

United Nations Special Session on Children: children's rights under attack

Jennifer Kitts, Katherine McDonald

How can we talk about a plan of action for children that doesn't deal with sex education and information? ... To face the challenges posed by HIV/AIDS and early pregnancy, we have to keep our children informed. To wait until they're over 18 is too late. — *Fernando Coimbra*, Brazilian negotiator, during meetings in preparation for the upcoming UN General Assembly Special Session on Children.¹

On May 8–10, 2002, the 10-year review of the 1990 World Summit for Children will be held at the United Nations headquarters in New York. This UN General Assembly Special Session on Children will review the progress made in the welfare of children since the 1990 World Summit, and since the adoption of the UN Convention on the Rights of the Child in 1989.

The Special Session will also set new goals for action to realize the rights of all children and adolescents up to the age of 18 in a document entitled *A World Fit for Children*. Governments have already held several meetings to negotiate what should be included in this final outcome document, and agreement has yet to be reached in a few contentious areas, notably the sexual and reproductive health of adolescents.

The upcoming Special Session will once again demonstrate that the challenges for this generation of children — the largest in history — are immense. It is well known that millions of children throughout the world grow up in poverty, without adequate nutrition, health care or education. But it must also be recognized that lack of access to sexual and reproductive health information and services is one of the most serious threats to this generation.

Girls and young women are especially at risk because they are biologically, socially and economically more vulnerable to coerced and unprotected sex.² In some countries, girls are becoming sexually active at younger and younger ages with men who believe that young girls are safe partners. It is difficult for many young women to refuse unwanted sex or to insist on condom use. Their immature reproductive systems are physically more fragile, increasing the likelihood of sexually transmitted infection (including HIV/AIDS), and of obstetric complications if they become pregnant.

Over 600 000 women die each year as a result of pregnancy and childbirth.³ Of these, 99% live in the developing world and many of them are children themselves.³ Each year, 15 million adolescent women, mainly in developing countries, give birth.⁴ A pregnant teenager is up to 5 times

more likely to die as a result of the pregnancy than a pregnant woman aged 18–25.⁵ As many as 4.4 million teenage girls undergo abortions every year.⁶ Of these, 40% are carried out under unsafe conditions, and 95% of all unsafe abortions take place in developing countries.⁷

Young people bear a special burden in the HIV/AIDS pandemic; of the nearly 22 million people who have died from this disease, 4.3 million were children.⁸ Almost a third of all people with HIV/AIDS are between the ages of 15 and 24 — some 10 million young people.² About 600 000 children under age 15 were newly infected with HIV in the year 2000.⁹ Studies in countries where HIV infection is prevalent show that most adolescents are unaware of even a single way to protect themselves from the disease.¹⁰

At numerous UN conferences in the 1990s, including the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, the international community made a commitment to improve and promote the sexual and reproductive health of adolescents. It was agreed that all people, regardless of age, have the right to access the information, education and services they need to protect their sexual and reproductive health — including contraceptives, prenatal care, care during and after delivery, and prevention of sexually transmitted infection.

A number of countries, including Canada, the European Union, Switzerland and the Rio Group (a negotiating bloc of 18 Latin American countries) are working hard to ensure that these commitments are maintained at the Special Session. The United States, on the other hand, has changed its position dramatically since the arrival of the Bush administration. At past UN conferences the US, along with Canada, the European Union and others, provided leadership in advancing sexual and reproductive rights. However, since President Bush took office, the US has lined up with unusual company — including Sudan, Libya, Iran, Pakistan and the Holy See — in attempting to roll back earlier agreements on the rights of adolescents to sexual and reproductive health information, education and services.¹¹ Clearly, the Bush administration intends to advance its conservative social agenda on the international stage.

The US delegation, reportedly “pro-family and pro-life,”¹² wants to be sure that the Special Session's final resolution will not promote explicit sex education.¹ It views abstinence as the primary strategy to prevent unintended pregnancies and HIV/AIDS. A delegate from Saudi Arabia

reportedly praised the US for focusing on sexual abstinence: "The best, if not the only, kind of prevention is chastity. Chastity and abstinence is the number one solution."¹²

Obviously, abstinence is one way to avoid pregnancy and sex-related infections. Just as obviously, it will not help the vast numbers of young people around the world who, willingly or not, become sexually active during their adolescent years. (The timing of sexual initiation varies by country and gender. The proportion of girls who have first intercourse by age 17 is reported as 72% in Mali, 53% in Jamaica, 52% in Ghana, 47% in the US, 45% in Tanzania, 7% in Thailand and 6% in the Philippines. Proportions reported for boys include 76% in Jamaica, 64% in the US, 63% in Brazil and 7% in the Philippines.)¹³ A focus on abstinence — a clear concession to the American right — has proved objectionable to many delegations and cannot be considered a workable solution to the core issue, namely, protecting and promoting the health of young people. "We would not highlight [abstinence] as a major means of dealing with the problem [of teenage pregnancy and HIV/AIDS]," said a delegate from the United Kingdom.¹⁴

The Bush administration also wants to ensure that the wording of the final document "does not support or advance the idea of abortion."¹⁵ As part of this plan, it is campaigning to have the phrase "reproductive health services" removed. During a June 2001 meeting, a Canadian delegate acknowledged that "sexual and reproductive health services" could include abortion.¹⁶ Carol Bellamy, Executive Director of the United Nations Children's Fund (UNICEF), points out that there have been references to "reproductive health services" in UN documents for years, ranging from the declarations at UN world conferences on population, poverty and women, to material published by UNICEF and the WHO.¹⁵ Françoise Girard, of the International Women's Health Coalition, points out that while the Cairo Programme of Action does include abortion in "reproductive health care," "it makes it perfectly plain that this is in circumstances where abortion is not against the law."¹¹ In Cairo, the world's governments agreed that where abortion is legal it should be safe and accessible.

The US also wants to remove a clause providing special rehabilitation for girls who are war victims, fearing that this could include birth control or abortion counselling for victims of rape.¹

The argument is often used that predominantly Catholic countries are opposed to sexual and reproductive rights. This is no longer the case. The Rio Group strongly supports sexual and reproductive rights as negotiated at the Cairo and Beijing conferences: "The bottom line is that we can't turn back the international agreements drafted by consensus over the last decade. We cannot lower the standards already set," said Loreto Leyton, First Secretary of the Chilean Mission and spokesperson for the Rio Group.¹⁷

The Canadian government has also demonstrated leadership at the Special Session in ensuring that the sexual and reproductive rights of all are respected. Officially, Canada

"fully supports the consensus reached at various international fora committing Members States to ensure the availability of and universal access to reproductive health services ... and believes that these standards should constitute the basis for negotiations on the outcome for the Children's Special Session" (Krista Wilcox, Department for Foreign Affairs and International Trade, Ottawa: personal communication, ref. AGH0114, 2002).

The Children's Special Session will set the direction for international policy with respect to children for the next decade. Any weakening of the language coming out of the Special Session could also set a dangerous precedent for future agreements, and encourage further and more aggressive activism by socially conservative interest groups.

Furthermore, although consensus documents emerging from UN conferences are policy documents rather than legal instruments or binding treaties, they are often used as a basis for the development of standards to interpret international human rights expressed in international conventions. Simply stated, any language coming out of the Special Session is likely to influence the interpretation and implementation of international human rights treaties.

The addition of the voice of the United States to those of conservative countries trying to deny adolescents their right to sexual and reproductive services means that Canada and its allies will have to work even harder to ensure that gains made in past years are not eroded.

Ms. Kitts is Senior Advisor, Sexual and Reproductive Health and Rights, Action Canada for Population and Development. Ms. McDonald is Executive Director, Action Canada for Population and Development (www.acpd.ca).

Competing interests: None declared.

Contributors: Ms. Kitts carried out the preliminary research and wrote the first draft. Ms. McDonald reviewed and revised the article and significantly rewrote selected sections.

References

1. Farley M. With conservative stand on minors' rights, US irks its allies. *Los Angeles Times* 2001 Aug 31;Sect A:5.
2. UNICEF Statistics. *HIV/AIDS*. Available: childinfo.org/eddb/hiv_aids/young.htm (accessed 2002 Mar 30).
3. Safe Motherhood Inter-Agency Group. *Safe motherhood*. Available: http://safemotherhood.org/init_what_is.htm (accessed 2002 Mar 30).
4. United Nations Population Fund (UNFPA). *UNFPA and adolescents*; 1997. Available: www.unfpa.org/icpd/round%26meetings/ny_adolescent/reports/adoles.htm (accessed 2002 Mar 30).
5. United Nations Population Fund (UNFPA). *Women's empowerment and reproductive health: pregnancy and abortion*. Available: [www.unfpa.org/modules/intercenter/cycle/adolescence.htm#Pregnancy and Abortion](http://www.unfpa.org/modules/intercenter/cycle/adolescence.htm#Pregnancy%20and%20Abortion) (accessed 2002 Mar 30).
6. United Nations General Assembly. *Report of the Round Table on Adolescent Sexual and Reproductive Health and Rights: key future actions*. Available: http://www.unfpa.org/icpd/round%26meetings/ny_adolescent/reportrt1.htm (accessed 2002 Mar 30).
7. World Health Organization. *Unsafe abortion: global and regional estimates of incidence of mortality due to unsafe abortion with a listing of available country data*. 3rd ed; 1997. Doc no. WHO/RHT/MSM/97.16. Available: www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html (accessed 2002 Mar 30).
8. Joint United Nations Programme on HIV/AIDS (UNAIDS). *UN Special Session Fact Sheets*; June 2000. Available: http://www.unaids.org/fact_sheets (accessed 2002 Mar 30).
9. Joint United Nations Programme on HIV/AIDS (UNAIDS). June 2000. UN Special Session Fact Sheets. Available: www.unaids.org/fact_sheets.
10. In fight against AIDS, UNICEF challenges leaders to do more with schools.

- [press release]. 2000 Nov 28. Available: www.unicef.org/newsline/00pr70.htm (accessed 2002 Mar 30).
11. Girard F. Reproductive health under attack at the United Nations [letter]. *Reproductive Health Matters* 2001;9(18):68.
 12. Mercer F. Pro-family participants report gains at Child Summit negotiations. *VIVANT! Pro-Family News from the United Nations*. 2001;3(5):4.
 13. United Nations Population Fund. *The state of the world population 2000. Lives together, worlds apart: men and women in a time of change*. New York: The Fund; 2000. p. 18. Available: www.unfpa.org/swp/2000/english/index.htm (accessed 2002 Apr 5).
 14. European patience wears thin. *On the Record for Children* 2001;2(6):3. Available: www.ngosatunicef.org/Special%20Session/newsletters/volume2newsletter6article2.html (accessed 2002 Apr 4).
 15. Lederer EM. *US gets assurance on kids conference*. Associated Press; 2001 Aug 29.
 16. Language on reproductive health care alarms pro-life and pro-choice advocates. *On the Record for Children* 2001;2(5):3. Available: www.ngosatunicef.org/Special%20Session/newsletters/volume2newsletter5article7.html (accessed 2002 Apr 4).
 17. Engh G. Don't forget adolescents, warn Latin American governments. *On the Record for Children* 2001;2(1):3. Available: www.ngosatunicef.org/Special%20Session/newsletters/volume2newsletter1article4.html (accessed 2002 Apr 4).

Correspondence to: Ms. Jennifer Kitts, 260 Dalhousie St., Suite 3000, Ottawa ON K1N 7E4; jkitts@acpd.ca; fax 613 562-9502

CMAJ's new online continuing professional development course

Erica Weir, John Hoey

Samuel Clemens is reputed to have said, "I never let my schooling interfere with my education." The efficacy of organized education is rightly debated, and no more so the variety known as continuing medical education, or continuing professional development (CPD) to use the current euphemism. Evidenced-based educators tell us that traditional continuing education does not appear to change practice patterns at the bedside. In the midst of serious inquiry into the best ways to educate practising physicians¹ has come pressure on the self-regulating bodies to monitor their members and assure the public that they are keeping up to date. Consequently, in addition to the ethical imperative to maintain knowledge and skills, physicians now face the threat of losing some of the letters after their names if they don't.

The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada have each recently revised their requirements for CPD that physicians must meet if they are to continue to be accredited. For example, in addition to spending 50 hours a year in continuing medical education activities to maintain college membership, family physicians must now spend 24 hours in enhanced Maintenance of Proficiency (MAIN-PRO-C) activities every 5 years in order to maintain certification (www.cfpc.ca/cme/mainpro/mainpro.asp). Fellows of the Royal College must earn 400 credits selected from a variety of educational options over 5 years under the Maintenance of Certification Program (rcpsc.medical.org/english/maintenance/programinfo/index.php3). Didactic methods such as attending rounds or reading medical journals receive less credit than do more active undertakings such as

reviewing personal learning objectives before rounds or participating in small-group discussions. For a CPD course to receive accreditation at these higher levels, it must assess and respond to the individual learning needs of the participants, support and facilitate interaction between peers and require participants to measure the impact of the course on their practice 3 months down the line.

These new criteria have implications for physicians as they familiarize themselves with college requirements and for course developers as they design courses in accordance with these requirements. They also have implications for medical journals as they try new ways to package medical knowledge while still upholding the standards of peer review and open access. The availability of CMAJ in an electronic format allows us think about delivering knowledge in different ways.

Last year CMAJ embarked on a process to bring online CPD courses to the journal. We consulted physicians who had successfully run accredited CPD courses online,²⁻⁴ we sought guidance from university continuing education offices, we paid attention to the criteria and accreditation process outlined by the colleges, and we sought out and transformed traditional workshop material for online delivery. Along the way we met and collaborated with an unexpected number of enthusiasts: authors willing to spend time converting their material into an online curriculum, educators candid about their lessons learned, community physicians keen to facilitate discussions with their peers, and agencies willing to sponsor initiatives to educate physicians for the benefit of public health. We are grateful to everyone who helped us.

From these efforts comes our first of what we hope will