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International Commitments and Guidance on Unsafe Abortion

Fred Sai

Correspondence: Dr Frederick Sai, Advisor to the President on Reproductive Health, HIV/AIDS, 24 Sir Arku Korsah Road, Airport Residential Area, P. O. Box 9983, KIA, Accra, Ghana. Tel: 233-21-774404; Fax: 233-21-773309;
E-mail: fredsai@ug.edu.gh, fredsai@idngh.com

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Abstract

Most of Africa's 54 countries have restrictive abortion laws, outdated remnants of former colonial laws that result in nearly five million unsafe abortions annually. To stem maternal mortality and morbidity, it is essential to look beyond strictly medical or health system approaches to solving this critical public health problem. The issue must be approached from a human rights perspective that emphasises the individual's right to self-determination. This article examines ways in which advocates can use established human rights standards, international consensus documents, and the World Health Organization's new technical and policy guidance for health systems to press for safer abortion care for African women. (*Afr J Reprod Health* 2004; 8[1]:15-28)

Key Words: *Abortion, law, policy, international agreements, maternal mortality and morbidity*

Résumé

Engagements internationaux et conseils sur l'avortement à risqué. La plupart des 54 pays de l'Afrique ont des lois restrictives sur l'avortement, des vestiges périmés des

anciennes lois coloniales qui occasionnent presque cinq millions avortements à risque chaque année. Pour enrayer la mortalité et la morbidité maternelles, il est essentiel de dépasser le niveau des approches basées purement sur le système médical ou de santé pour résoudre ce problème critique de santé publique. Il faut aborder le problème de la perspective de droits de l'homme qui met l'accent sur les droits de l'individu à l'auto-détermination. Cet article étudie les façons dont les défenseurs peuvent se servir des normes établies des droits de l'homme, des documents de consensus international et le nouveau guide de la politique et la technique de l'Organisation mondiale de la santé pour lutter en faveur de l'avortement moins à risque pour la femme africaine. (*Rev Afr Santé Reprod* 2004; 8[1]:15-28)

Introduction

Currently, 62% of the world's inhabitants live in the 64 countries where induced abortion is allowed legally either without restrictions or on broad social and economic grounds. The remaining 38% live in the 127 countries where abortion is prohibited completely or is allowed only to protect a woman's life or health.¹ While the last 20 years have seen a clear trend toward the removal of legal barriers to abortion access, the right to choose abortion remains unavailable or under threat in many parts of the world.

Each year, millions of women living in countries that impose severe restrictions on abortion attempt to end unwanted pregnancies through clandestine abortions, the majority of which are unsafe. African women in particular bear the brunt of these restrictive laws. More than 40%-or 34,000 per year-of the world's deaths due to unsafe abortion occur in Africa.² To put this in more concrete terms, consider the following facts: In Italy, a woman's chances of dying from a maternal cause are 1 in 6,000. In Ethiopia, a woman's chances of dying from complications of childbirth or pregnancy are an appalling one in seven, with more than half of those deaths attributable to unsafe abortion.³

The reasons for these immense disparities are readily apparent when we consider that most of Africa's 54 countries have restrictive abortion laws, resulting in nearly five million unsafe abortions each year. In Africa, abortion is available on request in three countries, namely, Cape Verde, South Africa and Tunisia, with terminations permitted fully through the first trimester. Twenty eight nations allow abortion only to save the life of the woman, and the remaining countries impose various restrictions on whether a woman can choose to terminate an unwanted pregnancy or not.

In the vast majority of those countries, abortion remains both unauthorised and unsafe. Safe procedures are accessible only to wealthier and more educated women, ensuring that poor, already marginalised women suffer disproportionately. Furthermore, in many countries, the laws punish both the woman and the provider. In virtually the entire region, these laws are outdated remnants of the former restrictive laws of the colonial powers.

Since most African countries achieved their independence from colonial rule in the 1960s, the legal status of abortion has changed drastically in two of those major powers—France and England—where abortions have become routinely available to women. Following independence, African nations changed many laws imposed by the former colonial powers, yet selectively left others on the books, particularly those that relate to women's rights and health. For this and other reasons, abortion reform in Africa has been significantly slower to occur than in many other regions of the world. It is essential that we accelerate the pace of abortion law reform across the continent. We can do this in part by using existing legal precedents and other advocacy tools to change restrictive laws so that they address the grim health-related realities that face many African women today.

In its constitution, which came into force in 1948, the World Health Organization defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. That definition has remained unchanged over the past 50+ years. Yet, in places where abortion is restricted, women seeking to terminate unwanted pregnancies face an all-too-real threat to their physical, mental and social well being. It is important to bear this in mind when examining the full range of approaches needed to address the problem of unsafe abortion in Africa. Ensuring women's health is not just the responsibility of the health care system—it is also the responsibility of individuals, advocates, citizens, and of entire communities. It is essential to look beyond strictly medical approaches to solving this critical public health problem. Instead, advocates for safe abortion must place their work within a human rights framework that emphasises the individual's right to self-determination.

Fortunately, a woman's rights to safe legal abortion could be derived from a more accurate interpretation of several international treaties, conventions, charters and other documents. Most countries have endorsed at least some international treaties that pertain to women's ability to exercise their human rights. Governments, United Nations agencies and non-governmental organisations (NGOs) are increasingly acknowledging that human rights also encompass reproductive and sexual rights.

This article will examine some of the most important conventions and other documents that have contributed to the evolution of women's rights within a human rights framework. This evolution began with the recognition of the right to health as a fundamental human right; the right to family planning, contraception and safe motherhood; and to the present day concept of broader reproductive health and rights. In particular, the article will examine the landmark 1994 International Conference on Population and Development (ICPD), 1995 Fourth World Conference on Women, and the five-year review conferences ICPD+5 and Beijing +5. All four events were groundbreaking in their inclusion of NGOs and activists not merely as observers, but as active participants, and led to the growing international consensus that unsafe abortion is a critical public health problem that requires immediate action in Africa and elsewhere. The article then examines the ways in which some African governments have responded to this growing international consensus

and pressure for policies that advance women's reproductive health. It concludes with a call for advocates to use these established human rights standards, international consensus documents and the World Health Organization's new technical and policy guidance for health systems to press for safe abortion care in Africa.

Several documents referred to in the paper are included as appendices, including the UN Millennium Development Goals and excerpts relevant to abortion care from the ICPD Programme of Action, Fourth World Conference on Women, ICPD +5, Beijing +5, as well as statements and recommendations of the International Federation of Obstetrics and Gynecology (FIGO) and the International Con-federation of Midwives (ICM).

The Evolution of the Right to Health

The concept of protecting individual dignity and rights is not a modern notion; precedents exist in the philosophical and legal traditions of African and other countries. This long-held concept was codified with the adoption of the United Nations' Universal Declaration of Human Rights (UDHR) in 1948. The UDHR laid the groundwork for the development of subsequent treaties and covenants that set forth human rights standards and obligations to which signatory countries must adhere. This system, which has continued to evolve and expand over time, includes the formation and endorsement of international conventions by States; the creation of committees to monitor the compliance of States with the treaties they have signed; and the establishment of international courts that consider cases involving human rights violations.

For example, the 1966 International Covenant on Economic, Social and Cultural Rights (ICESC) stressed individual rights in the social, economic and cultural arenas. This covenant also articulated the right to health for the first time as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It also mandates that States take steps to ensure the creation of conditions that assure all medical service and medical attention in the event of sickness.

The right to health was further articulated in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which came into effect in 1981. CEDAW explicitly addressed women's right to health, stating that it includes health care services related to childbirth, family planning, pregnancy and postnatal care. In 1999, the CEDAW committee further commented that States must eliminate discrimination against women in their access to health care services throughout their life cycle. Simply put, it is discriminatory for signatory States to deny access to health services that only women need, including reproductive health services. As of June 2003, 174 States have ratified CEDAW, including the quasi totality of African nations.

International conventions such as ICESC and CEDAW-also called treaties, charters,

covenants or pacts-are international agreements that States sign or ratify. The States are legally obligated to put their provisions into practice. They are also committed to submit national reports, at least every four years, on measures they have taken to comply with their treaty obligations. The two conventions are also evaluated by treaty monitoring committees, teams of experts that evaluate the degree to which a State has made efforts to comply with the treaties. For example, nations might take steps to amend national laws, policies and practices in ways that honour treaty provisions. Individuals and NGOs may also submit information-sometimes called "shadow reports"-on the progress of State compliance.

Although they have not yet addressed abortion specifically, the monitoring bodies that evaluate countries' progress toward achieving treaty commitments are beginning to offer guidelines for how to interpret existing treaty language. For example, General Recommendation 24 to Article 12 of CEDAW states that health systems cannot deny women any services that only women need, and that access to health services must not be withheld because women lack consent or approval from their husband, mother-in-law or anyone else. These recommendations are critical for advocates seeking to reduce unsafe abortion, as women in Africa rarely have the right to make their own decisions about their health care particularly regarding childbearing issues.

Family Planning and Safe Motherhood

Over the past 30 or so years, we have witnessed growing emphasis placed upon the fundamental right of women and couples to make decisions about whether and when to have children. This right, which is so essential to the ability to control one's life, was first formally agreed upon in 1968, when UN member States met in Tehran to assess progress made since the option of the 1948 Universal Declaration of Human Rights. At the Tehran conference, governments agreed that parents have a basic right to determine freely and responsibly the number and spacing of their children. Several years later, at the United Nations World Population Conference, held in 1974 in Bucharest, this consensus was expanded: "...all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so." This additional language was critical, as it acknowledged the right to information, education and services to prevent unwanted pregnancy and ensure safe motherhood. At the 1984 International Conference on Population, held in Mexico City, participants called on governments to make family planning services universally available.

Over the past two decades, we have also seen growing recognition given to the broader health concerns of women beyond family planning and contraception, and to the evolving concept of reproductive health and rights. For example, various conventions and conferences have re-affirmed governmental commitments to safe motherhood. In particular, the Safe Motherhood Initiative, launched in 1987 by the World Health

Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA) and other organisations has drawn attention to the dimensions and consequences of poor maternal health in developing countries.

Women in African and other developing countries face numerous health risks with regard to childbearing. Ninety nine per cent of all maternal deaths occur in the developing world, making maternal mortality the health statistic with the largest disparity between developed and developing countries. The WHO estimates that in 1995 there were approximately 515,000 maternal deaths worldwide. Of those deaths, more than half (some 273,000) took place in Africa. There are 22 countries in sub-Saharan Africa with maternal mortality ratios of at least 1,000 deaths per 100,000 live births. Haiti is the only other country with ratio in excess of 1,000.⁴ Another useful measure of the vast disparity in reproductive health status between rich and poor countries is that of lifetime risk as measured by the reproductive risk index.[‡] In developed countries, a woman has only a 1 in 2,125 risk of dying in pregnancy or childbirth over the course of her lifetime. That risk is 35 times higher, at 1 in 65, for women in developing countries. In Africa as a whole, it is 1 in 16. As mentioned earlier, in Ethiopia the rate is 1 in 7. These figures are staggering when we consider what they mean in human terms.

‡The reproductive risk index, developed by Population Action International, ranks 133 countries on 10 key indicators of sexual and reproductive health for which comparable national data are available. The indicators include abortion policies, family planning and unwanted pregnancy, and early childbearing and adolescent reproductive health.

In September 2000, 189 countries at the UN Millennium General Assembly in New York endorsed a series of millennium development goals that aim to reduce poverty worldwide. All participating countries agreed on the need for a global mandate to reduce poverty and inequity. The need to improve maternal health was identified as one of the key millennium development goals, with a target of reducing maternal mortality levels by three quarters between 1990 and 2015.

These efforts to reduce maternal mortality are all extremely important milestones, particularly with regard to the dire situation facing African women. However, although millions of unwanted pregnancies end each year in unsafe abortion, few safe motherhood programmes have actively addressed that issue. This is all the more astonishing given that complications resulting from unsafe abortion are responsible for 13% of all maternal deaths, yet are among the most easily preventable fatalities. It can safely be said that the millennium development goal to reduce maternal mortality will not be achieved until unsafe abortion, one of the leading causes of maternal mortality, is addressed effectively.

In an important step, WHO's recent *Making Pregnancy Safer Initiative* does deal directly with unsafe abortion. It advocates contraceptive counselling for women who have had an

abortion, appropriate care for women who experience abortion complications and, where abortion is not prohibited by law, safe services for termination of pregnancy.

Cairo and Beijing: The Turning Points

The tide began to turn at the 1994 International Conference on Population and Development (ICPD), held in Cairo, Egypt. The conference was truly a watershed event in terms of international commitment to women's rights to reproductive self-determination. It was unprecedented for two major reasons. First, the Programme of Action that resulted from the meeting is a comprehensive, rights-based document that discusses issues—including sexuality, male involvement, adolescents, violence and unsafe abortion—that had been neglected or have received short shrift at other meetings. Second, the conference was remarkable for the way in which its process unfolded. Through a series of intensive meetings, networks and negotiations, women's rights advocates collaborated closely with key government allies, progressive religious leaders and others to include the perspectives and needs of diverse groups of women worldwide.

The importance of this process cannot be overstated. Previously, in the types of international agreements described above, NGOs had been relegated to observer status. For example, at the 1984 Mexico City World Population Conference, 146 countries participated and 139 NGOs "observed" the proceedings. In contrast, at ICPD in Cairo, 180 countries and 1,200 NGOs participated. For the first time, NGOs and other civil society groups had a major voice in constructing an international consensus agreement, and their active participation changed the tone of the debate entirely. Several African governmental delegations and women's groups played key leadership roles at the conference, were instrumental throughout the consensus building process, and supported the participation of a wide variety of NGOs.

Participants agreed that abortion should be safe where legal, and that women who suffer from unsafe abortion have a right to treatment for complications. For example, paragraph 8.25 of the Programme of Action states as follows: "In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion."

One year later, at the 1995 Fourth World Conference on Women, held in Beijing, participants expanded on the commitments made in Cairo. In the resulting document, paragraph 106(j) states that governments should collaborate with NGOs and employers' and workers' organisations, with the support of international institutions, to "recognise and deal with the health impact of unsafe abortion as a major public health concern," as agreed to in ICPD Programme of Action. Furthermore, paragraph 106(k) states that women should not be criminalised for having an abortion and that governments should "...consider reviewing laws containing punitive measures against women who have undergone illegal

abortions."

Translating Policy into Action

In 1999, the United Nations General Assembly held a five-year review of Cairo, commonly referred to as ICPD+5, that appraised the progress of governments in implementing the ICPD Programme of Action. The resulting consensus document elaborated further on the issue of unsafe abortion, with paragraph 63(iii) stating that "...in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that abortion is safe and accessible." This agreement holds health systems responsible for ensuring that all health facilities providing reproductive health services employ appropriately trained and equipped providers. Furthermore, legally permitted safe abortion services must be accessible and referral systems for post-abortion care should be available to treat the complications of unsafe abortions and incomplete miscarriages. In essence, paragraph 63 (iii) mandates that governments, NGOs and communities share responsibility for ensuring that abortion, where not against the law, is safe and offers guidance on how this ideal can be realised.

These conferences were major breakthroughs in the global recognition that unsafe abortion is a significant public health problem that requires immediate action. While these documents are political in nature, rather than legally binding, they express a "good faith" intention by the governments signing them to honour their recommendations.

As a result of all these efforts, many institutions, including UN agencies, NGOs, professional associations and national bodies are increasingly advocating safe legal abortion services. For example, in September 2000, the highly influential International Federation of Gynecology and Obstetrics went on record supporting women's rights to safe abortion in a vote of the FIGO General Assembly, stating that a woman has the right to have access to medical or surgical induced abortion.

In April 2002, the International Confederation of Midwives Council re-affirmed that the care of women after abortions is an integral part of the role of the midwife. The council urged its member associations to ensure that midwives possess the knowledge and skills needed to provide high quality post-abortion care. A few months later, in October 2002, the Latin American Federation of Obstetric and Gynecological Societies (FLASOG) agreed that members should work to broaden indications for legal abortion and ensure easier access to abortions permitted by law.

And, in an extremely important move, in response to the ICPD+5 recommendations about training and equipping health service providers, the World Health Organization has developed a technical and policy guidance for safe abortion for health systems.⁶ The

resulting document provides an overview of preferred abortion methods; addresses health system issues regarding the provision of appropriate, skilled care; and reviews policy and legal considerations related to safe abortion and the elimination of unnecessary barriers.

Where Do We Stand Today?

National governments worldwide, including some in Africa, have responded to the growing international consensus and pressure for policies that enhance women's well being and reproductive health. In some African countries we are witnessing a movement toward strengthened commitments to women's rights and bodily integrity. Abortion law reform has been taking place slowly yet steadily since the 1960s as part of the decolonisation process and in response to other pressures.

This process began in Anglophone countries and has tended to mirror changes made by the former colonial power. For example, in 1972, Zambia enacted one of the most liberal abortion laws in Africa based almost verbatim on England's 1967 Abortion Act, as did the Seychelles at a later date. The governments of Botswana, Ghana and Zimbabwe have also loosened their bans to include broader indications.

With regard to Francophone Africa, the most significant change has occurred in Tunisia. In 1965, Tunisia became the first African country to revamp its abortion law, which is very liberal, allowing abortion on request through the first trimester and thereafter on various grounds. Morocco has amended its Penal Code to allow abortion to be performed at any point during pregnancy to preserve the health of the woman, making no distinction between physical and mental health.

Until the mid-1990s abortion legislation in Burkina Faso was based on the French Napoleonic Code of 1810 and contained no explicit exceptions to a general prohibition on the performance of abortions. In 1997, however, government revised the penal code to expand indications for legal abortion, including exceptions in which both the mental and physical health of the woman are factors.

Perhaps the most dramatic example has occurred in South Africa where, in 1994, the first democratically elected government of South Africa implemented an equality-based constitution that helped pave the way for expanded sexual and reproductive rights. On October 31, 1996, the South African Parliament passed the Choice on Termination of Pregnancy (CTOP) Act. The law allows termination of pregnancy on request through the 12th week of pregnancy and under specified circumstances from the 13th through the 20th week.

The preceding is in no way intended to be an exhaustive overview of changes in African abortion laws since the end of colonialism. However, these examples serve to show that

significant progress has been made over the past 20 or so years. In various African countries, advocates from many sectors are joining to advocate for liberalised abortion laws. At the same time, African governments are increasingly acknowledging that high rates of maternal mortality caused by unsafe abortion cannot remain unchecked. This trend toward liberalising abortion has been gaining momentum even in countries like Kenya and Nigeria that have very restrictive laws. For example, in Kenya, where abortion is permitted only to save the life of the mother, many gynaecologists and other medical providers have pressed for liberalised abortion laws. The Kenya Medical Association has urged the government and civil society and religious groups to review abortion and other reproductive health laws. Furthermore, a 2000 report from the Kenya Family Health Programs-a five-year effort involving the Ministry of Health and many NGOs-asserts that the harm caused by unsafe abortion outweighs any argument for retaining anti-abortion laws.

In Ethiopia, the current penal code permits abortion only if the woman's life or physical health is in jeopardy. A committee of NGOs and professional associations are collaborating to analyse and make recommendations on proposed revisions to the Ethiopia penal code on issues such as rape, domestic violence, abduction and abortion. In Ethiopia, public forums on adding these exceptions for legal abortion are currently being held, and could lead to expanded indications and, ultimately, decreased maternal mortality rates.

Despite the progressive trends, we must candidly acknowledge that liberalised laws do not automatically translate into expanded access for women. The laws themselves are often narrowly interpreted, placing greater restrictions on services than is legally required or medically necessary. Laws that allow abortion to preserve the woman's health often do not provide guidance about what type of conditions or diseases apply. Shortages of providers and equipment may also contribute to reduced services even in countries like South Africa and Ghana that have more liberal laws. In many places, there are shortages of abortion providers; to help counter this, nurses and midwives are being trained and permitted to perform abortions, providing greater access to safe abortions at conveniently located facilities. In South Africa in particular, a barrier to abortion care services has been the refusal of some health care providers to provide abortions based on conscientious objection.

Finally, we must take into consideration the US government's continued reversal on reproductive health policies. At the 1984 World Population Conference in Mexico City, the US government announced that it would withdraw funding from any organisation that provided abortion services, even with funds from non-US sources. This policy became known as the Mexico City Policy or "Global Gag Rule." Nearly a decade later, in 1993, then President Clinton reversed the Mexico City Policy. However, in 2001, a mere two days after taking office, President Bush reinstated the Mexico City Policy. Over the past two years, the current US administration has withdrawn from previously made commitments concerning sexual and reproductive rights. Most recently, the Bush

administration has announced its intention to extend the "Global Gag Rule," which has applied only to family planning funding, to also include US government funds given for maternal and child health and for HIV/AIDS programmes.

These Bush administration policies, which amount to the export of domestic debates and policies, also have the effect of undermining international consensus-building processes such as ICPD. By withdrawing from, and flip-flopping on, previously agreed upon international agreements, they lessen the hard won effects of these processes and provide African and other governments with an excuse to also not respect them. These policies also endanger the health and lives of women across Africa, and a study examining its effects is forthcoming from Ipas and Population Action International.

Conclusion

Abortion has always occurred and will continue to occur in all societies, including those in Africa. In many traditional African cultures, the termination of unwanted pregnancies has long been an accepted practice. Anecdotal reports indicate that many traditional communities regard abortion as vital to maintaining societal order and harmony and had their own related protocols. For example, among the Maasai of Kenya, communities had defined categories of unwanted or "social unacceptable" pregnancies, including those involving a young unmarried girl or a woman who had been raped. And in South Africa, proponents of the CTOP Act highlighted traditional abortion practices to illustrate that terminating unwanted pregnancies was a familiar approach to fertility management in many traditional settings of that country.

Despite these historical precedents, however, the restrictive laws in effect in most African countries force women to seek clandestine, often unsafe, abortions. Countries that have liberalised their laws and made safe abortion services accessible demonstrate significantly reduced maternal mortality rates without a corresponding demand for abortion services or a rise in unwanted pregnancies. From 1996 to 1989, when Romanian law strictly prohibited abortion, 85% of maternal mortality in that country was abortion-related.⁵ Under the restrictions, the abortion-related maternal mortality rate increased steadily, reaching nearly 150 deaths per 100,000 live births by the early 1980s. Following the liberalisation of abortion laws in 1989, the maternal mortality rate decreased by 50% in a one-year period, and has continued to decline. By 1997 Romania's abortion-related maternal mortality rate had dropped to 21 deaths per 100,000 live births.⁵ The fact is that thousands of women—our mothers, sisters, daughters and wives—die or are injured as the direct effect of these restrictive laws. It is imperative that we address the discrepancy between these laws and women's actual needs. The laws and policies of African nations must reflect the realities that face African women, their families and their communities.

Health care providers, lawyers, women's health advocates, parliamentarians and other

advocates for safe abortion can work to change these laws and policies by understanding what current laws permit, how they are being implemented, and whether there are barriers that inhibit women from exercising their legal rights. In countries where legal reform is possible, health care professionals and others can work to liberalise laws by involving colleagues, taking an active role in helping shape debates on current laws and policies, and disseminating statistics on abortion-related maternal mortality and other indicators from the reproductive risk index. Also, as mentioned earlier, the new WHO technical and policy guidance on safe abortion is an invaluable tool for advocates. As medical professionals and advocates, we can offer this guidance to our governments as they revise laws, ease restrictions, and develop their own guidelines for safe abortion. It offers a blueprint for translating policy into reality and ensuring that safe abortion services are available at all levels of the health system.

Finally, we must also hold governments accountable for ensuring access to legal abortion and work with NGOs, health care providers, legal groups and other advocates to reduce the barriers African women face in accessing abortion services. We must ensure the full implementation of agreements, conventions, treaties, and charters related to sexual and reproductive health and rights to which governments are signatories. We must support laws and policies that uphold women's right to make and act on their own reproductive decisions, and work to break down legal and policy barriers that restrict basic human rights. African women deserve no less.

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Appendices

Appendix A: UN Millennium Development Goals

<http://www.un.org/millenniumgoals/>

1. Eradicate extreme poverty and hunger

- Reduce by half the proportion of people living on less than a dollar a day
- Reduce by half the proportion of people who suffer from hunger

2. Achieve universal primary education

- Ensure that all boys and girls complete a full course of primary schooling

3. Promote gender equality and empower women

- Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015

4. Reduce child mortality

- Reduce by two thirds the mortality rate among children under five

5. Improve maternal health

- Reduce by three quarters the maternal mortality ratio

6. Combat HIV/AIDS, malaria and other diseases

- Halt and begin to reverse the spread of HIV/AIDS
- Halt and begin to reverse the incidence of malaria and other major diseases

7. Ensure environmental sustainability

- Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources
- Reduce by half the proportion of people without sustainable access to safe drinking water
- Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020

8. Develop a global partnership for development

- Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. Includes a commitment to good governance, development and poverty reduction—nationally and internationally
- Address the least developed countries' special needs. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction
- Address the special needs of landlocked and small island developing States
- Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term
- In cooperation with the developing countries, develop decent and productive work for youth
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries
- In cooperation with the private sector, make available the benefits of new technologies—especially information and communications technologies

Appendix B: 1994 Programme of Action Adopted at the International Conference on Population and Development, Cairo

"Advancing gender equality and equity and the empowerment of women...and ensuring women's ability to control their fertility are cornerstones of population and development-related programs..." — *Principle 4*

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law." — *Paragraph 7.2*

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ... The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning...." — *Paragraph 7.3*

"[G]overnments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family planning services and methods." — *Paragraph 7.20*

"In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion* as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from

abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions." — Paragraph 8.25

Appendix C: 1995 Fourth World Conference on Women, Beijing

"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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences." — *Paragraph 96*

"Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions [should]:

j. Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development;

k. In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development... consider reviewing laws containing punitive measures against women who have undergone illegal abortions." — *Paragraph 106*

Appendix D: 1999 Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development

(i) "In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion* as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.

* *Unsafe abortion is defined as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both. (WHO)*

(ii) Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counseling of women who have had recourse to abortion.

(iii) In recognizing and implementing the above, and in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health." — *Paragraph 63*

Appendix E: 2000 Further Actions and Initiatives to implement the Beijing Declaration and the Platform for Action

o. "In light of Paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, ... [governments should] consider reviewing laws containing punitive measures against women who have undergone illegal abortions." — *Paragraph 72*

f. "Design and implement programmes with the full involvement of adolescents, as appropriate, to provide them with education, information and appropriate, specific, user-friendly and accessible services, without discrimination, to address effectively their reproductive and sexual health needs, taking into account their right to privacy, confidentiality, respect and informed consent and the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child and in conformity with CEDAW and ensuring that in all actions concerning children, the best interests of the child are a primary consideration..." — *Paragraph 79*

Appendix F: 2000 Statement of the International Federation of Obstetrics and Gynecology (FIGO)

Ethical Guidelines Regarding Induced Abortion for Non-Medical Reasons

Adopted by the FIGO General Assembly as part of the pre-Congress Workshop Report at the XVI FIGO World Congress, Washington DC, September 2000

1. Induced abortion may be defined as the termination of pregnancy using drugs or surgical intervention after implantation and before the conceptus has become

independently viable....[1]

2. Abortion is very widely considered to be ethically justified when undertaken for medical reasons to protect the life and health of the mother in cases of molar or ectopic pregnancies and malignant diseases. Most people would also consider it to be justified in cases of incest or rape, when the conceptus is severely malformed, or when the mother's life is threatened by other serious disease.

3. The use of abortion for other social reasons remains very controversial because of the ethical dilemmas it presents to both women and the medical team. Women frequently agonize over their difficult choice, making what they regard in the circumstances to be the least worst decision. Health care providers wrestle with the moral values of preserving life, of providing care to women and of avoiding unsafe abortions.

4. In those countries where it has been measured, it has been found that half of all pregnancies are unintended and that half of these pregnancies end in termination. These are matters of grave concern, in particular to the medical profession.

5. Abortions for non-medical reasons when properly performed, particularly during the first trimester when the vast majority take place, are in fact safer than term deliveries.

6. However, the World Health Organization has estimated that nearly half of the 50 million induced abortions performed around the world each year are unsafe because they are undertaken by unskilled persons and/or in an unsuitable environment.

7. The mortality following unsafe abortion is estimated to be very many times greater than when the procedure is performed in a medical environment. At least 75,000 women die unnecessarily each year after unsafe abortion and very many more suffer life-long ill-health and disability, including sterility.[2]

8. Unsafe abortion has been widely practiced since time immemorial. Today it occurs mainly in countries with restrictive legislation with respect to the termination of pregnancy for non-medical reasons. Countries with poorly developed health services and where women are denied the right to control their fertility also have higher rates of unsafe abortion.

9. When countries have introduced legislation to permit abortion for non-medical reasons, the overall mortality and morbidity from the procedure has fallen dramatically, without any significant increase in terminations.

10. In the past most pregnancy terminations were undertaken surgically, however, recent pharmaceutical developments have made it possible to bring about safe medical abortion

in early pregnancy.

11. In addition, the reproductive process can be interrupted before pregnancy begins by classical contraceptive methods or by the more recently popularized emergency contraception. The latter is not an abortifluent because it has its effect prior to the earliest time of implantation. Nevertheless these procedures may not be acceptable to some people.

Recommendations

1. Governments and other concerned organizations should make every effort to improve women's rights, status, and health, and should try to prevent unintended pregnancies by education (including on sexual matters), by counselling, by making available reliable information and services on family planning, and by developing more effective contraceptive methods. Abortion should never be promoted as a method of family planning.
2. Women have the right to make a choice on whether or not to reproduce and should therefore have access to legal, safe, effective, acceptable and affordable methods of contraception.
3. Providing the process of properly informed consent has been carried out, a woman's right to autonomy, combined with the need to prevent unsafe abortion, justifies the provision of safe abortion.
4. Most people, including physicians, prefer to avoid termination of pregnancy and it is with regret that they may judge it to be the best course, given a woman's circumstances. Some doctors feel that abortion is not permissible whatever the circumstances. Respect for their autonomy means that no doctor (or other member of the medical team) should be expected to advise or perform an abortion against his or her personal conviction. Their careers should not be prejudiced as a result. Such a doctor, however, has an obligation to refer the woman to a colleague who is not in principle opposed to termination.
5. Neither society, nor members of the health care team responsible for counselling women, have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different. Counselling should include objective information.
6. Very careful counselling is required for minors. When competent to give informed consent, their wishes should be respected. When they are not considered competent, the advice of the parents or guardians and when appropriate the courts, should be considered before determining management.

7. The termination of pregnancy for non-medical reasons is best provided by the health care service on a non-profit-making basis. Post-abortion counselling on fertility control should always be provided.

8. In summary, the Committee recommended that after appropriate counselling, a woman had the right to have access to medical or surgical induced abortion, and that the health care service had an obligation to provide such services as safely as possible.

— Originally published in *International Journal of Gynecology & Obstetrics* 1999; 64: 317-322.

1 Note: This is not relevant to the lethally mal-formed fetus, cf. Ethical Aspects of the Management of the Severely Malformed Fetus. *International Journal of Gynecology and Obstetrics* 1996; 53:300. It is also important to consider Ethical Aspects in the Management of Newborn Infants at the Threshold of Viability. *International Journal of Gynecology and Obstetrics* 1997; 59:165-168.

2 WHO (1998). *Unsafe abortion: global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data*. 3rd Edition. WHO/RHT/MSM/97.16.

Appendix G: 2002 Statement of the International Confederation of Midwives (ICM)

Care of Women Post-Abortion

(p/counc02/reworded/pac 08-02)

Rationale

The care of women post-abortion is an integral part of the role of the midwife as defined in the International Definition of the Midwife (ICM/WHO/FIGO, 1992).

Statement of Belief

The International Confederation of Midwives believes that a woman, who has had an abortion, whether spontaneous or induced, is entitled to receive midwifery care. In keeping with this belief the midwife should:

- Consider such care to be within the role of the midwife
- Provide any immediate care and counselling following abortion

- Appropriately refer the woman for any further treatment that may be required and which is beyond the scope of midwifery practice
- Provide the woman (and where appropriate her family) with education concerning the woman's future health, including family planning
- Recognise the emotional, psychological and social support which may be needed by the woman and respond appropriately

Policy

Education of midwives should include the care of women following abortion

Guiding statement for member associations

Member associations are urged to:

- Seek to influence the training/education of midwives to ensure that they have the knowledge and skills to care for women post-abortion

Adopted by the International Confederation of Midwives Council, Oslo, May 1996.
Revised version adopted by the International Confederation of Midwives Council, Vienna, Austria, April 2002

Date for Review: 2008 *Appendix H: Recommendations of the Latin American Federation of Obstetric and Gynecological Societies (FLASOG)*

The following recommendations were adopted by the FLASOG General Assembly on 22 October 2002 at its seventeenth congress in Santa Cruz, Bolivia:

The Obstetrics and Gynecology Societies in Latin America and their members should work proactively to accomplish the following objectives:

1. The right to have a satisfying sexual life, free of violence and the risk of disease and unwanted pregnancy.

- Include the diagnosis, treatment and prevention of gender violence among gynecology and obstetric outpatient clinic services.
- Implement services that respond to the needs of women who suffer sexual violence, including prevention of STD/HIV and unwanted pregnancy and assist women with other

physical, social and psychological needs. Services should include attention immediately following violence as well as address medium and longer term affects.

- Develop programs to prevent recurrence of violence, directly addressing the men responsible for aggression.
- Assure easy access at the community level to condoms to avoid the STD/HIV infection and emergency contraception to prevent unwanted pregnancies.
- Include themes, such as gender equality, responsible sexuality and human rights in the formal and informal education of boys and girls.

2. The right to motherhood without unnecessary risk of illness and death Improve the coverage and quality of prenatal care, using recent scientific evidence as indicators of quality.

- Provide continuing medical education to professionals responsible for prenatal care in order to improve their capacity to identify warning signs and manage obstetric emergencies.
- Assure that all birthing facilities have the capacity to offer essential obstetric functions (as defined by the World Health Organization, WHO), and have emergency obstetric "kits" available and accessible to the entire population.
- Improve routine care for low risk deliveries, including activities which have been shown to be beneficial and excluding those seen as harmful or ineffective according to currently accepted scientific evidence, and with an emphasis on the respectful treatment of women receiving services.
- Gradually reduce the use of caesarean sections without medical indications, and promote medical review of all cases.
- Provide appropriate care for women with abortion complications, without judgment or discrimination that may affect their timely treatment and healthy recovery.
- Implement an epidemiological surveillance system of maternal-child morbidity and mortality to identify problems and generate proposals to improve the quality of care beginning at the primary care level. Monitor the implementation of such proposals.
- Implement a system for certification of health institutions, with FLASOG participation, using standardized models of care and periodic measurement of impact.

- Implement protocols for surveillance during the first 6 hours, 6 days and 6 weeks after delivery, in order to identify and treat the primary causes of maternal death in the postpartum period.

3. The right to freely decide about their own fertility (when, how and whether to have children) • Assure that all scientifically approved contraceptive methods are available continuously in all public services, in order to ensure that all women, including adolescents, have access to them.

- Train all health professionals to manage all contraceptive methods. Each country should define the level of professional that should be trained to provide the different methods. Training should include a gender perspective, sexual and health education, human rights and the use of Informed Consent.

- Assure that all women have access (the right) to infertility treatment.

4. The right to interruption of pregnancy according to the law of each country

- Ensure easy access to legal interruption of pregnancy for those women who meet the legal requirements of each country.

• Introduce guidelines that define the criteria and procedures to facilitate the rapid authorization of an abortion (pregnancy interruption), when legal conditions are met. The guidelines currently in effect in Brazil, prepared by the Brazilian Ministry of Health in close collaboration with FEBRASGO, on the care of high risk pregnancy and care of women and adolescents who suffer sexual violence, and which include criteria and procedures for pregnancy inter-ruption in both conditions, could be useful for the obstetrics and gynaecology societies in other countries.

- When the country's legislation does not penalize abortion when a woman's life or health are at risk, the women's own opinion on how much risk she is willing to accept should be the determining factor in the decision to interrupt the pregnancy.

• Physicians should be informed that they could be held responsible in cases of indirect maternal death (caused by a disease aggravated by the pregnancy) if they have refused a request for therapeutic abortion.

- Broaden the conditions in which abortion is legally permitted to include cases of fetal malformation incompatible with life (as documented by a qualified specialist) and when the woman presents with conditions in which the pregnancy places her life at risk.

Actions required to achieve these objectives

- Obstetrics and gynaecology societies should work with government health authorities to prepare and implement norms and guidelines which define the procedures necessary to assure sufficient public sector services, staffing and supplies for the promotion and protection of sexual and reproductive rights.
- Work with professors of medical schools and schools responsible for training of professionals from health and related sciences, to include in their curricula content related to women's sexual and reproductive rights. This should include gender and human rights concepts, respect for diversity, and the importance of not imposing their own personal values on the rights of women.
- Include themes related to women's reproductive and sexual rights in the continuing education activities promoted by the obstetrics and gynaecology societies in each country.
- Work directly with gynaecologists and obstetricians, particularly university professors, chairs of departments, service directors or professionals in executive positions in public and private institutions, in order to promote the implementation of services that respond to the needs of promoting, protecting and applying women's reproductive and sexual rights.
- Serve as a source of information to the media in order to disseminate correct scientific information related to women's sexual and reproductive rights.
- Establish alliances with public and private institutions and with national and international NGOs, concerned with these topics, in order to strengthen the effects of its actions.
- Establish committees on sexual and reproductive rights in each obstetrics and gynaecology society and federation with the participation of professionals from other disciplines in order to promote these rights and to ensure compliance with these recommendations.

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