ICPD Paragraph 8.25:

A Global Review of Progress Executive Summary

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INTRODUCTION

The 1994 International Conference on Population and Development (ICPD), held in Cairo, was an important event for women's lives. For the first time, a host of nations were signatory to an agreement that would fundamentally alter the way women's reproductive health and development issues were regarded, both legally and socially.

While the conference participants examined a range of issues, one of the most ground-breaking, and most needed, developments was reflected in Paragraph 8.25 of the Programme of Action (POA), which acknowledged the significance of unsafe abortion as a public health problem:

Paragraph 8.25, excerpts:

> ***All Governments and relevant...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...Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling...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. Postabortion counseling, education and family planning services should be offered promptly.***

Unsafe abortion is one of the most easily preventable and treatable causes of maternal mortality and morbidity. Yet individuals the world over have seen how cultural, legal, and religious opposition to even the most modest abortion-related services has driven women to resort to dangerous unsafe abortions in record numbers. A bitter irony is the fact that criminalizing abortion does not reduce its incidence—but it

does cause the number of abortion-related fatalities, injuries, and infections to skyrocket. The death rate alone from unsafe illegal abortion is several hundred times higher than that of safe, legal abortion.[1] ICPD's formal recognition of this problem finally gave many governments, donor agencies, and individual NGOs the official "go-ahead" they needed to begin addressing this most sensitive women's health and rights issue.

This report is our preliminary survey of the progress that has been made in living up to the steps agreed to in ¶8.25.

Effecting Policy Change

Paragraph 8.25 presented abortion for the first time as a *public health problem*, not a moral or cultural one. This reframing of the issue caused the global health community to step up its efforts to deal with the need for treatment of postabortion complications—the one aspect of abortion care on which most can agree. The number of agencies, ministries of health, and NGOs now addressing this life-saving care to some extent has increased dramatically.

For those interested in seeing abortion be legalized, the ICPD recommendations were disappointing. Clearly absent from ¶8.25 is any call for liberalization of restrictive abortion laws, despite evidence that such changes usually result in dramatic and immediate decreases in maternal mortality and morbidity. Many women's health and rights advocates

> ***"I think the negative language of 8.25 contributes to a pariah status for abortion."***
>
> ***Frances Kissling, President, Catholics for a Free Choice***

feel that the language of ¶8.25 describes abortion negatively and isolates it from other reproductive health services rather than placing it in the context of comprehensive care or women's rights. The ICPD POA's focus on postabortion care—the treatment of complications of unsafe abortion—rather than provision of elective termination of pregnancy has allowed governments to avoid the more difficult question of legal change. And although the POA includes an endorsement of safe abortion where it is legal, few countries have been willing to fulfill even this narrow aspect of ¶8.25's recommendations.

Governmental policy change

The ICPD POA's focus on abortion as a public health problem has changed the policy climate to this extent: many government agencies that were unwilling even to discuss abortion-related issues before Cairo are now actively addressing them (albeit to varying degrees). Throughout Latin America, Africa, and other regions where abortion has long been considered too sensitive to discuss, Ministries of Health are beginning to prioritize the provision of life-saving postabortion care and expand family planning programs to reach women after abortion. National health plans in countries as diverse as Mexico, Zambia, Bolivia, Tanzania and Ghana have been revised to reflect the ICPD reproductive health paradigm, and postabortion care is being included for the first time.

Professional associations

Several influential professional associations have set new guidelines or resolutions in the last five years that support or go beyond ¶8.25 recommendations. The International Confederation of Midwives passed a resolution on Care of Women Post-Abortion. Meetings of ob-gyn societies in Peru, Mexico, Brazil, and countries throughout Africa have put the health crisis of unsafe abortion and maternal mortality and morbidity on their agendas and called for action by their constituents. Most recently, the ethics committee of the International Federation of Gynecology and Obstetrics (FIGO) concluded in its Ethical Guidelines Regarding Induced Abortion for Non-Medical Reasons that in all settings, "after appropriate counseling, a woman [has] the right to have access to medical or surgical induced abortion, and that the health care service [has] an obligation to provide such services as safely as possible".

Parliamentarians

Parliamentarian groups have been active in many regions, including the International Medical Parliamentarians Organization which met in Bolivia in September 1998 to discuss abortion in Latin America; an October 1998 meeting in Colombia of Latin American and Caribbean parliamentarians who discussed abortion legislation and its consequences in the region; the UK All-Party Parliamentary Group on Population, Development and Reproductive Health which prepared recommendations for the development of a Commonwealth Women's Agenda in 1997, and parliamentarians in Nepal who have met several times since 1995 to consider legislation to liberalize the abortion law.

UN agencies

In many cases, the United Nations cohort of agencies and multi- or bilateral funding agencies have quietly expanded their mandates regarding abortion. UNHCR has recognized the treatment of abortion complications as a key reproductive health service needed by refugee women and worked jointly with other UN agencies to produce a reproductive health field manual for health workers. The Interagency Working Group guiding the global Safe Motherhood Initiative, composed of WHO, UNICEF, UNFPA, UNDP, the World Bank, IPPF, and the Population Council, added postabortion care to its list of official interventions to treat emergency obstetric complications. And WHO has produced a series of technical guidelines and training tools on the topic of unsafe abortion.

While these examples demonstrate some progress, UN agencies remain under pressure from conservative political and religious leaders to limit their involvement in abortion-related activities, even those endorsed in the ICPD POA. Despite their roles as major implementing agencies for development issues, threats of funding cuts have limited the leadership UN agencies should be demonstrating in support of ¶8.25 recommendations.

FINDING FINANCIAL SUPPORT

A post-ICPD meeting of donors held in Washington, D.C. evidenced a willingness to talk about abortion as part of the range of reproductive health services that should be available to women. Nevertheless, many of the largest health and population donors limit their funding to postabortion care, even in countries where abortion is legal for a range of indications.

USAID has progressed dramatically since the early 1990s in its support for postabortion care, which is now considered a top priority in its population, health and nutrition program. Since 1994 USAID has funded numerous postabortion care training and service delivery opportunities, the development of educational and reference materials, and many of the core operations research studies that have been conducted.

UNFPA also chooses not to provide funds for legal elective abortion services, but did change its guidelines after Cairo to "address the realities of unsafe abortion as a public health issue from an ethical, social justice, and gender perspective."[2] UNFPA also provides funds for medical instruments needed to treat incomplete abortion.

Several European governments have long supported abortion-related programs, including Sweden, the Netherlands, and the United Kingdom. Private foundations, less politically exposed, have given generous grants to help advance the cause of safe abortion-related services for women, yet they cannot carry the burden alone. While it is difficult to determine what percentage of donor funds are being applied to improving abortion-related care, it is clear that reproductive health services in general are still greatly underfunded: of the five largest contributors of population

assistance in 1996, only the Netherlands has reached its Year 2000 goal.[3] The global funding shortfall is expected to result in at least 49 million additional abortions.[4]

Despite the increase in donor support for abortion and postabortion care training and service delivery programs, it is still difficult to find funding for the technology used to provide these services. Manual vacuum aspiration (MVA) is the preferred technology for treatment of incomplete abortions and elective abortion during the first trimester.[5] Yet USAID refuses to purchase these instruments even for their own postabortion care training programs. While a few multi- and bilateral agencies have stepped in and partially filled this crucial funding gap, donors and governments alike must prioritize MVA instruments as key reproductive health commodities and plan to supply them as they would any other medical consumable.

Putting the Money to Work

Ministries of Health are stepping up their efforts in some countries to go beyond policy to action. Ghana's Ministry of Health, for example, has developed an exemplary program to expand reproductive health care services and extend them to the community level. The national program involves training and equipping community-level midwives to provide postabortion care, re-examining training curricula for doctors and midwives, and strengthening the referral system between all levels. [6]

NGOs, long the leaders in recognizing the reality of abortion in women's lives, have redoubled their efforts, putting more money and programs in place. There have been several new NGO-driven initiatives worthy of note since Cairo:

- **Sensitization training** has been helpful in illuminating for health-care providers that while their values may differ from those of the women they treat, these women are not "criminals", and providing this care is a medical, rather than a

moral issue. Sensitization and values clarification training has been conducted successfully by NGOs for public health professionals in several countries, notably in South Africa and Bolivia.

- **Clinical training in abortion and postabortion care** has greatly expanded since Cairo. Conducted primarily by NGOs in partnership with Ministries of Health, hospital-based and national training schemes have been initiated or expanded in Ethiopia, Uganda, Kenya, Malawi, South Africa, Mozambique, Nigeria, Ghana, Burkina Faso, Senegal Guinea, Viet Nam, Nepal, Kazakhstan, Azerbaijan, Indonesia, Mexico, Guatemala, Colombia, Brazil, Peru, Paraguay, Chile, and Bolivia. NGO pressure has been the driving force in making legal abortion services available in public health settings in Brazil and Mexico for women who have been raped.

- **Community education** efforts have less frequently included abortion-related messages. Sol Radio in Mexico, however, broadcast radio spots in Spanish and other local languages to inform listeners about the visual signs of miscarriage, where to go for treatment, how to prevent unwanted pregnancy, and what the dangers of unsafe abortion are. UN Radio also produced a segment for world-wide broadcast about how Ghanaian midwives are providing postabortion care in rural communities.

- **Reference materials** now exist about a variety of abortion-related issues, including videos on postabortion family planning in Africa and how to use MVA in Mexico; an issue of *Population Reports*, one of the most widely-read publications by family planning professionals around the world, about postabortion care; numerous curriculum guides and trainee reference manuals; and an annotated bibliography that lists the primary tools and publications for abortion and postabortion care.

- **Monitoring systems and tools** have been developed and refined to address progress and challenges in abortion and postabortion care services. Notable examples include the COPE self-assessment guide, a new Technical Resources for Postabortion Care series, and DataPAC, an online archive of resources on PAC operations research that includes the DataPAC Core Questionnaire Series of standardized research questionnaires.

- **Policy and advocacy materials** explore how unsafe abortion affects women in different situations, including reproductive health needs of refugee women;

postabortion care strategies for East and Southern Africa; and factsheets on unsafe abortion and maternal mortality updated for World Health Day 1998. Numerous national-level policy activities to address unsafe abortion or work for liberalization have taken place, including in South Africa, Namibia, Nigeria, Nepal, Poland, and countries throughout Latin America. Women's health and rights activists from around the world have worked together to call for action on areas they see as needing attention.[7]

- **South-to-South** exchanges have been organized in the form of study tours for Ministry of Health professionals, midwifery professionals, and NGO activists to learn from how neighboring countries are working to implement ¶8.25 recommendations.

RESEARCHING BEST APPROACHES

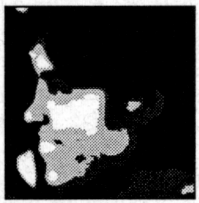
The World Health Organization estimates that 13% of maternal mortality is caused by unsafe abortion and admits that this is probably a gross underestimate. In most parts of the world with abortion-related deaths, statistics are not kept for the same reasons that the services are not provided, making accurate data difficult to collect. And yet, the problem is visible in the long lines of women who wait at emergency rooms for treatment, the overwhelming hospital costs devoted to treating abortion patients, and families who suffer the deaths of their mothers, sisters, and daughters as daily occurrences. Enough is known about unsafe abortion to take action now without waiting for further numbers.

> ***"Millions of women can die from unsafe abortion, and people are still sitting down trying to come up with new mathematical calculations to make sure we have the number exactly right."***
>
> ***Anne Wilson, Director, PATH-DC***

Research is important, however, on

topics such as how women define their needs for abortion and postabortion care, which models work best for offering these services, and how to build an enabling environment in communities that is supportive of women's reproductive health and rights. Several studies in this vein have been carried out since Cairo, including:

- **Kenya,** where studies looked at the best models for linking family planning services with treatment of incomplete abortion.
- **East and South Africa,** where a review of literature illuminated the magnitude of the problem of unsafe abortion in the region and made recommendations for policy change.
- **Peru,** where a postabortion care model was developed for improving quality of care and lowering costs by integrating emergency abortion treatment with other reproductive health services.
- **Viet Nam,** where a study of clients' perspectives on the quality of induced abortion services resulted in recommendations for improving family planning counseling, abortion service delivery and provider training.



KEY FUTURE ACTIONS

Five years post-ICPD, how can governments, donors, and NGOs best build on this progress to expand women's access to a range of abortion-related information and services?

Women's groups seek a stronger commitment by governments at a minimum to meet the Beijing commitment to review laws that punish women who undergo illegal abortion, and preferably to enact policies that make safe legal abortion accessible to all women.

Women activists have mixed feelings about ¶8.25 and how it has affected the movement to make abortion safe and legal for all women. Women see abortion

as an issue of equity, democracy and social justice, and one that is at the heart of reproductive rights and health and women's empowerment. Poor women remain the least likely to find a safe abortion, even where legal, and without access to safe legal abortion women are unable to make reproductive decisions that can protect their health and improve their lives. This view clearly differs from that expressed by government delegates in the ICPD Programme of Action.

Governments interested in responding to women's needs must involve women in the design of policies and programs that affect them.

Women's groups work directly with women and see the social, economic and family life consequences of unsafe abortion first-hand. These consequences—work-days lost due to treatment and recovery from incomplete abortion, infanticide, abandoned children, fear of being denounced to police—are rarely mentioned in policy-level debates about abortion, resulting in a gap between the realities of women's lives and the laws intended to support them.

A reproductive health and rights strategy designed to improve women's lives must include both full access to a range of contraceptives and safe legal abortion.

While access to contraception is a key factor in women's ability to manage their fertility and protect their health, a focus on expanded family planning services alone as the solution is simplistic. Major donor and implementing agencies have promoted messages that encourage behaviors that can prevent unwanted pregnancy but avoid mentioning the possibility of contraceptive failure and abortion. History shows that family planning will never eliminate abortion.

Authorities must take action to protect abortion providers and eliminate activities that limit women's access to information and services.

Virulent opposition by a vocal minority has caused problems for abortion care even in countries where women's right of choice is legally recognized. Harassment of and even violence against health providers has led to decreased opportunities for abortion training, limited access to information and services, particularly for young women, and even to murder of abortion care providers.

Governments and donors must prioritize integrating abortion-related care into reproductive health services.

While a key ICPD objective was for women to have access to integrated reproductive health services, abortion continues to be set apart in many ways or neglected completely. A recent demographic and health survey conducted in Nicaragua that explored reproductive intentions purposely excluded questions about abortion. When asked why, researchers responded that it was too costly to consider issues on which the government was not expected to act. In a country where eight percent of maternal deaths are caused by unsafe abortion, this type of decision demonstrates a limited commitment to women's health.

Building an enabling environment is perhaps the most difficult, yet most important factor in women's empowerment related to reproductive health and rights.

One of the biggest challenges in advancing the issues reflected in ¶8.25 has been that people—community members and health professionals alike—are unaware of what is legal, available, and safe. Fundamentalist and religious pressures on policymakers, teachers and community leaders have kept communities from building an environment that is supportive of women's right to protect their reproductive and sexual health, including seeking abortion-related care. Gender norms in many places continue to limit women's ability to make decisions about their fertility or speak openly about sexuality, resulting in little demand for better or more accessible services and a policy-level response that assumes the status quo must be acceptable.

"Reproductive rights are eroding rapidly in the U.S., but younger women don't realize how bad it will be without them. Most adolescents in the U.S. actually believe abortion is illegal, though it isn't. We're seeing more adolescents resorting to back alley abortionists. Training even for miscarriage treatment is unavailable in most medical schools in the U.S."

Patricia Anderson, Executive Director, Medical Students for Choice, USA

Conclusion

Framing unsafe abortion as a public health issue as in ¶8.25 forced policymakers and health administrators to face the question of why unsafe abortion happens at all, which is an important and crucial first step in addressing the problem. But for those interested in protecting women's health and rights, this approach doesn't go far enough. Up to now, most achievements have been in the area of postabortion care, which is a vital but limited approach to protecting women's reproductive health and rights. To make a real difference in women's lives during the next decade, the progress made to date must be seen merely as the starting point.

The actions we take in the next decade, as governments, health organizations, and individuals, will show whether we are truly committed to the welfare of the women of the world.

[1] WHO. Unsafe Abortion. Global and Regional Estimates of Incidence of a Mortality due to Unsafe Abortion with a Listing of Available Country Data. Third Edition. Geneva: WHO, 1997.

[2] Laura Laski, Senior Technical Officer, Technical Branch, UNFPA, interview, 1998.

[3] Shanti R. Conly and Shyami de Silva. *Paying their fair share? Donor Countries and International Population Assistance*. Washington, DC: PAI, 1998.

[4] The David and Lucile Packard Foundation. *Population Program Strategy 1998-2003*. Los Altos, CA: Packard Foundation, 1998.

[5] Salter, C., Johnson, H.B., Hengen, N. Care for postabortion complications: saving women's lives. *Population Reports*, Series L, No. 10. Baltimore: Johns Hopkins School of Public Health, Population Information Program, September 1997.

[6] Deborah Billings, Traci Baird, Victor Ankrah, Joseph Taylor, Kathlyn Ababio, Stephen Ntow, "Training Midwives to Improve Postabortion Care in Ghana," *MotherCare Matters*, Vol. 6, No. 4, October 1997.

[7] HERA. A Call to Action. Policy recommendations from the Cocoyoc Conference, Mexico, November 1998.