

EXPANDING ACCESS TO
SAFE ABORTION:
STRATEGIES FOR ACTION



ADRIENNE GERMAIN AND THERESA KIM

INTERNATIONAL WOMEN'S HEALTH COALITION

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The **International Women's Health Coalition (IWHC)** provides technical, financial, managerial, and moral support to women's organizations, advocacy groups, health and rights activists, and service providers in Africa, Asia, and Latin America. As a catalyst for action, IWHC forges alliances among diverse groups and individuals to influence the health and population policies and programs of national governments and international agencies. IWHC publishes reports and convenes meetings on critical or neglected issues in women's health. Located in New York City, IWHC is a non-profit organization supported by private sources and several European governments.



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Preface

Of all the scenes I've witnessed in 25 years of international work, one is particularly haunting: three women who had attempted to abort unwanted pregnancies lay on bare wooden shelves, one above the other – in a space the size of a closet. They had no light, no air, and virtually no care. One was thirteen, raped by a man who gave her a ride to school every day; one was a mother of four, desperate not to have another child; and the third? I don't know. She was in a coma, abandoned by those who had left her there.

The place, an emergency ward in Yaoundé, the capital city of Cameroon, was a decaying mud brick hulk, floors riddled with potholes, and walls covered with mold. One extraordinarily courageous doctor worked there – with no equipment, no blood for transfusions, and, clearly, no beds. In stunning contrast, not 50 yards away, up the hill out of the swampy area, was a new, sparkling white maternity hospital, fully equipped and staffed – with plenty of empty beds. The difference between these two places speaks volumes about the stigma and fear that surround abortion.

Around the world, women suffer and die by the tens of thousands every year because of unsafe abortions. Given modern technologies and expertise, no woman should suffer injury or death from an unsafe abortion. The technologies are known; they are simple, inexpensive, and safe in the hands of trained and properly equipped providers, both doctors and nonmedical personnel. *Expanding Access to Safe Abortion: Strategies for Action* is designed as a tool to generate and support concerted efforts to end needless death, injury, and suffering.

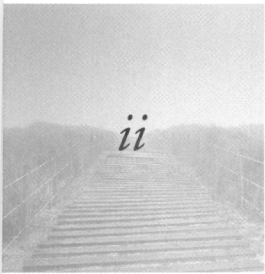


Induced abortion is legal for at least some indications in virtually every country. This fact, along with the letter *and* spirit of the agreements adopted at the United Nations' International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women (FWCW) in 1995, provides a strong basis for action to expand access to services, to liberalize laws and regulations, and to ensure the accountability of governments and international agencies for the ICPD and FWCW agreements.

In the first section of this paper, we briefly describe the global context in which abortion takes place. The following two sections review the agreements made at the international conferences and provisions of human rights instruments that can be used to argue for access to safe abortion services. The final section describes strategies that are being used across a wide range of countries. Appendices provide ready reference to the most relevant paragraphs of the international agreements and human rights instruments.

To make abortion safe everywhere, advocates, legislators, and policy makers must generate the *political will*, and health and family-planning providers must generate the *professional will* to change laws and ensure that good quality services are accessible and affordable. There is no room for complacency. We hope you will join with us to rid the world of scenes like the one I witnessed in Cameroon.

Adrienne Germain
President, IWHC
December 1, 1998



Introduction

Throughout history, women have resorted to induced abortion to terminate unwanted or ill-timed pregnancies. Of the 40 to 60 million abortions performed annually worldwide, an estimated 20 million are unsafe*, and 95 percent of these occur in developing countries. The World Health Organization (WHO) estimates that at least eighty thousand women die each year and many more experience lifelong physical or mental health problems as a result of unsafe abortion. Complications from unsafe abortion are one of the leading causes of maternal mortality, accounting for almost 13 percent of the estimated 600,000 maternal deaths each year (WHO, 1998). Unlike many pregnancy-related problems and other accidents and illnesses, deaths and disabilities resulting from unsafe abortion are entirely preventable. They are caused by punitive laws, narrowly defined health policies, and failure to provide adequate health and family-planning services.

Although many restrictive laws and policies have been liberalized in recent years, highly mobilized and well-financed anti-abortion forces everywhere are attempting to strengthen or introduce restrictive laws – including constitutional amendments – to block women’s access to safe services. Among its many tactics, the anti-abortion movement creates the impression that abortion is generally illegal. This is incorrect. Almost all countries allow abortion, at least



*WHO (1992) defines unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.

to save the woman's life.* Although 25 percent of the world's population reside in countries where induced abortion is permitted only to save the woman's life, almost 75 percent live in countries where abortion is permitted either for a wider range of indications or with no restrictions as to grounds (see Appendix I). It is thus more accurate to refer to abortion as more or less "legally restricted," rather than as "illegal."

Fostering the notion that abortion is "illegal" or that services should be provided "only where abortion is not against the law" is extremely misleading, and deliberately so. By comparison, recognizing that abortion is legal virtually everywhere for at least some indications, provides a basis for action by health professionals, policy makers, human rights advocates, and others working to ensure women's access to safe means of terminating a pregnancy. In addition, agreements reached in recent international conferences on women, population, and human rights, as well as human rights treaties, are powerful but underutilized tools for action.

Justifying Access to Safe Abortion: What International Conferences Have to Say

Agreements made at the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994 and at the Fourth World Conference on Women (FWCW) held in Beijing in 1995 represent a major advance from the document approved at the 1984 International Conference on Population in Mexico City. Declaring that "abortion should in no case be promoted as a method of family planning," the 1984 Plan of Action buried reference to the dangers of unsafe abortion in a minor chapter on mortality. By contrast, the main chapters of the ICPD and FWCW agreements (see Appendices II and III, respectively) recognize unsafe abortion as a major public health problem and

*149 of 151 countries with populations over 1 million. (Note: This figure has been revised since originally published in Rahman, Katzive, and Henshaw, 1998.)



define abortion-related services as an essential element of reproductive health care. The Programme of Action from the ICPD declares:

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. (ICPD, para. 8.25.)



Viewed through the most favorable lens, the ICPD and FWCW agreements, along with other international documents, can be used to argue strongly for the provision of safe abortion as a basic health service. Consider, for example, the several dimensions of human rights defined below:

Women's right to control their own fertility. This right has been implicit in population conference agreements since the world population conference in Bucharest in 1974, when the individual's, not just the couple's, right to decide "freely and responsibly" the number and spacing of children was recognized. The woman's right in particular was explicitly recognized in the Third World Conference on Women held in Nairobi in 1985. The 1995 FWCW agreement reinforces and extends this right to encompass women's right to

control “matters related to their sexuality” (para. 96). An affirmative interpretation of the individual’s right to control her or his own fertility can be interpreted to include a woman’s right to terminate an unwanted pregnancy.

2 Women’s right of access to safe abortion. The ICPD agreement, reinforced by the FWCW (para. 97), goes further than any other international agreement by recognizing the right of men and women “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” (para. 7.2). The ICPD defines safe abortion as a component of reproductive health services (para. 7.6) and asserts that, where legal, abortion should be safe (para. 8.25). The FWCW stresses the health risks of unsafe abortion and calls for review of laws that punish women who have undergone illegal abortion (para. 106k).

3 The rights of adolescents. Among the hardest fought provisions of the ICPD and FWCW agreements were guarantees of young people’s rights to confidential information and services for sexual and reproductive health. Ultimately, both conference documents included extensive and unprecedented agreements on this issue (ICPD paras. 7.41, 7.45 to 7.47; FWCW paras. 83l, 106m, 107e and g, 108k, 108l, 267, 281e and g, among others). Recognition of adolescents’ rights is essential to reduce both high rates of unwanted teenage pregnancy and large numbers of unsafe abortions in this age group.

4 Women’s right to privacy. The ICPD and FWCW documents support the individual’s right to privacy and argue against governmental intrusion (ICPD paras. 7.12, 7.17 to 7.20; FWCW paras. 103, 106f, 107e, 267). In at least one country, the United States, this right has been specifically invoked in a Supreme Court decision granting women the right to decide whether to have an abortion.



Justifying Access to Safe Abortion: What Human Rights Instruments Have to Say

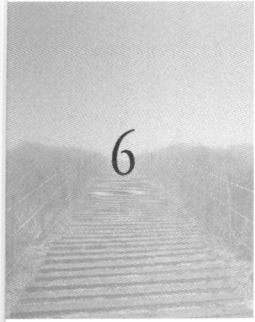
As described by Cook and Fathalla (1996), certain provisions of international human rights instruments* can also be used to argue for access to safe abortion services:

1 Women's right to life and security of person. Much of the negotiation at ICPD and FWCW on the reproductive rights of individuals drew on provisions regarding life and security contained in the Universal Declaration of Human Rights (Articles 1 and 3) and the International Covenant on Civil and Political Rights (Articles 6.1 and 9.1). The right to life would imply that abortion services must be provided for women whose lives are endangered by pregnancy. A country could be in violation of this right if it refuses to protect women from risk of death or disability resulting from unsafe abortion. The right to security of person can be interpreted to mean that a woman must not be coerced either to carry a pregnancy to term or to end it, and that she has the right to decide for herself whether to carry an unwanted pregnancy to term. Cook and Fathalla cite court decisions that have found restrictive, criminal abortion provisions unconstitutional because they violate a woman's right to liberty and security.

2 Women's right to the highest attainable standard of health. Human rights provisions in the Universal Declaration of Human Rights (Article 25), the International Covenant on Economic, Social and Cultural Rights (Article 12), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (Articles 11f, 12, 14.2b) were critically important negotiating tools in the ICPD and FWCW. These provisions can be interpreted and applied to argue that, in order for women to achieve the highest standard of health, they must have access to safe abortion services, among other reproductive health services, to meet their minimum health needs.

* See Appendices IV through VII for selected articles from the instruments.





3 Women's right to the benefits of scientific progress, and the right to receive and impart information. These rights, recognized in the Universal Declaration of Human Rights (Articles 27.1 and 19, respectively), the International Covenant on Civil and Political Rights (Article 19), the International Covenant on Economic, Social and Cultural Rights (Articles 15.1b and 15.3), and CEDAW (Articles 10h, 16e), were also used in the ICPD and FWCW to achieve agreement on several provisions that require access to new technologies (such as medical abortion and menstrual regulation), prioritization of reproductive health research, which has been relatively neglected, and full and free access to reproductive health information (ICPD paras. 7.2, 7.20, 7.23, 12.10 to 12.13, 12.17; FWCW paras. 95, 104, 223, among others).

These rights could be – but have not yet been – explicitly used to promote legal access to all methods of abortion, deriving from women's right to control their fertility, their right to health, and their right to security of their person (Dixon-Mueller, 1993).

Rationale for Action

The international conference and human rights documents cited above do not explicitly assert a woman's *right* to abortion, nor do they *legally* require safe abortion services as an element of reproductive health care. Moreover, the ICPD and FWCW agreements recognize the wide diversity of national laws and the sovereignty of governments in determining national laws and policies. Despite these qualifications, however, the conference documents and human rights instruments – if broadly interpreted and skillfully argued – can be very useful tools in efforts to expand access to safe abortion.

Those who undertake advocacy, public education, and political action to advance women's health and rights can assert that women have a right to

terminate unwanted and mistimed pregnancies safely. They need to move beyond the rhetoric of “prevention and management of unsafe abortion” to argue that access to safe abortion is the most direct way to eliminate unsafe abortion. It is simple and inexpensive, and many governments enable or allow women to obtain safe abortion, regardless of the law, based on health grounds or by ignoring violations of restrictive laws, among other means.

Expanding Access to Safe Services: Prospects and Possibilities for Action

Women’s groups, health professionals, and political leaders have made remarkable progress in many countries to challenge restrictive laws and to ensure that safe services are provided for women both within and outside the law. The ICPD and FWCW agreements and human rights instruments have bolstered their morale and confidence. Despite substantial opposition, dedicated individuals, groups, and broad-based coalitions are taking effective action to protect and to expand women’s access to safe services in countries as diverse as Bangladesh, Brazil, and Nigeria. From their efforts emerge a number of conclusions that could be useful in other settings.

■ Ensuring provision of services to the full extent allowed by existing law helps pave the way for wider access.

Governments participating in the ICPD agreed that, where legal, abortion services should be safe (para. 8.25). However, in countries with very restrictive laws (usually limited to saving the life of the woman and in cases of rape), health professionals are often ignorant of the law that permits abortion under these circumstances, refuse to comply with the law, or are not trained to provide services. Often, too, administrative regulations associated with restrictive laws are so cumbersome that health professionals who are willing to provide services cannot do so or are so confused about what they are allowed to do



that they will not take the risk. Informing hospital authorities about existing laws, training health professionals in basic abortion techniques, and equipping them with adequate resources can help improve access and change negative attitudes toward women who seek services. In addition, providers can adopt a broader definition of what constitutes a threat to a woman's life by considering the risk of death if she seeks a clandestine procedure or tries to abort herself. They could also consider marital rape as justifiable grounds for terminating pregnancies under the rape clause.

❖ Feminist health professionals and activists in several cities of **Brazil** have been working since the early 1990s with medical colleges and municipal health systems to increase knowledge of the law and to change training curricula. In just five years, the number of hospitals providing legal abortion has increased from one to at least thirteen in seven cities. In August 1997, a bill requiring all public hospitals to provide legal abortions (in cases of rape and to save the life of the woman) passed a final congressional committee, signaling an important symbolic victory for pro-choice advocates. Anti-abortion forces have mobilized to stop passage of the bill into law, but the Ministry of Health is likely, regardless of the legislative outcome, to introduce norms to make the provision of legal services obligatory in the public health system.

❖ In northeastern **Brazil**, a feminist organization mobilized to encourage provision of legal abortion services in its city and state, and to advance the debate about the legalization of abortion in general. The organization convened a seminar on abortion in September 1997, through which it secured the commitment of the state-level ministry to provide abortion services allowed by law. The ministry formed a commission on implementation, which includes the feminist group. The group plans to conduct workshops on legal abortion services for health professionals in a local maternity hospital in conjunction with the new governmental commission.

❖ In **Goiânia**, a state capital west of Brasilia, a small women's organization has worked since 1993 with government health officials, medical school faculty and students, and the city council to draft a resolution requiring public hospitals to provide legal abortion. After the resolution passed in 1995, the group mobilized

non-governmental organizations (NGOs) and women's groups to generate training in manual vacuum aspiration (MVA), public education, and media coverage. Despite persistent work by the group, however, anti-choice forces overturned the resolution in 1997. The women's organization is continuing to provide leadership as a key member of a diverse working group for the implementation of legal abortion. They have also made inroads with the media, helping generate almost 250 articles related to abortion in the local newspapers in one year.

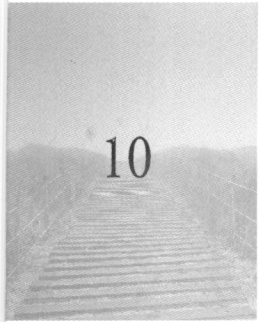
2 Training health providers – both M.D.s and others – to provide humane treatment for women who suffer complications from unsafe abortion broadens the base for access.

The ICPD agreement mandates that governments take appropriate steps to provide humane treatment and counseling to all women who suffer from complications of unsafe abortion (para. 7.24), and medical ethics require health professionals to treat women who are ill or injured. Health professionals thus require training not only to provide proper medical treatment but also to understand the dilemmas faced by women confronted with unwanted pregnancy, to provide counseling and emotional support, and to treat women with respect. Health providers' experiences in treating abortion complications can help them realize not only that safe abortion services are essential to prevent injury and death but also that such services are within their capacity to perform.

❖ In **Chile**, since 1995 feminists have been training health workers in post-abortion counseling, emphasizing the roles that sexuality and gender power play in unwanted pregnancy and the decision to abort. Feminist groups have also been teaching providers how to offer respectful and sympathetic care to women with incomplete abortions, in contrast to the punitive posture that such providers too often adopt.

❖ In **Kenya**, where complications from unsafe abortion contribute to about 35 percent of maternal deaths, a network of private physicians has been trained to provide comprehensive, affordable post-abortion care (PAC) and family-planning





services.* The training covers clinical and theoretical aspects of abortion and other reproductive health topics, such as STD diagnosis and management. Preliminary findings show that the costs associated with training physicians in PAC are affordable. The network is currently expanding in number and location, and plans are under way to link private physicians with primary health providers and local women's groups to increase awareness and action concerning unsafe abortion and unwanted pregnancy within these communities (Rogo, Orero, and Oguttu, 1998). This recent work complements long-standing work in the public sector, begun in 1987 by a national teaching hospital and Ipas, an international organization. Manual vacuum aspiration of the uterus for treatment of abortion complications was introduced into the medical curriculum, and MVA services were provided along with post-abortion, family-planning counseling and services. Among other benefits, bed occupancy rates and hospital costs for abortion complications were reduced dramatically. In 1992, the Ministry of Health began work to expand MVA services throughout the health system. MVA is provided at the national hospital and at nineteen district hospitals; over two hundred physicians and nurses have been trained to perform or support MVA services; and over fifteen thousand women have been treated for incomplete abortion using MVA services (French, Waithaka, and Ominde, 1998).

3 Close examination of laws and regulations can reveal loopholes under which safe abortion can be provided even in settings where laws are restrictive.

In some countries with highly restrictive laws, such as Indonesia, abortion is allowed for teaching purposes; medical colleges and some free-standing clinics therefore do provide services. Even where abortion is prohibited under all circumstances, physicians sometimes decide for ethical reasons to terminate pregnancies when a woman's health or life is seriously endangered. And in other countries where induced abortion is highly restricted by law, "menstrual regulation" (MR) by means of MVA is nonetheless allowed as a procedure for inducing a late period or "to ensure that a woman at risk of pregnancy is not actually

*Post-abortion care involves: (1) emergency treatment for any complications; (2) post-abortion counseling and family-planning information and provision; and (3) links with other reproductive health services (Rogo, Orero, and Oguttu, 1998).

pregnant.” To take full advantage of these windows of opportunity, advocates and health care providers need to inform women on where and how they may obtain safe services.

❖ In **Bangladesh**, although induced abortion is legally restricted, the government provides menstrual-regulation training and services in medical colleges and health posts throughout the country. Both medical doctors and paramedics are trained in the simple procedure of evacuating the uterus with a hand-held syringe and cannula (Dixon-Mueller, 1988). To be eligible for these services, however, women must present within six to eight weeks of a missed period. Many women try other methods, such as herbal remedies, to bring on a delayed period before going to a clinic or health post and thus present too late for menstrual regulation. The challenge for providers and advocates is to make sure that women understand the importance of presenting early in order to obtain MR services.

4

Abortion research and documentation can offer persuasive evidence for instituting legal policy and program change.

The ICPD (para. 12.17) and FWCW (para. 109i) call on governments “to understand and better address the determinants and consequences of induced abortion.” Obtaining accurate statistics on abortion-related complications and mortality can be extremely challenging, especially in legally restrictive settings. However, information from small-scale studies (e.g., in hospitals) can illuminate, among other facts, the magnitude and local impact of complications due to unsafe abortion and attitudes toward abortion among health professionals and the general public. Research findings can also challenge misperceptions about women who are in need of services, inform health providers and policy makers about the devastating impact on health of restricted access, and assess the potential impact of liberalized laws on women’s health. Documentation about the conditions under which women obtain clandestine services or accounts of women who are wrongly denied access to legal abortions can also prove useful for advocacy efforts (Rogow, 1989).

❖ In **Guyana**, advocates who successfully lobbied and helped to liberalize the



abortion law in 1995 attribute a large part of their success to information gathered through hospital-based research on admissions for incomplete or botched abortions and the impact of unsafe abortion on hospitals. Advocates also surveyed medical professionals, teenagers, and the general public to assess their attitudes on abortion and abortion law reform, and documented personal stories from women who had undergone clandestine abortion. They used the findings to inform policy makers about the wide extent to which illegal abortion was taking place, and the grave impact on public health of restricted access. Using these data, they conducted public education campaigns and used the media to gain public support (Nunes and Delph, 1995).

❖ In **Chile**, where abortion is not permitted for any reason – not even to save a woman’s life – the punishment under the current law for a woman who has an abortion is three to five years of imprisonment, and for providers, two years or more. Most women and providers who are prosecuted receive suspended sentences, however, and do not serve jail time (CRLP and the Open Forum, 1998). Anti-abortion forces are therefore promoting legislation to ensure they serve jail time, and to encourage women to testify against providers in exchange for reduced sentences. In August 1998, a prominent Chilean physician wrote an open letter in the press asking parliamentarians to decriminalize abortion, based on research and documentation showing that a majority of Chilean women who have abortions already have children. He argued that “punishing women with jail sentences [is] against family life, depriving children of their mothers.” Data revealed the profound inequity in society’s treatment of women who have abortions: women with money can obtain a safe service and are generally not discovered, prosecuted, and punished. (“Medico pide al congreso,” 1998).

❖ In **Bolivia** in 1996, six NGOs mobilized to defend the health secretary’s declaration of support for legalization of abortion to decrease needless deaths, and to counter the Church’s opposition to public discussion of abortion and the sale of condoms to young people. They produced a video and educational materials for young people and undertook a month-long media campaign that culminated in a cultural event with popular artists. While they succeeded in attracting considerable media attention, the NGOs also realized they needed more information about public opinion. In 1997, the NGOs conducted an

opinion poll in fourteen cities. Nearly 90 percent of the respondents said that the decision to have an abortion should rest with the woman or the couple, and approximately 50 percent disagreed with the Roman Catholic Church's positions on contraception and abortion. Though faced with continuing opposition, the NGOs continue to seek ways to keep the issue in front of the public.

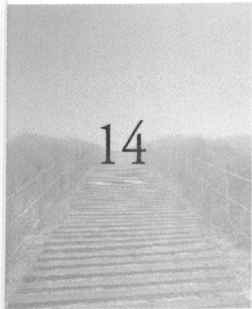
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Educating providers about administrative regulations and simplifying such regulations can facilitate access to services.

Typically, it is the abortion laws in each country that capture our attention in thinking of strategies for broadening access. However, it is often the case that even where legal statutes permit induced abortion on fairly broad grounds, complicated or unrealistic administrative procedures in hospitals and clinics make it very difficult for women who are eligible for services to obtain them. Such procedures require waiting periods, repeat visits, or interviews with medical doctors, who are in short supply. These other types of administrative requirements that restrict access, e.g., allowing only doctors to provide services, can be changed if clearly identified and pursued.

❖ In **Zambia**, where the laws on abortion are liberal, administrative regulations nonetheless require that three doctors (always in short supply, especially in rural areas) must approve a petition for abortion. Elimination of such needless regulations would significantly facilitate access.

❖ In **India**, while the Medical Termination of Pregnancy (MTP) Act of 1971 permits abortion on a wide range of grounds, regulations surrounding the training of providers and the qualifications of facilities have severely limited access to legal services. As a result, most abortions performed in India are unsafe and technically against the law. An administrative decision to distinguish between MTP, which can be legally provided only by ObGyns or other specially credentialed doctors, and MR, which could be provided (as in Bangladesh) by trained paramedics, could bring wider access to safe services in both rural and urban areas. Similarly, the National Association of ObGyns could modify its requirement that only trained medical doctors be allowed to provide abortion (both MTP and MR).



6 Concerted advocacy by broad-based coalitions at local and national levels can have legislative impact – or build a base for future legal change – even in the face of apparently overwhelming odds.

Whether attempting to liberalize restrictive laws or to counter anti-abortion campaigns to reduce access to legal services, advocates of safe services can often achieve remarkable results by building alliances with other supportive and interested parties. Frequently slow and often frustrating, alliance building nonetheless pulls into the political and educational process a variety of individuals and groups with vested interests in the outcome: women's associations of very different class or ethnic or regional backgrounds, health workers at all levels, supportive church groups, politicians willing to take risks on issues they believe in, members of the legal profession, and many others. While their interests may be different, and can even conflict, it is often the very diversity of interests that endows coalitions with strength and legitimacy in the political arena.

❖ In **Brazil** in 1995, the national network of feminist health organizations together with other NGOs and individuals undertook a national campaign to educate the public and lawmakers about the likely adverse impacts of a proposed constitutional amendment that asserted life begins at the moment of conception. One organization followed events in Congress and produced weekly bulletins to keep the movement informed. Simultaneously, numerous women's groups in different parts of the country worked with their local congressional representatives, health professionals, the media, and others to help generate broad understanding of the likely consequences of the proposed amendment. The proposed amendment was defeated.

❖ Following the first democratic elections in **South Africa** in 1994, a diverse coalition of women's health advocates and research, legal advocacy, community development, and health worker organizations from different parts of the country devoted time, skills, and other resources to a national campaign to liberalize the abortion law. Members drew on research documenting the extent of unsafe abortion in South Africa, as well as support from key political figures, to lobby successfully for the adoption by Parliament of a liberalized law in 1996.

❖ In **Nepal**, the law prohibits abortion in nearly all circumstances, and, except to save the woman's life, abortion is considered criminal homicide punishable by imprisonment for both the woman and service provider (Rahman, Katzive, and Henshaw, 1998). Women's groups have been fighting since 1994 to liberalize the law. The proposed amendment includes provisions that would allow women to obtain a first-trimester abortion with the consent of the husband, and if the pregnancy resulted from rape or incest, abortion would be permissible in the first and second trimesters (Equality Now, 1998). In these cases, women could no longer be jailed, as they are now, for having an abortion. While the current political climate is uncertain, and Parliament may choose not to address the issue, the persistent work of women's groups is helping to build a basis for future change.

7

Decisions to pursue liberalization of laws must be based on careful assessment of the possible risks.

Where safe services are fairly readily available despite restrictive laws, efforts to liberalize laws could lead to more, not fewer, restrictions, and to stricter implementation of existing laws. For example, in Bangladesh, where menstrual regulation services are widely provided throughout the government health system and in the private sector, it is widely believed that a public debate on the abortion law could jeopardize these services. In various Latin American countries, too, where laws are restrictive but women and providers are not usually prosecuted (though they may be harassed and forced to bribe police), advocates of legal change need to assess carefully the chances of success before bringing the issues into the limelight. In other cases where restrictive laws or policies are imposed on a liberal context, concerted action is essential.

❖ In **Poland** in 1996, an alliance of women's groups helped achieve liberalization of the 1993 abortion law, which had denied women legal abortions except in cases of rape, incest, severe birth defects, or extreme medical emergency. The 1996 law allowed women facing financial or personal problems to obtain a legal abortion up to twelve weeks of pregnancy, after receiving obligatory counseling and completing a three-day, post-counseling waiting period. A Constitutional Tribunal, pressured by anti-abortion forces, found abortion on



social grounds unconstitutional and repealed the 1996 law before it could be implemented. Although this is a major setback, a coalition of pro-choice groups, committed to the long, hard struggle required to liberalize the law, are collecting data on the impact of abortion restrictions on women's health; raising public awareness to build wider support for abortion as a basic women's right; monitoring implementation of the law to assess, among other aspects, whether hospitals are actually performing those abortions that are legally permitted; and monitoring schools to see whether sex education, which is legal, is being provided.

8

Public education is essential to gain support for liberal laws and to expand access to safe abortion services.

In every country, the general public needs to be made aware of the terrible costs of unsafe, clandestine abortion to women and families. Where laws are highly restrictive, the public may not understand the desperate lengths to which women must go to terminate a pregnancy; where laws are liberal, they may have forgotten. Keeping a finger on the pulse of public opinion in different social and economic sectors, focusing on issues of women's health and survival, and educating the public about the extent of, reasons for, and consequences of unsafe abortion are essential elements of the ongoing effort to expand and protect women's access to safe services.

In Nigeria and South Africa, across Latin America, and in Eastern Europe, groups are educating the media and holding seminars and demonstrations to publicize the enormous costs to women, families, and the health system of restricted access to safe abortion, and to counter disinformation spread by abortion opponents. In settings where laws are relatively liberal, such as the United States, advocates of choice also continue to educate the public about the potentially dangerous consequences of reverting to more restrictive laws and regulations.

❖ Across **Latin America**, the reproductive health and rights movement has sustained a regional campaign since 1992 to increase awareness of reproductive rights, to improve understanding of the need for safe, legal abortion services,

and to stimulate public debate. The movement mobilizes a Day of Action for the Decriminalization of Abortion each year, informs the media, and encourages dialogue between officials of countries with relatively liberal legislation and those from countries with more restrictive laws. This work across national boundaries is helping to create a climate for change.

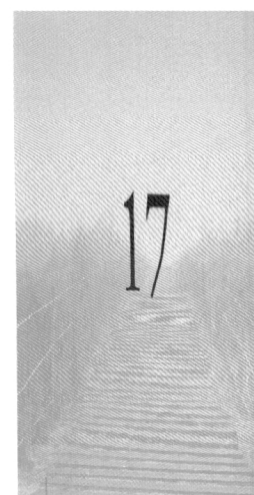
❖ In **Nigeria**, an alliance of health professionals, journalists, women's rights activists, lawyers, and NGOs working to reduce unwanted pregnancy has drafted legislation to liberalize access to safe abortion; published a newsletter; held a public symposium entitled "So That Our Daughters Do Not Die"; and worked extensively with the media, educating editorial boards and journalists.

One media workshop with twenty leading newspaper columnists and radio and television producers resulted in substantial coverage by Nigeria's largest

media outlets. The group also formed a speakers' bureau that includes media representatives. In response to policy makers who insisted that government could not move forward on the abortion issue owing to "insufficient" data, the alliance researched the extent of unsafe abortion and its impact on women's health in Nigeria and compiled several fact sheets for political advocacy and public education.

❖ In the **United States**, the National Abortion and Reproductive Rights Action League (NARAL), with an extensive grassroots network throughout the country, educates the public, works to elect pro-choice legislators, and promotes reproductive health policies. NARAL reviews abortion and reproductive rights legislation in each state and monitors violence against abortion providers and clinics, intimidation of women seeking services, and the number of women at risk of unintended pregnancy, among other information (NARAL, 1998). NARAL uses these comprehensive reviews to mobilize and to activate citizens and politicians alike to fight against increasing restrictions on access, such as mandatory waiting periods, parental consent requirements, bans on specific abortion procedures, and prohibition on use of government funds for abortion.

❖ A pro-choice group in **Uruguay** is producing a video and discussion guide especially to reach poor and marginalized populations across Latin America. The video will highlight the right of the couple, especially the woman, to live a



healthy sexual life independent of procreation, and the right to abortion as an option when a pregnancy is unwanted or mistimed.

9 Supportive laws and policies together with trained, well-equipped health providers are necessary, although not sufficient, to ensure access to safe services.

Safe abortion services are too often unavailable or inaccessible even in countries with liberal abortion laws, such as India. Sustained work to overcome legal and regulatory hurdles, therefore, is necessary but not sufficient. Investment must also be made to inform women and girls about when, where, and how to obtain such services. What can they do, where can they go, and how much will it cost?

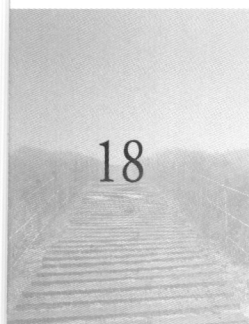
❖ In **South Africa**, with the passage of the Choice on Termination of Pregnancy Act in 1996, a national health NGO has been inundated with calls to its general health hot line from women and men requesting information about the legislation and about where to obtain services. The hot line provides the public with timely information about the abortion law, the abortion procedure, referrals, and in some cases counseling. An alliance of thirty groups has begun to monitor the implementation of the Act (Reproductive Rights Alliance, 1997).

Through its quarterly publication, members of the alliance inform the public about the implementation status (by province and hospital) and about barriers to access and problems with quality of care, among other issues.

10 Sustained technical, financial, political, and moral support is needed to ensure the viability and effectiveness of both services and advocacy.

National and international exchanges are important and effective means to sustain providers and advocates who often work in relative isolation and in the face of harsh criticism.

❖ In 1996, an international conference brought leaders of abortion rights movements together to review strategies for legal reform, service and program issues, and new medical technologies. Leaders from Guyana shared experi-



ences with activists from South Africa, Poland, Colombia, and Bangladesh.

Members of the Nigerian alliance for abortion-law reform compared ideas and strategies with colleagues from around the world, returning home revitalized with new insights and determined to coordinate more with their own African colleagues.

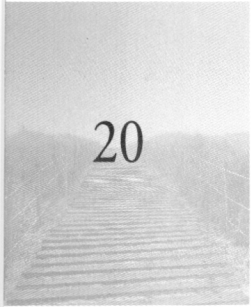
❖ In **Brazil** in 1997, a regional meeting on abortion gathered over eighty participants – elected officials, activists, legal and health professionals, and journalists – to reinforce progress made at the local level to provide legal services, to facilitate exchange and build strategic alliances among key actors and the women’s movement, and to raise awareness and promote debate on the abortion issue nationally. Participants shared experiences and developed strategies for the media and for continuing dialogue among participants working to decriminalize abortion. Among many highlights, a congressman spoke on “men’s ethical commitments and abortion,” revealing his own personal experiences with a partner who had undergone abortion. His political position and openness about the issue, along with the fact that the speech was televised, made a powerful impact.

❖ In October 1998, 95 parliamentarians from 22 countries in **Latin America** and the **Caribbean** met in Colombia to discuss induced abortion. The meeting was organized by a university in order to provide an academic setting in which parliamentarians with a wide range of political perspectives would feel free to discuss sensitive legal, ethical, and policy issues surrounding abortion. Despite the wide range of political perspectives, different country contexts, and personal views on abortion, parliamentarians forged a consensus declaration (Declaración de Bogotá, 1998). They acknowledged that existing legislation has not only been ineffective in reducing the number of induced abortions in the region, but it has also contributed to increased risk for impoverished women. They pledged to help save women’s lives in their respective countries and to maintain an open debate on issues related to abortion, with wide participation from many sectors of society, including women’s organizations.

❖ **HERA (Health, Empowerment, Rights and Accountability)**, an international working group of twenty-four women leaders from eighteen countries



who worked together to help achieve the ICPD and FWCW agreements, has produced sheets advocating action on sexual and reproductive health, including abortion, for use in training programs, in community education, and with government officials and international agencies (HERA, 1998). Members work in their own countries for implementation of the agreements, and with international agencies to ensure that their policies, budgets, and programs are in line with the conference agreements.



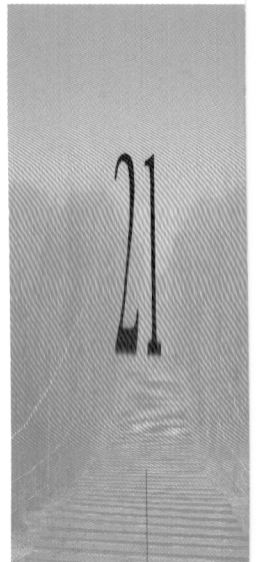
Appendix I

Countries by Restrictiveness of Abortion Law, According to Region, 1997*

Abortion restrictiveness	The Americas and the Caribbean	Central Asia, the Middle East and North Africa	East and South Asia and the Pacific	Europe	Sub-Saharan Africa	
To save the woman's life	Brazil-R Chile-ND Colombia Dominican Republic El Salvador-ND Guatemala Haiti Honduras Mexico-R Nicaragua-SA/PA Panama-PA/R/F Paraguay Venezuela	Afghanistan Egypt-SA Iran Lebanon Libya-PA Oman Syria-SA/PA United Arab Emirates-SA/PA Yemen	Bangladesh Indonesia Laos Myanmar Nepal Papua New Guinea Philippines Sri Lanka	Ireland	Angola Benin Central African Rep. Chad Congo (Brazzaville) Côte d'Ivoire Dem. Rep. of Congo-F Gabon Guinea-Bissau -SA/PA Kenya Lesotho Madagascar Mali Mauritania Mauritius Niger Nigeria Senegal Somalia Sudan-R Tanzania Togo Uganda	
Physical health	Argentina-R (limited) Bolivia-R/I Costa Rica Ecuador-R/I (limited) Peru Uruguay-R	Kuwait-SA/PA/F Morocco-SA Saudi Arabia-SA/PA	Pakistan Rep. of Korea-SA/R/I/F Thailand-R	Poland-R/I/F	Burkina Faso-R/I/F Burundi Cameroon-R Eritrea Ethiopia Guinea Malawi-SA Mozambique Rwanda Zimbabwe-R/I/F	
Mental health	Jamaica-PA Trinidad & Tobago	Algeria Iraq-SA/F/R/I Israel-F/R/I Jordan	Australia Malaysia New Zealand-F/I	Northern Ireland Portugal-PA/F/R Spain-F/R Switzerland	Botswana-F/R/I Gambia Ghana-F/R/I Liberia/F/R/I Namibia/F/R/I Sierra Leone	
Socio-economic grounds			India-PA/R/F Japan-SA Taiwan-SA/PA/I/F	Finland-R/F Great Britain-F	Zambia	
Without restriction as to reason	Canada-L Cuba*-PA United States-PV Puerto Rico-PV	Armenia* Azerbaijan* Georgia* Kazakhstan* Kyrgyz Rep.* Tajikistan* Tunisia* Turkey*-SA/PA Turkmenistan* Uzbekistan*	Cambodia†-PA China-PA/L Mongolia* N. Korea-L Singapore‡ Vietnam-L	Albania* Austria† Belarus* Belgium† Bosnia-Herzegovina* -PA Bulgaria* Croatia*-PA Czech Rep.*-PA Denmark*-PA Estonia* France*-PA Germany† Greece*-PA Hungary*	Italy§-PA Latvia* Lithuania* Macedonia*-PA Moldova* Netherlands-PV Norway*-PA Romania† Russian Fed.* Slovak Rep.*-PA Slovenia*-PA Sweden** Ukraine* Yugoslavia*-PA	South Africa*

*Gestational limit of 12 weeks. †Gestational limit of 14 weeks. ‡Gestational limit of 24 weeks. §Gestational limit of 90 days. ** Gestational limit of 18 weeks.
Notes: For gestational limits, duration of pregnancy is calculated from the last menstrual period, which is generally considered to occur two weeks prior to conception. Thus, statutory gestational limits calculated from the date of conception have been extended by two weeks. ND=Existence of defense of necessity is highly doubtful. SA=Spousal authorization required. PA=Parental authorization required. R=Abortion allowed in cases of rape. I=Abortion allowed in cases of incest. F=Abortion allowed in case of fetal impairment. L=Law does not indicate gestational limit. PV=Law does not limit previability abortions.

Source: Rahman, A., L. Katzive, and S. Henshaw. A global review of laws on induced abortion, 1985-1997. *International Family Planning Perspectives*, 24, no. 2, 1998. (Note: The table has been revised since originally published.) For further information, contact: The Center for Reproductive Law and Policy, 120 Wall Street, New York, NY, 10005, USA., Tel: 212-514-5534. Fax: 212-514-5538. E-mail: info@crlp.org



Appendix II

Selected Provisions of the Programme of Action Adopted at the International Conference on Population and Development, Cairo, 1994*

7.2 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, and the right of access to appropriate health-care services that will enable women to go

safely through pregnancy and childbirth and provide couples with the best chance of hav-

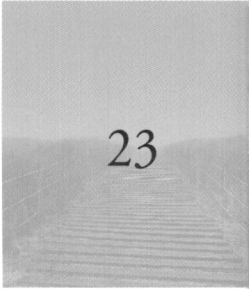
ing a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3 Bearing in mind the above definition, 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. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. 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. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

7.6 All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health care programmes.

7.12 The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. The success of population education and family-planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-



term success of family-planning programmes. Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives that affect individual decisions about child-bearing and family size. Over the past century, many Governments have experimented with such schemes, including specific incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive. Governmental goals for family-planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.

7.17 Governments at all levels are urged to institute systems of monitoring and evaluation of user-centred services with a view to detecting, preventing and controlling abuses by family-planning managers and providers and to ensure a continuing improvement in the quality of services. To this end, Governments should secure conformity to human rights and to ethical and professional standards in the delivery of family-planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision. In-vitro fertilization techniques should be provided in accordance with appropriate ethical guidelines and medical standards.

7.18 Non-governmental organizations should play an active role in mobilizing community and family support, in increasing access and acceptability of reproductive health services including family-planning, and cooperate with Governments in the process of preparation and provision of care, based on informed choice, and in helping to monitor public- and private-sector programmes, including their own.

7.19 As part of the effort to meet unmet needs, all countries should seek to identify and remove all the major remaining barriers to the utilization of family-planning services. Some of those barriers are related to the inadequacy, poor quality and cost of existing family-planning services. It should be the goal of public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning use by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births and protect themselves from sexually transmitted diseases.

7.20 Specifically, Governments 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.

7.23 In the coming years, all family-planning programmes must make significant efforts to improve quality of care. Among other measures, programmes should:

- (a) Recognize that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice;
- (b) Provide accessible, complete and accurate information about various family-planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases;
- (c) Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continuous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured;
- (d) Expand and upgrade formal and informal training in sexual and reproductive health care and family-planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling;
- (e) Ensure appropriate follow-up care, including treatment for side effects of contraceptive use;
- (f) Ensure availability of related reproductive health services on site or through a strong referral mechanism;
- (g) In addition to quantitative measures of performance, give more emphasis to qualitative ones that take into account the perspectives of current and potential users of services through such means as effective management information systems and survey techniques for the timely evaluation of services;
- (h) Family-planning and reproductive health programmes should emphasize breast-feeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival.

7.24 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 counselling of women who have had recourse to abortion.

7.41 The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. In particular, informa-



tion and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. This effort is uniquely important for the health of young women and their children, for women's self-determination and, in many countries, for efforts to slow the momentum of population growth. Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

7.45 Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, *inter alia*, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.

7.46 Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.

7.47 Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents will require special family-planning information, counselling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care. Adolescents

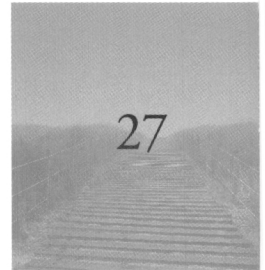
must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities.

8.25 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 counselling. 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.

12.10 Research, in particular biomedical research, has been instrumental in giving more and more people access to a greater range of safe and effective modern methods for regulation of fertility. However, not all persons can find a family-planning method that suits them and the range of choices available to men is more limited than that available to women. The growing incidence of sexually transmitted diseases, including HIV/AIDS, demands substantially higher investments in new methods of prevention, diagnosis and treatment. In spite of greatly reduced funding for reproductive health research, prospects for developing and introducing new methods and products for contraception and regulation of fertility have been promising. Improved collaboration and coordination of activities internationally will increase cost-effectiveness, but a significant increase in support from Governments and industry is needed to bring a number of potential new, safe and affordable methods to fruition, especially barrier methods. This research needs to be guided at all stages by gender perspectives, particularly women's, and the needs of users, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research.

12.11 The objectives are:

- (a) To contribute to the understanding of factors affecting universal reproductive health, including sexual health, and to expand reproductive choice;
- (b) To ensure the initial and continued safety, quality and health aspects of methods for regulation of fertility;
- (c) To ensure that all people have the opportunity to achieve and maintain sound



reproductive and sexual health, the international community should mobilize the full spectrum of basic biomedical, social and behavioural and programme-related research on reproductive health and sexuality.

12.12 Governments, assisted by the international community and donor agencies, the private sector, non-governmental organizations and the academic community, should increase support for basic and applied biomedical, technological, clinical, epidemiological and social science research to strengthen reproductive health services, including the improvement of existing and the development of new methods for regulation of fertility that meet users' needs and are acceptable, easy to use, safe, free of long- and short-term side-effects and second-generation effects, effective, affordable and suitable for different age and cultural groups and for different phases of the reproductive cycle. Testing and introduction of all new technologies should be continually monitored to avoid potential abuse. Specifically, areas that need increased attention should include barrier methods, both male and female, for fertility control and the prevention of sexually transmitted diseases, including HIV/AIDS, as well as microbicides and virucides, which may or may not prevent pregnancy.

12.13 Research on sexuality and gender roles and relationships in different cultural settings is urgently needed, with emphasis on such areas as abuse, discrimination and violence against women; genital mutilation, where practised; sexual behaviour and mores; male attitudes towards sexuality and procreation, fertility, family and gender roles; risk-taking behaviour regarding sexually transmitted diseases and unplanned pregnancies; women's and men's perceived needs for methods for regulation of fertility and sexual health services; and reasons for non-use or ineffective use of existing services and technologies.

12.17 Since unsafe abortion is a major threat to the health and lives of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care.

Appendix III

Selected Provisions of the Platform for Action Adopted at the Fourth World Conference on Women, Beijing, 1995*

83 By Governments, educational authorities and other educational and academic institutions:

- (k) Remove legal, regulatory and social barriers, where appropriate, to sexual and reproductive health education within formal education programmes regarding women's health issues;
- (l) Encourage, with the guidance and support of their parents and in cooperation with educational staff and institutions, the elaboration of educational programmes for girls and boys and the creation of integrated services in order to raise awareness of their responsibilities and to help them to assume those responsibilities, taking into account the importance of such education and services to personal development and self-esteem, as well as the urgent need to avoid unwanted pregnancy, the spread of sexually transmitted diseases, especially HIV/AIDS, and such phenomena as sexual violence and abuse.

95 Bearing in mind the above definition, 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. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities

* United Nations General Assembly, *Beijing Declaration and Platform for Action: Fourth World Conference on Women*. Doc. A/Conf. 177/20, New York, October 17, 1995.

towards the community. 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. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

96 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.

97 Further, women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. Complications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world. Similar problems exist to a certain degree in some countries with economies in transition. Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services, including safe and effective family-planning methods and emergency obstetric care, recognizing the right of women and men 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, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. These problems and means should be addressed on the basis of the report of the International Conference on Population and Development, with particular reference to relevant paragraphs of the Programme of Action of the Conference. In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of

women to control their own fertility forms an important basis for the enjoyment of other rights. Shared responsibility between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health.

103 The quality of women's health care is often deficient in various ways, depending on local circumstances. Women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available. Furthermore, in some countries, over-medicating of women's life events is common, leading to unnecessary surgical intervention and inappropriate medication.

104 Statistical data on health are often not systematically collected, disaggregated and analysed by age, sex and socio-economic status and by established demographic criteria used to serve the interests and solve the problems of subgroups, with particular emphasis on the vulnerable and marginalized and other relevant variables. Recent and reliable data on the mortality and morbidity of women and conditions and diseases particularly affecting women are not available in many countries. Relatively little is known about how social and economic factors affect the health of girls and women of all ages, about the provision of health services to girls and women and the patterns of their use of such services, and about the value of disease prevention and health promotion programmes for women. Subjects of importance to women's health have not been adequately researched and women's health research often lacks funding. Medical research, on heart disease, for example, and epidemiological studies in many countries are often based solely on men; they are not gender specific. Clinical trials involving women to establish basic information about dosage, side-effects and effectiveness of drugs, including contraceptives, are noticeably absent and do not always conform to ethical standards for research and testing. Many drug therapy protocols and other medical treatments and interventions administered to women are based on research on men without any investigation and adjustment for gender differences.

106 By Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions:

- (f) Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality; these services, information and training should be based on a holistic approach;
- (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, which states: “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 counselling. 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”, consider reviewing laws containing punitive measures against women who have undergone illegal abortions;

- (m) Ensure that girls have continuing access to necessary health and nutrition information and services as they mature, to facilitate a healthful transition from childhood to adulthood.

107 By Governments, in cooperation with non-governmental organizations, the mass media, the private sector and relevant international organizations, including United Nations bodies, as appropriate:

- (e) Prepare and disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction, taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as 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 the Convention on the Elimination of All Forms of Discrimination against Women; ensure that in all actions concerning children, the best interests of the child are a primary consideration;
- (g) Recognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account

the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph 107 (e) above.

108 By Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors and non-governmental organizations:

- (k) Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;
- (l) Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour, including voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through, *inter alia*, abstinence and condom use.

109 By Governments, the United Nations system, health professions, research institutions, non-governmental organizations, donors, pharmaceutical industries and the mass media, as appropriate:

- (i) Since unsafe abortion is a major threat to the health and life of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care.

223 Bearing in mind the Programme of Action of the International Conference on Population and Development and the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights, the Fourth World Conference on Women reaffirms that reproductive 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.

267 The International Conference on Population and Development recognized, in paragraph 7.3 of the Programme of Action, that “full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality”, taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as 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 the Convention on the Elimination of All Forms of Discrimination against Women. In all actions concerning children, the best interests of the child shall be a primary consideration. Support should be given to integral sexual education for young people with parental support and guidance that stresses the responsibility of males for their own sexuality and fertility and that help them exercise their responsibilities.

281 By Governments and international and non-governmental organizations:

- (c) Strengthen and reorient health education and health services, particularly primary health care programmes, including sexual and reproductive health, and design quality health programmes that meet the physical and mental needs of girls and that attend to the needs of young, expectant and nursing mothers;
- (e) Ensure education and dissemination of information to girls, especially adolescent girls, regarding the physiology of reproduction, reproductive and sexual health, as agreed to in the Programme of Action of the International Conference on Population and Development and as established in the report of that Conference, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention, recognizing the parental roles referred to in paragraph 267;
- (g) Emphasize the role and responsibility of adolescents in sexual and reproductive health and behaviour through the provision of appropriate services and counselling, as discussed in paragraph 267.

Appendix IV

Selected Articles of the Universal Declaration of Human Rights*

Article 1

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 3

Everyone has the right to life, liberty and security of person.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.



*United Nations General Assembly. Universal Declaration of Human Rights, G.A. 217A (III), Dec. 10, 1948. *Human Rights: A Compilation of International Instruments*. New York and Geneva: United Nations, 1994. [To order the full text of this document, see page 39.]

Appendix

Selected Articles of the International Covenant on Civil and Political Rights*

Article 6 (1)

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

Article 9 (1)

Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

Article 19

1. Everyone shall have the right to hold opinions without interference.

2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

(a) For respect of the rights or reputations of others;

(b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

*United Nations General Assembly. International Covenant on Civil and Political Rights, G.A. Res. 2200 A (XXI), Dec. 16, 1966 (entered into force March 23, 1976). *Human Rights: A Compilation of International Instruments*. New York and Geneva: United Nations, 1994. [To order the full text of this document, see page 39.]

Appendix VI

Selected Articles of the International Covenant on Economic, Social and Cultural Rights*

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest possible standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision or the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 15

1. The States Parties to the present Covenant recognize the right of everyone:
 - (b) To enjoy the benefits of scientific progress and its applications.
3. The States Parties to the present Covenant undertake to respect the freedom indispensable for scientific research and creative activity.

*United Nations General Assembly. International Covenant on Civil and Political Rights, G.A. Res. 2200 A (XXI), Dec. 16, 1966 (entered into force March 23, 1976). *Human Rights: A Compilation of International Instruments*. New York and Geneva: United Nations, 1994. [To order the full text of this document, see page 39.]



Appendix VII

Selected Articles of the Convention on the Elimination of All Forms of Discrimination Against Women*

Part III

Article 10

States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

h. Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 11

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

f. The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family-planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and

*United Nations General Assembly. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, Dec. 18, 1979 (entered into force September 3, 1981). *Human Rights: A Compilation of International Instruments*. New York and Geneva: United Nations, 1994.

the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

b. To have access to adequate health care facilities, including information, counselling and services in family planning.

Article 16

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

e. The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

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