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General debate on national experience in population matters: fertility, reproductive health and development. Agenda item 4

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Mr. Chairman,

Since it is the first time my delegation has the floor, please let me congratulate you and the rest of the bureau on your election.

Norway has always been a strong proponent of ICPD, and welcomed its visions. But when it comes to the ICPD Programme of Action targets, Norway was never a main recipient. The maternal mortality is so low that it can hardly be further reduced, and access to reproductive health care is universal. Even so, Norway has benefited from ICPD for its domestic work. Its values and principles are fundamental for a democratic society. Sexuality is never a neutral subject, and there are constantly political battles and a need for more scientific knowledge as a basis for policies and services. The global acknowledgement of these concerns has given an impetus for the government and NGO work at home and also guided us in our development cooperation.

Mr. Chairman,

Allow me to give some historical glimpses. Norway was among the first group of countries in the world to substantially reduce maternal mortality. This happened more than one hundred years ago, way before the introduction of the sophisticated technology that we benefit from today and at a time when Norway was still a very poor country. The two main strategies were to have midwives manage deliveries, to have and maternal care as the backbone of hospital services. The

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country was also blessed with researchers who documented people's living conditions, including sexual behavior, and the effects of various interventions. Courageous politicians insisted that it was a moral imperative to work towards the best outcomes, even if it meant taking up sensitive issues. Last, but definitely not least, NGOs, especially women's NGOs, have been active in providing neglected services and done advocacy for neglected areas and for disadvantaged groups. When we now pride ourselves of good results, these are very much thanks to these women's organization who took up ridiculed and hidden issues that were later incorporated into general public services.

When modern contraceptives became available, family planning services were integrated into publicly funded primary health care. Prevention and treatment of sexually transmitted infections were also given prominence.

The Total Fertility Rate was 1.95 last year, one of the highest in Europe. The high fertility level is believed to be associated with family-friendly policies of the government, with the goal to make it easer for women and men to combine family life and paid work. The cornerstones of these policies are long parental periods of leave with pay, presently 56 weeks, of which the fathers have to take at least 10 weeks; full kindergarten coverage for children over the age of one year, and up to 10 days of leave per year with full pay to care for a sick child. The greater equal parental share in child care seems to contribute to more positive attitudes to having children. Now even male cabinet ministers take such paternal leave.

Childlessness is low, only 12 per cent of Norwegian women do not have children at all. In spite of the high fertility Norwegian women have a very high labour force participation, many working part-time for periods, however. Due to the high fertility level the Norwegian population is expected to age significantly less than in most other European countries.

Breastfeeding rates are high when compared to other European countries. 98 % of newborns are breastfed from birth, and at 6 months 80 % still benefit from their mothers' milk.

The high fertility level is combined with reproductive choice and rights and easy access to family planning. Abortion on demand has been available since 1979, and unsafe abortions do not happen any more. Abortion rates are moderate. Health staff has the right to conscientious objection to participating in abortion procedures, and it is a requirement that health services be organized such that the services are available for all who require them. The percentage of those who object has remained low. In this way the women's rights to safely and legally terminate an unwanted pregnancy is secured.

Since 2002 young girls between 16 and 19 years of age can get contraceptives free of charge, and condoms are also distributed at no cost for young people. Sexuality education for youth is done both by government and by NGOs, and is generally focusing on the duality of sexual pleasure on one hand and the need for protection against unwanted sexual activities, sexually transmitted infections and unwanted pregnancies on the other. Respect for the diversity in human sexuality is also an important part of the education.

Teenage childbearing is declining and now only 9 out of 1000 teenagers per year, down from more than 40 in the early 1970s.

The mean age at first births has been increasing, and it is now 28 years for women and 31 years for men, but has now stabilized. When it comes to sexually transmitted infections, chlamydia infection is a concern, and especially among youth. In terms of HIV infection, heterosexual transmission between persons who live in Norway is still rare, with less than 60 new cases in 2010, for a population of close to 5 millions. There is concern about homosexual transmission of HIV, but it has not been even remotely as high as feared during the early years of the epidemic. Responsible reactions from NGOs that represent the interests of the gay community, and concerted actions for de-stigmatization, are some of the ingredients for this success story.

In order to ensure sexual and reproductive rights for homosexuals and lesbian people, same sex marriage has been introduced, and all couples have the right to adopt children.

A relatively new challenge is related to increasing immigration. Providing high quality health services in the area of sexuality and reproduction to a culturally diverse population asks for sensitivity and understanding of various needs.

The history of sexual and reproductive health of Norway is, as in all other countries, a never ending story. We cherish the present freedoms and rights in relation to sexuality and reproduction, including for adolescents, and the fact that fertility is close to replacement rate. Also in the future this must be combined with gender equality and men's involvement in child care, respect for sexual diversity and universal access to sexual and reproductive health services.

Thank you for your attention.