras the National Policy on Sexual and Reproductive Health and the National Policy for Women were approved. Similarly, a series of policy and legal instruments have been approved in Guatemala since the year 2000. Nevertheless, almost all the advances are in relation to reproductive health; they deal little with sexual health and have not been designed from a rights perspective.

Another difficulty is that even the timid integration of SRRR into national laws and policies implies constant conflict with conservative sectors. As a result, legislation and official policies have become fragmented and contradictory. Similarly, laws in this area have only a limited relationship to the overall body of national legislation while new policies fail to be mainstreamed into state policies in general.

3.3.1 *Sexual and reproductive health*

Proposed and approved legislation and policies
The greatest degree of progress has been made in Guatemala and Honduras. In Guatemala, since the year 2000, approval has been given to the following instruments that deal partly or completely with this area:

- ◆ 2000–2004 Health Plan.
- ◆ National Reproductive Health Plan and its corresponding programme.
- ◆ National Plan to Reduce Maternal Mortality.
- ◆ Social Development Law.
- ◆ General Law to Combat HIV and AIDS and for the Promotion, Protection and

Defence of Human Rights in the face of HIV/AIDS, plus a related programme.

◆ Post Abortion Care Programme (APA).

The approval of the APA has placed Guatemala in the vanguard for this area at Latin American level. Nevertheless, much is required for the programme to be properly implemented. An evaluation conducted at the end of 2002 showed that only two out of 37 hospitals that provide maternity services were fully implementing the concept of post abortion care. Of the others, 16 were partially implementing the concept while the other 19 were not implementing it all.

In the case of Honduras, the National Sexual and Reproductive Health Policy, the Equal Opportunities Law and Plan, and the National Policy for Women include a number of positive elements, some of which deserve mention here:

- ◆ Sexual and reproductive health is viewed in an integral manner that proposes the joint responsibility of all social actors.
- ◆ The right of individuals and couples to make their own decisions on reproduction is reaffirmed.
- ◆ Education and information for responsible and complete sexuality is promoted.
- ◆ Violence against women is considered as a health problem and it is established that programmes to support child victims of commercial sexual exploitation should be expanded.
- ◆ Training and awareness raising of health personnel are proposed and it is established that public health services should provide quality care to women with abortion complications.
- ◆ Regulations are proposed to provide adolescents with access to reproductive health services from ten years of age.

- ◆ It is established that the availability of family planning methods and advice should be increased.

Negatively, abortion is only dealt with in terms of the treatment of cases with complications. Even though activities to reduce maternal mortality are proposed, the relationship with abortion is not even mentioned. Another important limitation is the failure to recognise the subordination of women in decisions on reproduction and sexuality. To the contrary, it is proposed to include consideration of masculinity 'to facilitate the role of men in decision making by couples on sexual and reproductive health' as though men were somehow excluded from this at present.

In Nicaragua, attempts to make progress in this area have been blocked by the church. One of the first actions of the present government was the presentation of the document "Towards a National Sexual and Reproductive Health Programme" as part of health sector reforms. Nevertheless, the use of the term "sexual and reproductive rights" led to its withdrawal one month later. Similarly, for several years attempts to introduce a law on equal opportunities and rights have been blocked. The original legislative proposal would have introduced several important advances in the area of sexual and reproductive health and rights and was designed on the basis of very wide ranging consultations. Most recently, in 2003, a series of modifications proposed by the Catholic bishops were incorporated into the legislative proposal even though they distort it almost beyond recognition.

A National Health Plan was recently approved in Nicaragua, but although consultations were held with the women's movement none of their proposals were included. Several of the plan's proposals also seriously contradict each other as well

as the National Development Plan and the Strengthened Economic Growth and Poverty Reduction Strategy. Each of these documents outlines different priorities for the health sector and, while they express concern at the high rates of maternal mortality, none of them mention unsafe abortion even though this is considered to be its principal cause.²⁵

Legislation on HIV AIDS

All four countries have approved laws on the prevention and control of HIV AIDS. An important point they share is that they seek to protect the rights of people living with this disease, including their right to be treated without discrimination. Another important aspect is the establishment of guidelines on education and information.²⁶

Unfortunately, the effectiveness of these laws tends to be limited by church pressure and by common prejudices. In the first case, the promotion of condoms is avoided, for example in information given to young people that emphasises abstinence and relegates the use of condoms to the status of a last resort. Worse still, in Nicaragua, personnel from the Department of Moral Values of the Education Ministry veto all mention of condoms by The National Anti-AIDS Commission. In the second case, widespread prejudices and beliefs frequently lead to discrimination against people with HIV AIDS, including at the hands of people charged with the implementation and monitoring of legislation. The Guatemalan Health Ministry has admitted that there still is significant fear and ignorance among its personnel.

Finally, it should be noted that patent protection policies threaten to undermine progress in the treatment of HIV-infected people, as they limit access to generic medicines. In the most extreme case, in

2003 the Guatemalan congress prohibited the production of generic medicines.

Emphasis on reproductive health

With the exception of policies on HIV AIDS, national legislation and policy is largely concentrated on reproductive matters. There are examples of action on sexual health but they are the exception, not the rule. On top of this, there is a tendency to deal with women's reproductive health in terms of their role as mothers. For example, although Guatemalan policies deal with a wide range of issues, in practice they concentrate on mother-and-child health and contraception. In Nicaragua, according to the official responsible for the Health Ministry/UNFPA Management Unit, Freddy Cardenas, 'There has been an emphasis... on attending pregnant women, children, and now adolescents' but 'sexuality has been dealt with very little in the ministry's operational units'.

Obstacles to implementation

Notwithstanding their limitations, the laws and policies that have been approved constitute an improvement on the previous situation, so it is regrettable that their translation into practice has proved to be very difficult. There are many obstacles to implementation, most of which, in essence, are based on social attitudes. Frequently, the principal problem is lack of funding but this is due as much or more to government priorities than to a real shortage of funds. The Guatemalan Social Development Law establishes that the Finance Ministry should assign an annual budget specifically for implementation of its measures but this is yet to happen; consequently foreign aid continues to be the principal source of funding. Similarly, the APA is funded by international agencies. Nicaragua has, on paper, a National Programme for Integrated Care of Adolescents but it has not been implemented for lack of funds.

The lack of will is also demonstrated by the action and inaction of legislators and state officials. The Honduran Equal Opportunities Law was passed in 2000 but congress has yet to approve a set of operating regulations²⁷ thus leaving implementation dependent on the decisions of individual public functionaries. It is common to find that health service personnel are opposed to the implementation of the new policies. Because of religious or moral convictions, they fail to provide women with adequate information and resources, especially when dealing with teenagers and young, single women.

3.3.2 Sex education

The serious limitations of sex education have their roots in the action and inaction of the region's governments that appear to wish to promote it as little as possible. At present, Guatemala has no official sex education programme. Supposedly, teaching on sexuality is going to be integrated into other areas of the curriculum, but at present the only information that school students receive in this area is related to HIV AIDS.

The Nicaraguan state has formally assumed responsibility for sex education through a series of instruments including the Children and Adolescents' Code and the Population and Sexuality Education Programme. Nevertheless, these measures have not been implemented. Early in 2003, the Education Ministry published a sex education manual but this was the subject of a furious attack led by the hierarchy of the Catholic Church, which alleged that the manual promoted abortion and homosexuality, failed to respect national characteristics and would lead young people into a life of vice. Consequently, the President decided to withdraw the manual, saying that it would be reviewed in consultation with 'all social sectors' so that it incorporated 'the Christian

moral values of the Nicaraguan people'. The final result of this is the "Manual for Life", which has converted what was a sex education manual into a catechism.

The experience of El Salvador and Honduras is very similar. In 1999, the Salvadorian Health Ministry, in coordination with women's organisations, published the "Adolescents' Manual for Adolescents", but this was withdrawn the same year due to the opposition of the church and the conservative movement "Yes to Life", which argued that it promoted permissiveness.²⁸ In the case of Honduras, the Honduran Breastfeeding Association published the manual "Talking about Sexuality with Young People", which was funded by USAID. Nevertheless, following attacks by "pro-life" organisations, the National Congress intervened in the matter and the Education Secretary prohibited distribution and total or partial use of the manual.²⁹

3.3.3 Contraception

National policies on contraception suffer from a number of important limitations, beginning with the fact that almost all services and information are aimed at women, largely treating men as though they had little responsibility for the matter. Other limitations include:

- ◆ Sexual abstinence continues to be emphasised, especially with young women and men, even though it is not a realistic option for most people.
- ◆ In Honduras, important measures that are offered to adult women – contraceptive advice and emergency contraception (EOC) – are not available to teenagers, even though 15 to 19 is the age range in which women least use contraception and during which rural women, the poor and those with limited education tend to become pregnant for the first time.

- ◆ There are distortions in the types of contraceptives that are promoted and made available. On the one hand, in Guatemala there is excessive promotion of “natural” methods, even including the recommendation of *coitus interruptus*. On the other, the Honduran Health Secretariat has promoted EOC more than regular methods, including condoms, which raises suspicions that this is due to pressure from the transnational pharmaceutical companies that produce these pills.

3.3.4 Abortion

The Central American states severely restrict abortion. In El Salvador and Honduras it is prohibited without any exceptions while in Guatemala it is only permitted when necessary to save the woman’s life. Nicaraguan law allows abortion for “therapeutic reasons” but this term is not defined, leaving its meaning to be interpreted by three specialists who are named by the Ministry of Health on a case-by-case basis. In practice, this law is not being implemented; therapeutic abortions are not currently carried out in any of the country’s public hospitals.

The total prohibition in El Salvador and Honduras was a great step backwards. In El Salvador, until 1998, abortion was permitted when the mother’s life was in danger and in cases of rape or foetal malformation. In Honduras, therapeutic abortion was legal from 1906 until 1984 when it was banned under penal code reforms. The reform in Honduras was justified by articles of the constitution that establish that ‘The right to life must not be violated’ and ‘Unborn children will be considered as though they had been born in all senses that favour them within the limits of the law’. In the case of El Salvador, following approval of the law, the constitution was modified to establish protection of the right to life from the moment of conception.

Although therapeutic abortion is still legal in Nicaragua, the National Assembly is debating a new penal code that includes several modifications that would effectively restrict access to this procedure.³⁰ The most negative of these proposed modifications is the introduction of a new crime: ‘lesions of the unborn’ that establishes severe penalties for whoever causes ‘a grave physical or psychiatric change in the foetus’.

The prohibition of abortion does not lead to its reduction; women continue to make use of this procedure. The true impact is to condemn poor women to death, disability or prison by removing their access to opportune and quality attention and by increasing the risk of death for women who require a therapeutic abortion. By making abortion illegal it becomes clandestine and, very frequently, unsafe. Many women suffer complications following an unsafe abortion but their fear of arrest leads them to delay seeking medical help. On top of this, many women who have gone to hospital because of abortion complications have denounced that they have been subjected to mistreatment, in some cases even including inhumane procedures such as curettage without an anaesthetic.

These impacts are principally felt by poor women. On the one hand, because they are unable to pay the high prices charged by private practitioners offering quality services, much less go abroad for an abortion, they are obliged to undergo unsafe abortions with great risks to their health and life. On the other hand, because they also have less access to health services that provide information, advice, family planning methods and EOC to prevent unwanted pregnancies.

Finally, it should be noted that the prohibition of abortion leads to underestimates both of its frequency and

its consequences. In this sense, prohibition is a misleading measure: it does not reduce the problem but it hides it, allowing it to be treated as though it was of little importance.

3.3.5 Sexual orientation

The only country in the region that has current legislation against homosexuality is Nicaragua. Since 1992, the penal code typifies sodomy as a crime, defining it as ‘inducing, promoting, advertising or practising in a scandalous way sexual relations between persons of the same sex’. The new reforms of the code approved at a general level in 2000 include the elimination of this article, but it is possible that it could be ratified again during debate of the code’s specific provisions.

Although the other countries do not have laws that discriminate against gays and lesbians, they have resisted the recognition of their rights during international conferences (*see section 3.1*).³¹ There are also examples of official discrimination. For example, the Honduran Police and Citizens Harmony Law of 2001, which sanctions individuals that address others with ‘dishonest or disrespectful propositions or molest them with indecent gestures and attitudes’ has been used as a pretext to harass gay organisations.

3.3.6 Sexual violence

This is, perhaps, the area of SRRR in which the Central American states have made most progress in legal and policy terms. In Nicaragua, successive governments have approved an impressive range of measures that deal with sexual violence. These include, among others, Law 150 on sex crimes, the 2001–2006 National Plan for the Prevention of Intra-family and Sexual Violence, the Women and Children’s Police

Units (*comisarías*), and the National Anti-Violence Commission.³² Examples of progress in other countries include the inclusion of sexual violence as a specific category within the Salvadorian Reformed Law on Intra-family Violence and the incorporation into the Honduran penal code of the crime of sexual harassment.

The main problem with these measures is their poor implementation, which, essentially, is due to the lack of political will among the region’s governments to confront the many practical obstacles that exist, such as:

- ◆ Failure to assign funding. The Nicaraguan National Plan has not been translated into practice because it has not been provided with a budget.
- ◆ The lack of effective coordination with civil society. Central American governments use diverse forums to prove that they are consulting with civil society, a condition demanded by many donors, but this does not actually lead to concrete actions.
- ◆ The systems of justice are administered according to patriarchal criteria. Women frequently have to confront the attitude of officials who place the blame on them. Even in the Nicaraguan Women’s Police Units, “family stability” is prioritised when a separation or divorce could occur, leading to a worrying number of out of court settlements. A similar situation exists in Honduras, especially in small towns and rural areas.
- ◆ Corruption is rife in the judicial system. Influential aggressors generally walk free and it is common for witnesses and even judges to be “bought”.
- ◆ The systems for care of victims and the presentation of accusations are fragmented. In El Salvador, medical exams are only considered valid if they are conducted by forensic doctors from the

Legal Medicine Institute while the accusation must be made to the Attorney General's office. However, victims frequently turn to a wide range of bodies – health services, NGOs, the Salvadorian Women's Institute, the police and private services – that lack an appropriate level of inter-institutional coordination to be able to satisfactorily help them.

3.3.7 Commercial sexual exploitation

Legislation in the countries of Central America includes several measures in this area, with all countries penalising the procuring of prostitutes but permitting prostitution as such. However, in practice matters tend to function in reverse: the police harass sex workers but leave procurers and their “clients” in peace.

At present, in Honduras and Nicaragua official bodies are collaborating with civil society in the promotion of legal reforms that would increase the control of sexual exploitation. Among other measures, there are proposals to typify new crimes including commercial sexual exploitation, sex tourism, trafficking of people with sexual objectives, child and teen pornography, and payment for sex with adolescents. In Nicaragua, organisations working with children have made a series of proposals that are under consideration by the Justice Commission of the National Assembly, pending debate of the new penal code.

3.4 The church and recognition of SRRR by the state

3.4.1 Influence on governments

The influence of the church and its conservative allies has had multiple impacts

on laws and policies related to SRRR: abortion has been prohibited or severely restricted; access to contraception and health services limited; sex education blocked; the rights of gays, lesbians and other non-heterosexuals denied; and justice obstructed in cases of sexual violence and exploitation. The Catholic Church plays the most important role in this situation but evangelical churches also have considerable influence, especially in Guatemala.

The church is able to exercise this power even though the Central American states are secular. The Honduran constitution stipulates that, ‘The ministers of diverse religions, may not... make political propaganda invoking religious reasons or using the people’s religious beliefs to such an end’. The Nicaraguan constitution is even clearer, ‘Nobody may avoid observing the law or impede the exercise of others’ rights and the fulfilment of their obligations by invoking religious beliefs or rules’. This article touches the heart of the matter: the problem is not so much that the church makes its pronouncements, rather it is that governments and legislators meekly accede to its demands, excusing themselves on the grounds that most of their fellow countrymen and women profess to be Christians. In this sense, the Constitution is a dead letter. Secularism is not part of the culture and there is no social conscience of its significance, neither among the public nor civil society organisations, much less in the political class.

The influence of the church is not only due to religious identification but also to its relations with powerful groups. Church hierarchies and lay members of organisations such as “pro-life” groups and Opus Dei use their connections with governments and the media to promote their positions. Individuals that work directly with these organisations

participated in the official delegations from Guatemala and Honduras to the Cairo and Beijing international conferences. For her part, Mercedes Arzú de Wilson, president of the United States “pro-life” foundation “Family of the Americas” and sister of the president of Guatemala from 1996 to 1999, Alvaro Arzú, used her connections with the political “elite” of her country, the Republican Party of the United States and the Vatican to greatly influence the positions taken by Guatemala during these conferences.³³

3.4.2 Restricting debate

The religious right seek to avoid any debate on SRRR based on a careful analysis of reality. Instead, they tend to use arguments designed to scandalise public opinion even though they have no logical basis. For example, opinion pieces published in the Nicaraguan press have compared abortion to the death penalty and the death of Jesus. During the debate on abortion in El Salvador, fundamentalist religious movements managed to avoid both the clarification of basic concepts—such as therapeutic, ethical or eugenic abortion—and the discussion of the conflict of interests that arises when a woman’s life is put in danger by her pregnancy.

Another strategy used by the religious right is to denigrate those organisations and individuals that argue for the decriminalisation of abortion or propose an alternative vision of sexuality. They characterise them as “leftist organisations” and “communists” and accuse them of promoting homosexuality and lesbianism. At the same time, they claim that women’s rights are promoted because of foreign influences, attempting to induce the public to consider them as irrelevant with the argument that they are contrary to national customs.

3.4.3 Exceptions to its influence

The church is not always able to achieve its objectives. Its opposition to abortion is just as radical in Guatemala and Nicaragua as in El Salvador and Honduras, but it has not yet been able to achieve complete prohibition in the first two countries. In addition, the region’s governments are also under pressure from international aid organisations. Many of these, especially those of the United Nations System, promote the implementation of the ICPD and Beijing accords and/or advocate population control policies.

These tensions may have come into play when the Honduran Minister of Health did not capitulate in the face of opposition to his ministry’s sexual and reproductive health policies and several other measures. On the contrary, the minister formed a commission of experts to analyse the validity of these instruments. That commission recommended the implementation of the policies and rejected the principal criticisms made by the Catholic Church.

Pressure from international aid agencies also contributed to the rapid development of policies and laws on reproductive health in Guatemala from the year 2000. Other important factors included advocacy by the women’s movement and the initiatives of some public officials. In addition, the government that assumed power that year had strong support from the evangelical churches which had not been the case for previous governments. The loss of influence for Catholics caused by this situation, combined with more progressive attitudes of evangelicals on some aspects of women’s reproductive health helped to facilitate the approval of the new measures.

Nevertheless, these positive cases are the exception. Generally, when the church

speaks, governments listen. It should also be noted that the differences between evangelicals and the Catholic Church on these issues are more a question of form than substance. Evangelicals are also very conservative and equally opposed to the decriminalisation of abortion and the recognition of diversity in sexual orientation.

4 Notes for an agenda for action

4.1 Building consensus in the women's movement

Given the situation described here, the promotion of SRRR ought to be a priority for the women's movement. Nevertheless, the movement has tended to deal with these rights only in relation to health or within their work on other issues, for example in the context of work on violence. This should not be taken to mean that no significant progress has been made. Nevertheless, a clear, shared agenda has not been developed. In particular, there is a lack of consensus around highly controversial issues such as abortion and sexual orientation.

Many factors have contributed to create this situation, including:

- ◆ The difficulty of talking about sexuality, both because of its negative image in Central American culture and because it implies the need to open oneself to discussion.
- ◆ The power of patriarchal discourse is such that it affects the thinking of members of the movement inducing ambivalent and even negative responses to proposals on the most controversial issues.
- ◆ The tendency to view issues such as sexuality or lesbian rights as less urgent than others such as violence.
- ◆ The fear of some organisations that, if they promoted controversial proposals on SRRR, they would alienate many poor and working women.

To overcome these obstacles and begin to develop an agenda for action, the movement needs to engage in a wide-ranging process of discussion and debate. This process

should cover all relevant issues, but especially those that are most controversial. In this way, the members of the movement could better understand and take ownership of their SRRR, in turn facilitating the development of the kind of broad consensus that is needed for consistent and strong public advocacy on these issues, both with the state and the general public.

It is important that this debate is not limited to organisations based in the region's capital cities. On the contrary, it should be conducted at all levels of the women's movement—local, national and regional—and in its many groups and networks. In this way, women from different regions, of different ages, classes, ethnicities and sexual orientations, as well as those with disabilities, will be able to fully participate on the basis of their own particular circumstances and experiences.

It is also important that the debate goes beyond minimum demands. At present, the majority of the movement's demands fail to transcend the limits of the patriarchal system, even though this has usurped women's control of their sexuality and reproduction. There is a need to be more radical and incorporate all the proposals that women consider necessary to fully exercise their SRRR.

4.2 Proposals for an agenda

4.2.1 Issues for public advocacy

Cultural attitudes

Although the state plays a very important

role in facilitating or obstructing the exercise of human rights, it is clear that social norms are of equal or greater importance in relation to SRRR. The promotion of different values, beliefs and customs is vital. Particularly important changes would include: women valuing, taking ownership and exercising autonomy over their bodies; a positive vision of sexuality; and, the understanding of motherhood as an option rather than as an almost automatic characteristic of women.

Another critical issue is the question of sexual orientation. Overcoming prejudices against lesbians and other non-heterosexuals should be given priority both because of its importance in and of itself, and to counterattack fundamentalist campaigns. Their propaganda frequently accuses those who promote SRRR of promoting homosexuality. Similarly, they allege that feminists are all lesbians to undermine the women's movement and ridicule its demands. The only just and consistent way to respond to these accusations is to overcome the lack of visibility of lesbians within the movement and in society, and to publicly defend their rights. In so far as social attitudes towards lesbians and gays change, one of the principal weapons of opponents of SRRR will be neutralised.

Defence of the Secular State

This is a key political issue. By persuading the region's governments to stop following the dictates of the most conservative sectors of the church, one of the principal obstacles to more progressive laws and policies in relation to a series of themes would be removed. Similarly, the development of a secular culture is crucial to educate youth and children in respect for diversity of ideas, beliefs and life style. In this context, the creation in Nicaragua in 2003 of the "Movement to Defend the Secular State and

Citizen's Rights" formed by feminist and other civil society organisations is noteworthy.

Globalisation

The relationship between neoliberalism and the negation of women's SRRR should be made clear. On the one hand, given the way that cuts in public services limit women's access to the resources needed to exercise these rights, the integration of SRRR into instruments of economic policy should be promoted, including the Poverty Reduction Strategies. On the other hand, work is required to counteract the forms of violence and control of women's bodies that have arisen or been strengthened by globalisation, such as Internet pornography, sex tourism and international trafficking of women.

The right to information

Advocacy is required to promote the integration of sex education into the school curriculum and the distribution of information to the general public on issues such as contraception and sexual and reproductive health. Health professionals should be encouraged to provide appropriate advice to women patients and to abstain from obliging them to use particular forms of birth control without their informed consent. At the same time, the transformation of education and information in this area should be sought, seeking to replace the current biological and religious focus with a more complete approach to sexuality.

Sexual and reproductive health

It should be advocated that the governments in the region stop relegating sexual and reproductive health behind other supposed priorities. The consequences of negligence of this area should be publicised, especially maternal mortality and the growth of HIV AIDS, which the international community

recognises as problems of great importance.³⁴ Key points for advocacy could include:

- ◆ The implementation of an integrated vision of health. This implies the need for coordination within and between health ministries and other state institutions, especially in relation to education and information.
- ◆ Strategies for action should be based on analysis of the true conditions of women and of the health services.
- ◆ The need for significant increases in funding and reduced dependency on international aid.
- ◆ All women should receive quality care, free from all forms of discrimination.
- ◆ Coordination should be sought between the formal health system and midwives or traditional birth attendants; obstetric nursing should also be promoted.³⁵

Contraception

This is another area where work to change social attitudes is necessary given men's high degree of irresponsibility. Therefore, at the same time as advocating substantial improvements in women's access to contraceptives and the quality of advice that they receive, programmes directed to men and teenagers should be promoted. Advocacy is also needed so that official programmes stop emphasising the most aggressive or least effective types of contraception. The distribution of EOC is a positive measure but shouldn't be overemphasised.

Abortion

Arguments in favour of decriminalisation based on public health and social justice are important. Nevertheless, advocacy should be conducted with a focus on rights in which the right of each woman to take

decisions about her own body is a central demand.³⁶ This does not preclude the possibility of seeking, in the first place, decriminalisation of therapeutic abortion in those places where it is prohibited. Among the proposals presented in the Honduran and Salvadorian studies, this is one of the positions taken, arguing that the decriminalisation of abortion should be promoted for cases in which the mother's life is in danger, the foetus is deformed or the pregnancy is the result of rape.

When arguing for the decriminalisation of abortion—whether total or partial—it is important to go beyond arguments against the position of the Catholic Church, analysing the issue with all its implications. Rather than becoming trapped in a debate about abstract moral principles, the reality of the women who die every day because abortion has been forced underground should be emphasised. For this reason, the advocates of decriminalisation should demand that governments develop serious statistics on abortion-related mortality so as to make visible the problem.

It is important to note the opportunities for debate and change. Both in interviews with Salvadorian professionals from diverse disciplines and in focus groups with women from poor urban and rural areas of El Salvador and Honduras, a high level of support was found for the legalisation of abortion in cases of foetal malformation, illness of the mother or rape. There were also a significant number of interviewees who saw abortion as a woman's right to choose. In addition, in Honduras, the Commission of Experts convened by the Health Minister to analyse national health policies (*see section 3.4.3*) recommended the decriminalisation of abortion in cases in which the woman's life is in danger or the foetus presents severe deformations. Similarly, the Nicaraguan Association of

Gynaecology and Obstetrics has repeatedly made public declarations in the media in favour of therapeutic abortion, offering medical and scientific arguments to support its position.

4.2.2 Strategies for public advocacy

Preparation

To effectively defend women's SRRR, adequate preparation is a necessary corollary to the development of agreed positions. This implies both the collection of information and the development of arguments appropriate for use with the general public. More investigations of the reality of the region's women would be helpful, especially in relation to issues which are hidden or poorly understood such as clandestine abortion, sexual and domestic slavery of kidnapped women and girls, or the relationship between indigenous cultures and sexuality and reproduction. These resources should not be limited to the "elite" of the women's movement, rather they should be widely shared to develop the capacity to promote SRRR from the grassroots.

Another suggestion is that greater importance should be given to personal testimonies by women about their concrete, and diverse, experience of the denial of their rights. This would help more people to identify with the women's movement and participate in a struggle that they would see as their own.

Identification of protagonists, opponents and allies

It is important to identify and maintain an up-to-date description of the different social actors that influence public opinion and political decision-making. This should include an analysis of their positions and strategies and their relationships with each

other and with the state. This would permit the identification of major opponents and potential allies as well as aiding in the development of lobbying strategies and arguments to counter the actions of conservative and fundamentalist sectors.

Building alliances

A wide range of organisations and individuals already are, or could be, allies for the women's movement in the promotion of SRRR. These include professional associations, unions, NGOs, networks and loose groupings such as those that oppose privatisation, gay and lesbian groups, members of national legislatures, academics and progressive churches. Their support would provide the movement with greater political strength and help to gain wider public support. Internationally, the incorporation of the movement's demands on SRRR into the agendas of the anti-globalisation movement would be important.

However, it should be recognised that many of these potential allies will not be in agreement with the more radical elements of the feminist agenda. Professional associations tend to be particularly conservative but even social movements can present opposition to the recognition of women's SRRR. Consequently, while working to raise the awareness of these sectors great care must be taken in the management of these relationships. Encouragement should be given to the movement's allies to gain their fullest possible support but without sacrificing the radical aspects of the movement's own agenda.

Tools

Public and political advocacy can make use of a wide range of methods. Some that should be mentioned include:

- ◆ Debates and discussions in diverse forums
 - the media, universities, social

movements, unions, youth groups, etc. – and at all levels – local, national and regional.

- ◆ Demonstrations and marches on important dates for the women’s movement, to support legislative proposals, denounce specific cases of abuse, etc.
- ◆ Social audits, including monitoring the implementation of laws and policies, analysis of budget assignation and execution, and appeals to national and international systems of justice to counter the impunity of crimes against women.
- ◆ Public education and awareness raising campaigns.
- ◆ Youth work, given that the greatest degree of change can be expected among young people.
- ◆ Coordination with international organisations working in this field so that they also lobby the region’s governments.
- ◆ Participation in the Campaign for an Inter-American Convention on Sexual Rights and Reproductive Rights.³⁷

and that support women and girls who have suffered serious abuse.

4.2.3 Beyond advocacy

Government lobbying shouldn’t be the only strategy to promote SRRR. Combining this with the promotion of changes in public opinion and in Central American culture will also be insufficient. Instead, as was suggested at the start of this document, change must begin with women themselves taking ownership of their bodies, regardless of cultural and legal restrictions. Women must be helped to overcome the distortions in their upbringing. Government decisions that violate their rights must be resisted. Women’s groups and networks need to be strengthened as centres of alternative culture. And support must be given to initiatives that supplement the lack of sexual and reproductive health services

- 1** These studies are available (in Spanish) on the web site www.oneworldaction.org or from the organisations participating in the project. Contact details can be found on the back cover of this document.
- 2** Perez, Luisa (2001) "Me quieres virgen... Me quieres santa... ¡Me tienes harta!" Grupo Venancia, Nicaragua.
- 3** World Health Organisation definition.
- 4** Also see section 3.2 where the effects of privatisation and decentralisation are discussed.
- 5** The Catholic Church is telling people that condoms have tiny holes in them through which HIV can pass. According to the president of the Vatican's Pontifical Council for the Family, Cardinal Alfonso Lopez Trujillo, 'The Aids virus is roughly 450 times smaller than the spermatozoon. The spermatozoon can easily pass through the "net" that is formed by the condom'. Bradshaw, Steve. "Virus can slip through latex, says Church". The Guardian Weekly 16/10/2003 (UK).
- 6** During the presidency of George W. Bush, the United States administration has called into question the promotion of condom use and has limited their distribution through international aid programmes. Most recently, in June 2004, a new regulation was introduced which obliges those organisations which receive federal funds for HIV AIDS programmes to include information about 'the lack of effectiveness of condom use' in their sex education programmes. Source: The Nation (USA) 30th June 2004.
- 7** Data for women between the ages of 15 and 44, who are married or in stable relationships.
- 8** Paragraph 97 of the Beijing Platform for Action. See Section 3.1.
- 9** 12th March 2003.
- 10** "Niñas que tienen niños: Estado Mundial de las Madres, 2004"
- 11** World Health Organisation (2004) "Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA".
- 12** Other data published by the WHO in 1998, indicate that the number of unsafe abortions for every 1,000 women between 15 and 49 was slightly lower in Central America than the average rate for Latin America and the Caribbean (28 versus 30) but much worse than the global average (13). Positively, the rate of mortality associated with unsafe abortion was much lower than the global average (20 per 100,000 live births compared to 57). The combination of these situations resulted in the proportion of maternal mortalities due to this cause being 14%, slightly above the global average of 13%. "Aborto Inseguro. Cuando las mujeres se mueren por ser pobres", Campaña 28 de Septiembre.
- 13** Report presented during the Third Central American Congress on STDs/HIV/AIDS – Concasida. <http://news.bbc.co.uk/hi/spanish> 14th October 2003.
- 14** One factor affecting young women is their reluctance to attend health clinics for fear of being stigmatised.

- 15** ICPD definition.
- 16** For example, the Resolution on Human Rights and Sexual Orientation (E/CN.4/2003/L.092) and the Resolution on Extra-judicial, Summary and Arbitrary Executions (E.CN.4/2004/L.56/Rev.1). In addition, the United Nations Secretary General, Kofi Annan, promoted an initiative to provide benefits to same sex partners of United Nations employees who are nationals of countries which provide such benefits, including Australia, Belgium, Canada, Denmark, Finland, France, Germany, Norway, New Zealand and Sweden. Obanda, Ana Elena (2004) WHRNet.
- 17** Guatemala is an exception. At the 1994 and 1995 conferences its representatives expressed themselves strongly against all matters connected with sexual and reproductive health and rights. For example, the delegation to the ICPD presented their formal disagreement with all of Chapter VII 'Reproductive rights and reproductive health' and rejected all the key terms – "reproductive rights", "sexual rights", "reproductive health", "control of fertility", "sexual health", "individuals", "sex education and services for minors", "all types of abortion", "distribution of contraceptives" and "maternity without risks".
- 18** For example, the Action Plans of the 1994 and 1998 Summits of the Americas, and the annual reports of the Inter-American System of Human Rights.
- 19** Aitken (1998) quoted in Standing, H (2000) "Gender Impacts of Health Reforms. The Current State of Policy and Implementation". Institute of Development Studies, University of Sussex, UK.
- 20** Kennedy, Mirta, Sanchez, Jessica; Molina, Dilcia (2002) "Explotación sexual comercial de niños, niñas y adolescentes en Honduras", IPEC-OIT/CEM-H.
- 21** International Women's Health Coalition (2001) 'Millennium Development Goals – RH left out!!!' quoted in <http://lists.partners-intl.net/pipermail/women-east-west/2001-July/001093.html>. The goals were fixed during the United Nations Millennium Summit in 2000. It should be noted that they do include the reduction of maternal mortality and HIV AIDS.
- 22** A law that prohibits the funding of organisations that are considered to promote abortion.
- 23** "Estado Laico y el Derecho al Aborto, Por un Estado Laico, Por el Derecho a Decidir". www.campanha28set.org.
- 24** Ana María Pizarro. Spoken presentation "Ciudadanía y aborto en Nicaragua" during the forum "Politics and Women's Citizenship", Nicaragua, 8th October 2004.
- 25** Ana Maria Pizarro, op. cit. Also see section 2.2.2.
- 26** Negatively, these laws, at least in the case of Honduras, do not include a gender perspective. There is no recognition that women are affected by specific vulnerability factors and that measures are required to reduce the more rapid spread of the epidemic among women.
- 27** Laws in Central America require a set of operating regulations, which are approved separately by the national legislature, to permit their full implementation.
- 28** Marroquin, Dilcia. Personal communication.
- 29** Details from the "pro-life" web site www.vidahumana.org/news/30SEPT03.html
- 30** This penal code received general approval in 2000 but approval of its exact provisions is still pending.

- 31** The same month that this document was finished (November, 2004) the Honduran congress approved a constitutional reform that prohibits same-sex marriage and adoption by gay or lesbian couples.
- 32** At the time of writing (November 2004), proposed changes in the Nicaraguan penal code threaten to weaken existing legislation. If the most recent draft of the new law is passed, it would be regressive in several aspects: the security measures established by Law 230 on intra-family violence would be eliminated; the age limit for consensual sexual relations, below which these constitute rape, would be dropped from 14 to 13; and the typification of "illegitimate seduction" as a type of sexual harassment would be eliminated.
- 33** Santiso G., Roberto y Bertrand, Jane T (2000) "The Stymied Contraceptive Revolution in Guatemala". Measure Evaluation, Carolina Population Center, USA.
- 34** Both problems are addressed among the Millennium Development Goals.
- 35** Recently, the WHO has recommended training of midwives as a measure to reduce maternal mortality. "Muerte en el parto: epidemia oculta." <http://news.bbc.co.uk/hi/spanish/news>, 29th September 2004.
- 36** During the recent "Fourth Central American Women's Encounter: Building Alliances around Abortion" it was agreed that the central aim of this regional grouping should be 'To coordinate activities in Central America in defence of safe abortion, understood as the right of women to take decisions about their own bodies'. For more information about this informal network send an email to derechos@lasdignas.org.sv.
- 37** www.convencion.org.uy/default.htm

Building Women's Citizenship and Governance, Central America

This document forms part of a series of 10 presenting the experience and opinions of five Central American feminist organisations. These organisations are working together in a regional project which seeks to promote the exercise of women's citizenship. Documents in the series include: the participation of the women's movement in the development of public policy; feminist perspectives on globalisation; the promotion of gender equity and women's participation through local government; and the role of public policy in the defence of sexual and reproductive rights. All the documents are available on the web site <http://www.oneworldaction.org>

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