Founded in 1973, Ipas is a global nongovernmental organization dedicated to ending preventable deaths and disabilities from unsafe abortion. Through local, national and global partnerships, Ipas works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies. At Ipas, we believe that:

- Every woman has a right to safe reproductive health choices, including safe abortion care.
- No woman should have to risk her life, her health, her fertility, her well-being or the well-being of her family because she lacks reproductive health care.
- Women everywhere must have the opportunity to determine their futures, care for their families and manage their fertility.

Along with caring, committed health professionals and other colleagues worldwide, Ipas tackles this neglected public health problem head on in some of the world’s poorest countries. While many international donors and governments have focused attention and resources elsewhere, we struggle against the fundamental social injustice that results in the deaths of so many women in the prime of their lives.

International Human Rights Bodies on Unwanted Pregnancy and Abortion

Part 2

Statements from regional treaties, human rights commissions, Special Rapporteurs, and other intergovernmental bodies

COMPILATION OF CITATIONS
June 2014
Maternal mortality, unwanted pregnancy and abortion

Introduction
In the decades since the United Nations human rights system was established, human rights bodies have increasingly addressed issues that are important for women’s and men’s reproductive health. Though most human rights conventions (also known as treaties, covenants and pacts) do not directly mention unwanted pregnancy or abortion, the rights contained in these agreements are linked to reproductive health and rights, including abortion. Experts appointed by member nations of the UN to monitor State compliance – known variously as Treaty Monitoring Committees, Special Procedures, Special Rapporteurs, and Commissioners – have a mandate to provide guidance to States Parties on the conventions should be interpreted, to guide States on how to respect, protect and fulfill human rights. Documents issued by these human rights authorities give guidance to States Parties on how human rights – which are indivisible and interrelated – apply to areas such as reproductive health, including unwanted pregnancy and abortion.

Treaty monitoring bodies – including representatives of States themselves when they review one another’s human rights records during Universal Periodic Reviews at the Human Rights Council – have given recommendations in their General Comments, General Recommendations and Concluding Observations to States Parties on what governments must do to ensure women’s human rights when they experience unwanted pregnancies and unsafe abortion. These recommendations include amending laws that criminalize abortion in circumstances such as rape and danger to a woman’s health and life, revising laws on abortion so that unsafe, illegal abortions no longer contribute to maternal mortality and morbidity, and withdrawing criminal penalties on women who undergo abortions.

At the regional level, human rights conventions and commissions also address reproductive health, in some cases with more explicit language. For example, the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa explicitly grants women the right to legal abortion, as a part of the right to reproductive health. According to Professor Charles Ngwena, “the Protocol has the potential to contribute toward transforming abortion law from a crime and punishment model…to a reproductive health model that complements the objects of CEDAW and the broader philosophy of the International Conference on Population and Development (ICPD).” While the UN conventions do not explicitly include abortion in their text, the guidance provided by the treaty monitoring bodies can move States toward the same end.

With knowledge of how instruments are interpreted by human rights authorities advocates and policy makers can push governments accountable to respect, protect and fulfill women’s reproductive rights. The documents can be cited in educational programs to inform individuals about their rights, in advocacy with government, through media, and in litigation at the national, regional and international level.

This four-part series of documents aims information on interpretation of human rights treaties. It includes statements made in international and regional human rights conventions and by various human rights monitoring bodies that are relevant to addressing unwanted pregnancy and abortion.

Part One cites relevant texts in conventions, statements and recommendations by UN human rights bodies and commissions. Part Two (this section) provides excerpts from treaties, statements and recommendations by regional human rights bodies.

Parts Three and Four list human rights monitoring bodies’ recommendations and decisions with regard to specific countries (listed in alphabetical order). They also include recommendations made by Special Rapporteurs and in Working Group Reports on Universal Periodic Reviews at the United Nations Human Rights Council.

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ABBREVIATIONS

- African Commission on Human and Peoples' Rights (ACHPR)
- Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention on the Elimination of Racial Discrimination (CERD)
- Covenant on Economic, Social and Cultural Rights (CESCR)
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)
- European Court of Human Rights (ECHR)
- Human Rights Committee (Committee monitoring the Covenant on Civil and Political Rights, CCPR)
- Human Rights Council (HRC)
- Inter-American Commission on Human Rights (IAHCR)
- Universal Periodic Review (UPR, reports made to the Human Rights Council)
1. **PROVISIONS OF HUMAN RIGHTS TREATIES**

**African Charter on Human and Peoples’ Rights**

**Protocol to the African charter on Human and Peoples’ Rights on the Rights of Women in Africa**

Article 14: 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a) the right to control their fertility;
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;
d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
f) the right to have family planning education.

Article 2: States Parties shall take all appropriate measures to:

a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.
2. STATEMENTS FROM REGIONAL HUMAN RIGHTS RAPPORTEURS AND COMMISSIONS

African Commission on Human and Peoples' Rights (The African Commission or ACHPR)

ACHPR. General Comments on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa. 6 November 2012

Paragraph 4: According to the African Commission there are multiple forms of discrimination based on various grounds such as: race, sex, sexuality, sexual orientation, age, pregnancy, marital status, HIV status, social and economic status, disability, harmful customary practices and/or religion. In addition, the African Commission recognises that these forms of discrimination, individually or collectively, prevent women from realising their right to self-protection and to be protected.

Paragraph 8: The African Commission welcomes the commitments made by African governments recognizing the need for enhanced efforts to promote and protect women’s sexual and reproductive health rights such as the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja Declaration), the 2006 Continental Policy Framework on Sexual and Reproductive Health and Rights, and the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (Maputo Plan of Action) adopted in 2006.

Paragraph 11: The right to self-protection and to be protected includes women’s rights to access information, education and sexual and reproductive health services. The right to self-protection and the right to be protected are also intrinsically linked to other women’s rights including the right to equality and non-discrimination, life, dignity, health, self-determination, privacy and the right to be free from all forms of violence. The violations of these rights will impact on women’s ability to claim and realise her right to self-protection.

Paragraph 13: The right to be informed on one’s health status includes the rights of women to access adequate, reliable, non-discriminatory and comprehensive information about their health. This also involves access to procedures, technologies and services for the determination of their health status. In the context of HIV, this right includes, but is not limited to: access to HIV testing, CD4 count, viral-load, TB and cervical cancer screening.

Paragraph 15: The right to be informed on one’s health status is applicable to all women irrespective of their marital status, including: young and adolescent women, older women, rural women, women who engage in sex work, women who use drugs, women living with HIV, migrant and refugee women, indigenous women, detained women, and women with physical and mental disabilities.

Paragraph 17: Caution should be exercised in relation to the conditions and environments under which the right to be informed on the health status of one’s partner may be exercised, in particular, where the revealing of a partner’s health status may result in negative consequences such as harassment, abandonment and violence.

Paragraph 18: Information about the health status of one’s partner may be obtained through notification by a third party (usually a healthcare worker) or disclosure (for instance, by the person themselves). Disclosure of one’s health status is not always explicit. It may take various forms, including coded and implicit actions, by the person concerned. Coded or implicit actions may include disclosure that allows for the communication of a person’s health status in a manner other than direct verbal dialogue. States must ensure that all forms of disclosure are recognised.

Paragraph 21: The obligation to respect in relation to Article 14 (1) (d) & (e) requires States to refrain from interfering directly or indirectly with the rights to self-protection, to be protected, and the right to be informed on one’s health status and the health status of one’s partner.

Paragraph 22: The obligation to protect in relation to Article 14 (1) (d) and (e) requires States to take measures that prevent third parties from interfering with these rights. Special attention, in the implementation of this obligation, should be given to action by third parties that may impact on the right to sexual and reproductive health of all women, including those mentioned under paragraph 14 above.

Paragraph 23: The obligation to promote in relation to Article 14 (1) (d) and (e) requires States to create the legal, social and economic conditions that enable women to exercise their rights in relation to sexual and reproductive health. This involves engaging in sensitisation activities, community mobilisation, training of healthcare workers, religious, traditional and political leaders on the importance of the right to protection and to be informed on one’s status and that of one’s partner.
Paragraph 24: The obligation to fulfil in relation to Article 14 (1) (d) and (e) requires States to adopt all the necessary measures, including allocation of adequate resources for the full realisation of the right to self-protection and to be protected and the right to be informed on one’s health status and the health status of one’s partner.

Paragraph 28: States Parties are obliged to provide appropriate pre-service and on-going in-service training for health providers and educators, including community based health care providers, on health and human rights.

Paragraph 29: Ensuring availability, accessibility, acceptability and quality sexual and reproductive health care services for women is crucial. Therefore, States Parties have the obligation to ensure comprehensive, integrated, rights-based, women-centred and youth friendly services that are free of coercion, discrimination and violence.

Paragraph 31: States Parties should also ensure that health workers are not allowed, on the basis of religion or conscience, to deny access to sexual and reproductive health services to women as highlighted in this document.

Paragraph 34: States Parties should ensure implementation of laws and policies through establishment of accountability mechanisms, the development of implementing guidelines, a monitoring and evaluation framework, and the provision of timely and effective redress mechanisms where women’s sexual and reproductive health rights have been violated.

Paragraph 40: States Parties are obliged to guarantee the availability, accessibility and affordability of comprehensive and quality procedures, evidence based technologies and services for the medical monitoring of one’s sexual and reproductive health. These procedures, technologies and services should be evidence-based and should be appropriate to the specific needs and context of women. In the context of HIV, this should include: access to HIV testing, CD4 count, viral-load, TB and cervical cancer screening that may affect women’s sexual and reproductive health.

Paragraph 41: States parties should provide training for healthcare workers on, amongst others, non-discrimination, confidentiality, respect for dignity, autonomy and informed consent in the context of sexual and reproductive health services for women.

Paragraph 42: States Parties must ensure that testing is not used as a condition for access to other health services, including treatment, contraception, abortion, medical examination, pre- and post-natal services, or any other reproductive health care. Furthermore, positive test results should not be a basis for coercive practices, or, the withholding of services.


Paragraph 2: URGES States Parties to the African Charter on Human and Peoples' Rights to:…

- Ensure that victims of sexual violence have access to medical assistance and psychological support;
- Ensure participation of women in the elaboration, adoption and implementation of reparation programmes;
- Ratify without reservations and ensure the effective implementation of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and the Convention on the Elimination of All Forms of Discrimination against Women as well as its Optional Protocol;

**Inter-American Commission on Human Rights (IACHR)**

**Annex to Press Release 23/13 on the 147th Regular Session of the IACHR. April 5, 2013**

Situation of Women: During several hearings throughout this period of sessions, the Inter-American Commission also received information related to the negative impact on women of restrictive laws pertaining to abortion in countries such as Argentina, Bolivia, Brazil, El Salvador, Nicaragua, and Peru. The Commission was informed of how these laws contravene a range of women’s rights in the realms of discrimination, equality, life, health, integrity, privacy, and to be free from cruel, inhumane, and degrading treatment.

The Commission received information stressing the link between these restrictive laws and the performance of unsafe and clandestine abortions, leading to high rates of maternal mortality and morbidity. It was also informed of the dilemma faced by women who often have to choose between seeking the health services they need and risking being denounced to the authorities for having committed a crime. The organizations present highlighted the systemic violations to due process guarantees that women face when they are indeed reported to the authorities. The information provided also underscored the pernicious and disproportionate impact of these laws on women who belong to the most vulnerable sectors of the population on account of their poverty, race, ethnicity, age, and educational background.

For example, in the case of El Salvador, the Commission received information in the context of a hearing indicating that between 2000 and 2011 at least 129 women have been processed for the crimes of abortion or for aggravated homicide. Most of these women are young, affected by poverty, have low educational levels, and are marginalized, facing...
HR and abortion statements – Part 2

noteworthy challenges in their access to emergency health services. Individual cases were presented in which women who had miscarriages were arrested and deprived of their liberty. More generally, information was provided of convictions of women for aggravated homicide after being denounced by their doctors to the authorities without sufficient elements of proof.

In regards to this very alarming human rights issue, the Commission reiterates the obligation of States to undertake a detailed review of all public laws, standards, practices, and policies whose language or their practical implementation can have a discriminatory impact on women’s access to reproductive health services; their duty to eliminate all de jure and de facto barriers that impede women’s access to the maternal health services they require, such as the criminalization of the same; and to take into account that restrictive laws tend to have a special effect on girls and women who are affected by poverty, have low-levels of education, and live in rural areas. The Commission also underscores the importance of recognizing therapeutic abortion as a specialized health service required by women, the purpose of which is to save the mother’s life when it is at risk owing to a pregnancy. Lastly, the Commission highlights the need to implement human rights training initiatives of doctors and medical personnel offering services related to the maternal health of women, regarding their human rights and specific needs.


Paragraph 287: During the follow-up period [to its 2006 report], the Commission was informed of the way in which criminal law is used against women defenders of women’s rights. The institution of these criminal cases is viewed as retaliation for the work they do that challenges longstanding social concepts or stereotypes in the States. The prospect of prosecution has a significant chilling effect on defenders of sexual and reproductive rights, whose activities are even prohibited in some countries. According to the information provided by civil society during the Commission’s 140th session, criminalization of women human rights defenders who promote therapeutic abortions is a pattern in Nicaragua, El Salvador and Honduras, where abortion, irrespective of the circumstances, is a criminal offense.


Paragraph 47: The Committee that oversees compliance with the CEDAW has ruled that all forms of violence against women constitute discrimination, including “acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.”68 In addition, rape, sexual slavery, forced prostitution, forced pregnancy, forced sterilization, or any comparably serious form of sexual violence are considered, in specific circumstances, crimes against humanity and war crimes under the Rome Statute.

Paragraph 105: Some the most severe consequences of sexual violence against women in educational institutions are those that have resulted in unwanted pregnancies. As Amnesty International observed, “Unintended pregnancy can have serious repercussions – unsafe abortions, suicides and family reactions that may include social isolation, ostracism or even murder. Unsafe abortions sought to end unwanted pregnancies also have many health complications, including the risk of death, for teenage girls.

Access to justice for women victims of sexual violence in Mesoamerica. OEA Ser.L/V/II. Doc.63. 9 December 2011

Paragraph 36: International criminal law has also established important guidelines for addressing sexual violence and the care and treatment of victims and witnesses. In 1999, the international community approved the Rome Statute of the International Criminal Court9 which prosecutes the most heinous crimes against humanity: genocide, crimes against humanity, war crimes and crimes of aggression. Among the crimes that the Statute lists as crimes against humanity are a number of acts involving sexual violence and associated with extermination, sexual enslavement, ethnic cleansing, forced prostitution, forced sterilization and forced abortion, among others. The Statute requires that all appropriate measures be taken to ensure effective investigation and prosecution of crimes within the jurisdiction of the Court, and in doing so, that the victim’s interests and personal circumstances be respected, one of those circumstances being gender. The Statute creates the Victims and Witnesses Unit, which is to be staffed with persons having expertise in trauma, including trauma related to crimes of sexual violence.

Paragraph 242: In Costa Rica, emergency contraception is not officially included among the services that the Official Health System provides, and is not widely publicized among women who may require it. The health personnel are afraid to offer this type of medication, since there is still confusion and ignorance about emergency contraception. Some think it is a way of inducing an abortion and medical personnel who offer this service can be reported and penalized; others think that as it is not part of any protocol, handbook or guide for the health sector, it might cause problems for the institution. In Honduras, this method is not available. In El Salvador and Nicaragua, abortion is not an option, not even therapeutic abortions; the result is that hundreds of girls and women get pregnant as a result of rape.

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Paragraph 243: The IACHR concludes, therefore, that within the Mesoamerican region there is no comprehensive legislation to protect women’s rights and protocols that join the health and justice sectors in partnership to effect significant change in the lives of women who file complaints. In other words, there is no mechanism that combines the efforts to help the victim recover with those to prosecute and punish the crime; despite the fact that rape violates essential aspects and values of private life, it also represents an intrusion in the victim’s sexual life, and takes away her right to decide freely with whom to have intimate relations, causing her to lose total control over these most personal and intimate decisions, and over her basic bodily functions.

Access to information on reproductive health from a human rights perspective. OEA/Ser.L/V/II. Doc. 61. 22 November 2011

Paragraph 1: Women who have historically been marginalized based on their race, ethnicity, economic status, or age are those who face the most barriers in access to information on health, and these barriers become even greater when the information has to do with matters related to sexual and reproductive health. Access to information is closely linked to the attainment of other human rights; thus, a failure to respect and guarantee this right for women can lead to an infringement of other rights, such as their right to personal integrity, the right to privacy, rights of the family, and the right to be free from violence and discrimination.

Paragraph 3: The right to access to information is especially relevant in the area of health, and specifically in the area of sexuality and reproduction, since it helps to ensure that everyone is prepared to make free and informed decisions with regard to intimate aspects of their life. In the inter-American system, access to information on sexual and reproductive health involves a series of rights such as the right to freedom of expression, to personal integrity, to the protection of the family, to privacy, and to be free from violence and discrimination.

Paragraph 26: In this regard, women's right of access to information on reproductive health gives rise to a proactive obligation by the State, due to the recognition of the limitations that tend to affect women—particularly those who are poor, indigenous, and/or of African descent, or who live in rural areas—in terms of accessing reliable, complete, timely, and accessible information that allows them to exercise their rights or meet their needs. In these cases, as will be set forth below, the right of access to information takes on an instrumental nature that is usually, though not necessarily, associated with the satisfaction of other human rights enshrined in the American Convention.

Paragraph 32: Specifically with respect to adolescent girls' access to information on reproductive health, the Committee on the Rights of the Child has established States' obligation to provide them with access to information on the potential harm that can be caused by early pregnancy. It has also established that adolescent girls who become pregnant should have access to health services that are sensitive to their rights and particular needs.

Paragraph 85: As has already been noted, it is important that the information that is provided helps women make informed decisions about their reproductive health. In this framework, the obstruction of access to information or the provision of inadequate or erroneous information contravenes the right to access to information.

Paragraph 86: On this point, the IACHR emphasizes that States have an obligation to refrain from censoring, either administratively or judicially, information on reproductive matters that falls within existing laws in this area, for example on the effects and effectiveness of family-planning methods. This means, for the States, that the public policies and programs on sexual and reproductive health should be based on scientific evidence that provides certainty.

Paragraph 91: As an example of this situation, on March 8, 2002, the IACHR received a petition alleging the violation of the human rights of the minor child Paulina Ramírez Jacinto, who was a victim of a rape that resulted in pregnancy and was prevented by State authorities from exercising her right to interrupt the pregnancy, in accordance with Mexican law. Among other methods employed to dissuade her from getting a legal abortion, she and her mother were given incomplete and erroneous information about the medical procedure and its consequences. The case was resolved through a friendly settlement agreement dated March 8, 2006. In that agreement, the IACHR stated that women cannot fully enjoy their human rights without having timely access to comprehensive health care services, and to information and education in this sphere. The IACHR is monitoring compliance with the agreement.

Paragraph 92: Consequently, the IACHR considers that to guarantee access to information on reproductive matters, the OAS Member States must refrain from censoring, withholding, or misrepresenting information. Moreover, pursuant to the respect and guarantee obligations imposed by the IACHR, and under the principles of equality and non-discrimination, the States must guarantee that women have access to information that is timely, complete, accessible, reliable, and proactive on reproductive matters; this should include information about the sexual and reproductive health services that are legally available.

Paragraph 95: Conscientious objection is a very relevant issue when it comes to access to information in the area of reproductive health. Many health professionals have their own convictions with respect to the use of family-planning methods, emergency oral contraception, sterilization, and legal abortion, and they prefer not to provide these services. As
was indicated in the preceding paragraph, the health professional's right to conscientious objection is a freedom. However, this freedom could come into conflict with patients' freedoms. Consequently, the balance between the rights of healthcare professionals and the rights of patients is maintained through referrals. In other words, a health professional may refuse to take care of a patient, but should transfer the patient without objection to another health professional who can provide what the patient is seeking. For example, if a woman needs family-planning information and services and/or other lawful reproductive health services, and the health professional has his or her own convictions with respect to the utilization of such services, the professional has the obligation to refer the patient to another health provider who can provide the information and services in question. This is in order not to create barriers in access to services.

Paragraph 99: In this regard, the IACHR considers that the States must guarantee that women are not prevented from accessing information and reproductive health services, and that in situations involving conscientious objectors in the health arena, the States should establish referral procedures, as well as appropriate sanctions for failure to comply with their obligation.

Paragraph 112: The IACHR considers that the States should compile information on the status of women’s human rights and reproductive health—including specific information on groups that have suffered exclusion, such as indigenous women, women of African descent, migrant women and women who live in rural areas—in order to identify and address the specific problems of these populations in this sphere.

Paragraph 115: The IACHR concludes that the production of reliable statistics on reproductive matters and the dissemination of that information will help to bring greater attention to countries' public health policies so the States can meet their international obligations in this area. Moreover, being aware of the true situation regarding women’s sexual and reproductive health will raise collective awareness about the real needs that must be addressed.

Paragraph 116: This report has reviewed the minimum principles the OAS Member State should observe in order to guarantee the protection, under equal conditions, of the right of access to information on reproductive health. The Commission trusts that its recommendations will contribute to the efforts the States are carrying out in this area:

1. Adapt domestic laws on access to information and education on sexual and reproductive health so that they meet the international standards the States have pledged to follow with regard to the right of access to information. Ensure that policies and programs, designed with the participation of women themselves, are consistent with the goals established by the States to improve the flow of information related to reproductive health.

2. Analyze—at the level of the legislative, executive, and judicial branches, and with strict scrutiny—all laws, regulations, practices, and public policies in the area of health so that they guarantee the right to access to information on sexual and reproductive health and the obligation of the State to provide such information. Ensure, therefore, that the information provided is timely, complete, accessible, reliable, and proactive.

3. Incorporate simple, effective, and appropriate administrative procedures which can be used by anyone to request needed information.

4. Incorporate effective judicial procedures for reviewing decisions by public officials that deny women the right of access to certain information or that simply fail to respond to requests.

5. Guarantee confidentiality in access to information on sexual and reproductive health.

6. Ensure health professionals’ obligation to inform women about their health so that women can make free, informed, and responsible decisions related to sexuality and reproduction.

7. Ensure that the information provided is adapted to the audience that needs it, particularly so that women who speak other languages can have access to the information in their own tongue.

8. Establish protocols for effective access to information in cases involving conscientious objection.

9. Revise criminal-law provisions that force health professionals to violate confidentiality and professional secrecy in accordance with international standards in this area.

10. Guarantee that patients can have access to their medical records when needed, and establish mechanisms for sanctioning the failure to comply with such a provision.

11. Implement measures so that information systems adequately reflect the situation of women’s health, at the national and local level, including figures on family-planning needs, maternal morbidity and mortality, and neonatal mortality, along with their causes, so that effective decisions and actions can be taken.

12. Establish systematic policies for training and capacitating government officials on the right of access to information in all spheres of the State.

13. Promote the widespread dissemination of information on the health and the rights of indigenous and Afro-descendant women, and women who live in rural areas, to ensure their effective participation in decision-making concerning their reproductive health. Include adolescent girls, with a focus on preventing early motherhood.

14. Ensure that national budgets contemplate producing reliable statistics on sexual and reproductive matters, broken down at the very least by sex, gender, ethnicity, and age.
Paragraph 170: This judgment – presented by the State of Colombia in its response to the questionnaire - addresses a constitutional motion presented against the provisions of the Criminal Code of Colombia that categorically prohibited the practice of abortion in the country. The action was filed by the plaintiff, who argued that those provisions violated the right to equality, to reproductive autonomy, and to the free development of the personality, to equality and self-determination; the rights to life, health, and integrity; the right to be free from cruel inhuman, and degrading treatment; and the obligations under international human rights law; all rights enshrined in the Constitution. On May 10, 2006, the Constitutional Court announced its decision, ruling that abortion could not continue being considered a crime in three circumstances: (a) when the life or health (physical or mental) of the woman is in danger; (b) when the pregnancy results from rape or incest; and (c) when there is a serious fetal deformation that makes life outside of the uterus unviable.

Paragraph 171: The Constitutional Court made extensive reference in this judgment to inter-American and international human rights law precedent – including the American Convention and the Convention of Belém do Pará – considering that the absolute prohibition on abortion to protect the interests of the fetus imposed a disproportionate burden on the exercise of women’s human rights. The Court also emphasized the link between preventing sexual violence against women and undesired pregnancy, which entails positive obligations on the State to mitigate the effects of sexual violence, offering the necessary health services.

Paragraph 172: Following are some excerpts from the judgment:

‘7. The fundamental rights of women in the Colombian Constitution and international law

The Colombian Constitution of 1991 made an all-important change in relation to the position and rights of women in Colombia society and in their relations with the State….Along these lines, the 1991 Constitution made clear its interest in recognizing and lifting up the rights of women and in strengthening the safeguarding of these rights, protecting them effectively and in a reinforced manner. Consequently, nowadays women enjoy special protection in the Constitution, and to that extent all their rights should be looked after by the authorities, including judicial officers, without exception….

It should be recalled that with respect to women it is clear that there are situations that affect them above all, and differently, such as those that concern their life, and in particular those that concern their rights over their body, their sexuality, and reproduction….

In effect, women’s rights have been occupying an important place in world conferences called by the United Nations, which constitute an essential frame of reference for interpreting the rights contained in international treaties….

In effect, different international treaties are the basis for recognizing and protecting the reproductive rights of women, which begin with the protection of other fundamental rights, such as the rights to life, health, equality and non-discrimination, liberty, personal integrity, and being free from violence, which constitute the essential core of reproductive rights. Other rights are also directly affected when the reproductive rights of women are violated, such as the right to work and to education, which, on being fundamental rights, may serve as a parameter for protecting and guaranteeing their sexual and reproductive rights….

It should be recalled that in addition to the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the American Convention on Human Rights, protection of the rights of Latin American women finds special support in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which entered into force for Colombia as of February 19, 1982, by Law 51 of 1981, and the Convention on the Prevention, Punishment and Eradication of Violence against Women “Convention of Belém do Pará,” which came into force for Colombia on December 15, 1996, with the adoption of Law 248 of 1995; these, together with the documents signed by the governments of the signatory countries in the World Conferences, are fundamental for protecting and guaranteeing the rights of women insofar as they constitute a frame of reference on establishing concepts that help interpret them in the international and domestic spheres….

In effect, the various forms of gender violence constitute a violation of women’s reproductive rights, as they have repercussions for their health and sexual and reproductive autonomy. Sexual violence violates the reproductive rights of women, in particular their rights to bodily integrity and to the control of their sexuality and reproductive capacity, and places at risk the right to health, not only physical but also psychological, reproductive, and sexual….

Accordingly, the CEDAW Committee has declared: “Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.” The Convention of Belém do Pará, in force since March 5, 1995 and for Colombia since December 15, 1996 – Law 248 of 1995 – is one of the most important instruments for the protection of women’s rights in the face of the various forms of violence to which they are subjected in the various spaces of their lives. This has determined two elements that make it especially effective: the
definition of violence against women, which considers these acts as violations of human rights and fundamental freedoms, taking into account the abuses that occur both in public and in private; and the establishment of state responsibility for violence perpetrated or tolerated by it, wherever it may occur…’

Annex to Press Release 28/11 on the 141st Regular Session of the IACHR. April 1, 2011
Situation of the Rights of Women: In the hearing on the Reproductive Rights of Women, the IACHR received information from organizations from 12 countries in the region with regard to the serious obstacles women face throughout the Americas to be able to fully and effectively exercise their reproductive rights. Information was received on a restricted interpretation of the right to health that excludes reproductive rights within the framework of States' public policies. Second, the organizations informed the IACHR about the consequences and impact of restrictive laws on the legal interruption of pregnancy, including the practice of abortion in unsafe conditions and maternal morbidity rates—problems that particularly affect girls and young women who are poor, have little education, and live in rural areas. The organizations also presented information on individual cases of women who, upon seeking health services to receive obstetric care for premature deliveries, were accused of the crime of abortion or kinship murder and were sentenced to jail. On this point, the IACHR reiterates that women's reproductive health should be considered a priority in legislative initiatives and national and local health programs in the areas of prevention and protection. This implies the obligation to analyze in detail all laws, regulations, practices, and public policies that, in words or in practice, could have a discriminatory impact on women in terms of their access to reproductive health services, and the obligation to prevent any negative consequences that such measures could have on the exercise of women's human rights in general. The States are likewise obligated to eliminate all barriers of fact or of law that keep women from obtaining access to maternal health services they need, including criminal sanctions for seeking such services. The IACHR also reminds the States that therapeutic abortion is recognized internationally as a specialized, necessary health service for women intended to save the mother's life when it is at risk during pregnancy, and that denying this service constitutes an attack on the life and physical and psychological integrity of women.

Access to maternal health services from a human rights perspective. OEA/Ser.L/V/II. Doc. 69. 7 June 2010
Paragraph 8: Maternal mortality rates in the Americas represent a total of 22,680 deaths each year. The principal causes of maternal death in the region’s countries are preventable and consistent: preeclampsia, hemorrhage, and abortion, with the order varying according to the rate of maternal mortality, coverage levels for prenatal care and childbirth, and the prevalence of contraceptive use.

Paragraph 42: In its on-site visits, the IACHR has confirmed the maternal health situation in some countries and has made recommendations to the States on addressing some of the most significant problems associated with protecting the right to personal integrity. For example, the Commission referred to the serious maternal mortality situation in the region and how that situation reflects the poverty level and exclusion of women. It also referred to abortion as a very serious problem for women, not only from a health perspective but also in terms of women’s human rights to integrity and privacy.

Paragraph 50: Another important case before the IACHR in the area of maternal health that was resolved through a friendly settlement agreement is the case of Paulina Ramirez Jacinto of Mexico. The petitioners alleged that Paulina Ramirez, aged 13, was the victim of sexual violence, was prevented from exercising her right to a legal abortion because she and her mother were the victims of intimidation and delays on the part of agents of the State. In 2007, the parties ratified a friendly settlement agreement that includes public recognition of the responsibility of the Government of Baja California and a series of measures to compensate the victim and her child, including court costs for processing the case, medical expenses arising from the events and health services, financial support for their maintenance, housing, education and professional development, psychological care, and reparation for moral damages. In publishing the report, the IACHR emphasized that it is impossible to achieve women’s full enjoyment of human rights unless they have timely access to comprehensive health care services as well as information and education on the subject. The IACHR also noted that the health of the victims of sexual violence must have priority in the States’ legislative initiatives and in health policies and programs. The IACHR is monitoring fulfillment of the agreement.

Paragraph 84: Following international standards on the protection of maternal health and the inter-American system’s own jurisprudence, the IACHR notes that the duty of the States to guarantee women’s right to physical, mental and moral integrity in terms of access to maternal health services under equal conditions implies giving priority to resources to serve women’s specific needs with respect to pregnancy, childbirth, and the post-partum period, particularly by implementing key interventions that contribute to guaranteeing maternal health, as well as emergency obstetrical care. At a minimum, the States must guarantee maternal health services that include the basic factors that are determinants of health. Thus, the CEDAW specifies in Article 12(2) the States’ obligation to ensure equal conditions for women to obtain health services required by women only according to their specific health needs. The CEDAW Committee even recommended that the States Parties ensure ‘that women are not forced to seek unsafe medical procedures such as illegal abortion because of a lack of appropriate services in regard to fertility control’.

HR and abortion statements – Part 2

Ipas – June 2014/12
Paragraph 98: With respect to protecting adolescents’ right to integrity, the IACHR has previously stated that early pregnancy poses various risks that, in addition to health problems, include higher risk of abortions under unsafe conditions and interrupted education. In this regard the Human Rights Committee has established the duty of the States to provide adolescents with access to information on the harm early pregnancy can cause. In addition, the Committee has established that pregnant girls and adolescents must be given health services appropriate to their rights and specific needs. For its, part, the Committee on the Rights of the Child has urged the States Parties to adopt measures to reduce maternal morbidity and mortality among adolescent girls, particularly that produced by pregnancy and unsafe abortion practices, and to provide support to the parents of adolescents. As a result, the Commission believes that the States must design policies and programs for this specific group based on their specific maternal health needs, while respecting their rights to privacy and confidentiality.

Paragraph 100: It should be noted that the Inter-American Commission on Human Rights developed a series of guidelines for assessing and monitoring economic, social, and cultural rights provided in the Protocol of San Salvador. The document specifically develops a series of structural, process and outcome indicators relating to pregnancy and maternity. The outcome indicators for measuring progress in the right to health include the percentage of individuals who have access to basic sanitation, the number of professionally attended deliveries, and the percentage of women of reproductive age with anemia. The outcome indicators for measuring progress in the right to health with respect to equality are specified as: the rate of maternal and perinatal mortality; the distribution of maternal mortality by cause, broken down by age group; the perinatal mortality rate; the percentage of newborns weighing less than 2.5 kg; the rate of assistance due to domestic violence; and estimated cases of illegal abortion by age, place of residence (urban and rural), and socioeconomic circumstances of the pregnant woman or other available data.

Paragraph 101: At the International Conference on Population and Development held in Cairo in 1994, more than 171 States agreed to the following objectives related to women’s health and maternity: (a) To promote women’s health and safe motherhood to achieve a rapid and substantial reduction in maternal morbidity and mortality and to reduce the difference between and within developed and developing countries. On the basis of a commitment to improving women’s health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion; (b) To improve the health and nutritional status of women, particularly pregnant and nursing women.

Paragraph 102: The measures agreed upon included increasing the delivery of maternity services within the framework of primary health care. Said services, based on the concept of choice based on correct information, should include education on safe motherhood; coordinated and effective prenatal care; maternal nutrition programs; appropriate care for deliveries; avoiding excessive use of caesarean sections and providing emergency obstetrical care; referral of cases when there are complications during pregnancy, childbirth, and abortion; prenatal care; and family planning. All births should be attended by trained personnel, preferably nurses and midwives, but at least by trained birth attendants.

Footnote 151: The measures agreed upon included increasing the delivery of maternity services within the framework of primary health care. Said services, based on the concept of choice based on correct information should include education on safe motherhood; prenatal care that is focused and effective, maternal nutrition programs; adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth, and abortion, post-natal care and family planning…


On February 26, 2010, the IACHR granted precautionary measures for a person who the IACHR will identify as Amelia, in Nicaragua. The request seeking precautionary measures alleges that Amelia, mother of a 10-year-old girl, is not receiving the necessary medical attention to treat the cancer she had, because of her pregnancy. The request alleges that the doctors had recommended to urgently initiate chemotherapy or radiotherapy treatment, but the hospital informed Amelia’s mother and representatives that the treatment would not be given, due to the high risk that it could provoke an abortion. The Inter-American Commission asked the State of Nicaragua to adopt the measures necessary to ensure that the beneficiary has access to the medical treatment she needs to treat her metastatic cancer; to adopt the measures in agreement with the beneficiary and her representatives; and to keep her identity and that of her family under seal. Within the deadline set to receive an answer, the State of Nicaragua informed the IACHR that the requested treatment has been initiated.

GUIDELINES FOR PREPARATION OF PROGRESS INDICATORS IN THE AREA OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS. 19 July 2008

B. Right to Health

Paragraph 95: The right to health has a large number of measurement instruments, in particular quantitative instruments. At the same time the right to health is addressed in three Millennium Development Goals (on child mortality, maternal mortality, and HIV/AIDS, malaria and other diseases), for which there is information available in most countries in the HR and abortion statements – Part 2
region. In these cases, it is up to the reporting State if it wishes to combine information on progress in the MDGs with the indicators suggested here.

Paragraph 96: In keeping with the aforesaid framework, for the purpose of monitoring the implementation process in terms of the scope of the provisions contained in the Protocol, the table below sets out the main (structural, process and outcome) indicators as well as qualitative signs of progress. We should reiterate that the indicators shown should be regarded as a guide for a broader process in which further indicators and more precise signs of progress are included.

(Guidelines relevant to abortion-related issues are highlighted in bold.)

<table>
<thead>
<tr>
<th>RIGHT TO HEALTH</th>
<th>STRUCTURAL INDICATORS</th>
<th>PROCESS INDICATORS</th>
<th>OUTCOME INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUALITY</td>
<td>- Rules on abortion.</td>
<td>- Estimated number</td>
<td>- Maternal mortality rate</td>
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<tr>
<td></td>
<td>Cases, scope, prohibitions.</td>
<td>abortions by age, place of</td>
<td>- Distribution of maternal mortality by cause, disaggregated by age groups</td>
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<tr>
<td></td>
<td>- Existence of a law or national policy for persons with physical and mental disabilities. Scope and coverage.</td>
<td>residence (urban or rural) and socioeconomic status of pregnant woman.</td>
<td>- Percentage of persons with physical or mental disabilities who have access to services at public or social facilities</td>
</tr>
<tr>
<td></td>
<td>- Recognition of sexual and reproductive rights. Mention legal-regulatory instruments and their scope.</td>
<td>- Percentage of population that uses indigenous or alternative health care systems.</td>
<td>- Treatment of persons with disabilities at community facilities</td>
</tr>
<tr>
<td></td>
<td>Existence and availability of mental health services, by region.</td>
<td>- Existence and implementation of programs on sexual and reproductive health. Scope and coverage.</td>
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<tr>
<td></td>
<td>- Food program coverage of boys and girls (%).</td>
<td>- Maternal mortality rate.</td>
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<td></td>
<td>- Proportion of boys and girls who receive prenatal care and care up to age five.</td>
<td>- Percentage of children under five years old who are underweight.</td>
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<tr>
<td></td>
<td>- Births attended by skilled personnel.</td>
<td>- Percentage of children with low birth weight (less than 2.5 kg).</td>
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<td></td>
<td>- Percentage of pregnant women with HIV/AIDS tests</td>
<td>- Rate of assistance due to domestic violence</td>
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<td></td>
<td>- Percentage of infants born to HIV-positive mothers who contract HIV/AIDS within the first two years of life. (reported number of vertically transmitted aids cases).</td>
<td>- Composition by sex of reported cases of AIDS and HIV diagnoses.</td>
<td></td>
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<tr>
<td></td>
<td>- Percentage of pregnant women who received prenatal care.</td>
<td>- Estimated number of illegal abortions, by age, place of residence (urban or rural) and socioeconomic circumstances of the pregnant woman, or other available data.</td>
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<tr>
<td>RIGHT TO HEALTH</td>
<td>STRUCTURAL INDICATORS</td>
<td>PROCESS INDICATORS</td>
<td>OUTCOME INDICATORS</td>
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<tr>
<td>SIGNS OF PROGRESS</td>
<td>- Existence of studies on health care needs. Description and main findings. - Existence of public awareness campaigns in this respect. Scope.</td>
<td>Indicate which of the following mechanisms are used to disseminate information to the public about their health care rights: a) government public awareness campaigns; b) public awareness and action campaigns by civil society organizations; c) community-based measures d) print media</td>
<td></td>
</tr>
</tbody>
</table>
**Reproductive Rights: Constitutional motion 146/2007 and its joined motion 147/2007, Supreme Court of Justice of the Nation, Mexico**

Paragraph 173: The State of Mexico presented information regarding this judgment in its response to the questionnaire. This judgment is related to the regulation of the legal interruption of pregnancy before twelve weeks of gestation in the Federal District. The Legislative Assembly of the Federal District approved the decriminalization of the voluntary interruption of pregnancy within the first twelve weeks of gestation in the Federal District on April 26, 2007. Such reform was challenged by the President of the National Commission of Human Rights and the Federal Executive Branch - by means of the Attorney General of the Republic - on May 24 and 25 of 2007 respectively, before the Supreme Court of Justice of the Nation. Motions of constitutionality were presented, which were later accumulated. The Supreme Court resolved constitutional motion 146/2007, and its joined motion 147/2007 on August 28 of 2008, ruling that the reforms approved by the Legislative Assembly of the Federal District were constitutional.

Paragraph 174: In this respect, the Commission notes the arguments put forth by the Supreme Court of Justice in terms of the content of the right to life under Mexican legislation and international treaties. In particular, the IACHR mentions the argument put forth by that Court in terms of the “content of the applicable international instruments, such as the case of … Article 4 of the American Convention, to determine in what sense its content refers to the existence of a right to life and what would be the conditions for its application.” On this point, the Court took into account the antecedents that led to the drafting of the Convention in the following terms: ‘… as the American Convention on Human Rights is the only international treaty that sets forth a specific moment for beginning protection of the right to life, and as the Mexican State is a party to it, it is worth analyzing the intent of those who adopted that international instrument to determine whether one might derive from it an absolute right to life or special obligations for the protection of that right from a specific moment.”

Paragraph 175: Thus, after analyzing the content of the travaux préparatoires of the American Convention with respect to the wording of said Article 4, the Court indicated that: “… the only thing that we can find in the Constitution expressly are constitutional provisions that positively establish obligations for the State to promote and make normatively effective rights related to life…. In other words, the Constitution does not recognize a right to life normatively, but establishes that once given the condition for life there is a positive obligation on the State to promote it and develop conditions for all individuals subject to the provisions of the Constitution to increase its level of enjoyment and to procure what is materially necessary for it.

In this context, this case brings us face-to-face with a peculiar problem, in which one must pose a question inverse to that raised by the courts or constitutional courts in the examples noted above: we must ask ourselves whether the State is obligated or has a mandate to criminalize a specific conduct, and not whether criminalization of a particular conduct impairs or violates constitutional rights.

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<td></td>
<td></td>
<td>e) broadcast media</td>
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<td>f) other media</td>
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<td>g) mail shots</td>
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<td>h) other</td>
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<tr>
<td>ACCESS TO JUSTICE</td>
<td>INDICATORS</td>
<td>- Existence of pre-judicial mechanisms to lodge complaints alleging breach of obligations connected to the right to health. Jurisdiction and scope.</td>
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<tr>
<td></td>
<td></td>
<td>- Jurisdiction of government ministries to receive complaints from health system users. Scope and powers.</td>
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<td></td>
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<td>- Number of judicial decisions that have upheld guarantees in the area of health, in general, and in specific cases (inter alia, sexual and reproductive health, persons with HIV/AIDS).</td>
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<tr>
<td></td>
<td></td>
<td>- Number of complaints on the right to health received, investigated and disposed of by the competent national human rights protection agencies in the country.</td>
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The Mexican State, from the international sphere, has undertaken to punish certain conduct, as in the case of the …, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ‘Convention of Belém do Pará,’ which establishes at its Article 7(c) the commitment of the states parties to: ‘include in their domestic legislation penal, civil, administrative and any other type of provisions that may be needed to prevent, punish and eradicate violence against women and to adopt appropriate administrative measures where necessary’ (78).

Paragraph 176: Mindful of the foregoing considerations, the Court concluded that: ‘… if based on what has been argued it turns out that life, as a constitutionally and internationally protected interest, cannot constitute a precondition of all other rights, in addition to the fact that even as a right it would at no moment be considered absolute; that its specific expressions domestically and internationally refer to the arbitrary deprivation of life and the prohibition on re-establishing the death penalty; that it is a problem of decriminalizing a specific conduct and that there is no specific constitutional mandate for its criminalization; and, finally, that the evaluation of the social conditions and weighing done by the Legislative Assembly of the Federal District is constitutional and is within its powers in keeping with democratic principles, this court sitting en banc considers that the arguments analyzed in this section in relation to the nature and existence of the right to life are unfounded.’

Paragraph 192: The IACHR concludes this report by reiterating the need for the States to continue making diligent efforts to apply the standards of the inter-American human rights system in all spheres of the exercise of government authority. The legal development by the inter-American system in the spheres of violence and discrimination against women should be accompanied by State initiatives to implement these standards domestically. The judgments analyzed point to the potential of the judicial branch as a key sector for the protection of women’s rights and the advancement of gender equality.

Paragraph 193: The next step in the struggle against discrimination and violence against women is to close the gap between the commitments assumed by the States and their full implementation domestically. As the IACHR has indicated previously: It is crucial that legal and policy achievements translate into concrete results for women in the Americas. To achieve this goal, we need collaboration and commitment from a variety of actors and entities. Among these, we highlight the importance and efforts of the States, civil society organizations and networks, regional and international agencies, the academic sector and the media.

175 The State of Mexico submitted, along with its response, a list identifying 26 decisions handed down by the Supreme Court of the Nation related to the issues of: (i) reproductive rights; (ii) gender equity; (iii) indigenous women; (iv) violence against women; (v) sexual rights; (vi) right to health; (vii) gender equity in political participation; (viii) equality and non-discrimination; and (ix) violence between spouses. In this section, the IACHR highlights two particularly important judgments, given that they are historic for Mexico for reproductive and sexual rights; and a third one on women’s political rights. The IACHR also notes that it has received information on judgments handed down by courts in Mexico associated with the issues discussed in this report by the organization GIRE and from Miguel Angel Antemate Mendoza, a graduate student at the Universidad Autónoma de México.

176 Specifically, the Court analyzed, within the “concepts of invalidity” raised by the moving parties, whether “in effect the [Mexican] constitution recognizes or does not recognize a right to life, and if so, what its normative bases would be.”

177 According to the final decision handed down by the court, the constitutional motion presented was found to be “partially founded and unfounded” and ordered that it be dismissed with respect to Article 148 of the Criminal Code for the Federal District and Article 16 bis(7) of the Law on Health for the Federal District, and the third transitory articles of the right challenged of reforms to those precepts. In addition, the validity of Articles 144, 145, 146, and 147 of the Criminal Code for the Federal District was upheld, along with Articles 16 bis(6), third paragraph, and 16 bis(8), last paragraph of the Law on Health for the Federal Distric.
3. Statements from Regional Councils and Organizations

African Union


Paragraph 54: WHO estimates that the leading causes of maternal mortality in Africa (excluding North Africa) are maternal haemorrhage (34%), hypertensive disorders (19%), maternal sepsis (9%), abortion (9%), and other maternal conditions (11%). However, data from other sources give higher proportions of maternal deaths due to abortion.

Paragraph 55: The 2008 WHO data indicate that unsafe abortions account for 12% maternal deaths in Southern Africa and Western Africa, and 18% in Eastern Africa. It is estimated that there were 2.4 million unsafe abortions in Eastern Africa in 2008, and that unsafe abortions account for 13,000 maternal deaths in the region every year. In the same period, there were about 1.8 million abortions in Western Africa, with about 28 unsafe abortions out of every 1,000 women of reproductive age. In comparison, there were about 120,000 unsafe abortions in Southern Africa in 2008. Unsafe abortions also cause other long-term maternal disabilities, which do not even get documented.

Paragraph 60: It is estimated that almost three-quarters of maternal deaths can be prevented by increasing women’s access to comprehensive reproductive health services, including antenatal care, having skilled attendants during childbirth, emergency obstetric care (including post abortion care), maternal nutrition, postpartum care for mothers, and family planning.

Paragraph 69: Except for South Africa, which has liberalized its abortion laws, all SADC countries had restrictive abortion laws. Considering that the removal of legal restrictions paves the way for the provision of safe abortion services that would save many women’s lives, it is important for SADC countries to continue reforming their abortion laws.

Paragraph 70: In Eastern Africa, unsafe abortions are estimated to account for almost 1 out of 5 of all maternal deaths (18%), the highest rate, while the Southern Africa region has the lowest rate, being almost 1 out of 10 maternal deaths (9%). The reasons for the region’s poorer abortion indicators could be partly explained by its restrictive abortion laws compared with the other regions’. The EAC countries only allow abortion in two instances: to save a woman’s life, and based on a woman’s physical and mental health. In Western Africa, unsafe abortions are estimated to account for almost 1 out of 8 of all maternal deaths (12%).

Paragraph 71: Considering that removing legal restrictions to abortion facilitates the provision and uptake of post-abortion care, and that safe abortion services can significantly reduce maternal deaths, countries that have very restrictive abortion laws should explore the possibilities of reforming their relevant policies. But having safe abortion services is not just about removing or relaxing legal barriers. It also entails addressing service-level challenges as well as stigma to ensure that women who legally qualify for safe abortion can access this service. Increasing access to FP is also cost-effective in reducing unplanned pregnancies, which drive many women to have unsafe abortions in circumstances where they cannot access safe abortion.

Recommendations maternal health. Abortion laws should be reviewed appropriately to prevent maternal deaths resulting from unsafe abortions; to provide post-abortion care; and enhance access to FP to reduce unplanned pregnancies, in the context of national laws.


Paragraph 5: This Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. It is a short term plan for the period up to 2010 built on nine action areas: Integration of sexual and reproductive health (SRH) services into PHC, repositioning family planning, youth-friendly services, unsafe abortion, quality safe motherhood, resource mobilization, commodity security and monitoring and evaluation. The Plan is premised on SRH in its fullest context as defined at ICPD/PoA 1994 taking into account the life cycle approach. These elements of SRHR includes Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and newborn care; Abortion Care (1Abortion as specified in para. 8.25 of ICPD/PoA, includes prevention of abortion, management of the consequences of abortion and safe abortion, where abortion is not against the law.); Family
Paragraph 17: Key strategies for operationalisation of the SRH Policy framework:

i. Integrating STI/HIV/AIDS, and SRHR programmes and services, including reproductive cancers, to maximize the effectiveness of resource utilization and to attain a synergetic complementary of the two strategies;

ii. Repositioning family planning as an essential part of the attainment of health MDGs;

iii. Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component;

iv. Addressing unsafe abortion;

v. Delivering quality and affordable services in order to promote Safe Motherhood child survival, maternal, newborn and child health.

vi. African and south-south co-operation for the attainment of ICPD and MDG goals in Africa.


The Council of Europe Commissioner for Human Rights

Human Rights Comment, Sex-selective abortions are discriminatory and should be banned, January 15, 2014.

…It is hard to address the problem of sex-selective abortions without being drawn into debates on abortion as such. However, the practice is highly problematic from the standpoint of the principle of equality between men and women. Irrespective of one’s choice to view the problem either as violence against the foetus or the woman, sex-selective abortion is a clear case of discrimination with strong elements of physical and psychological violence.

Member States, within their wide margin of appreciation, should find ways to put in place laws, policies and practices that allow the different legitimate interests involved to be taken into account. In the vast majority of Council of Europe member states, where abortion is legal, this includes an adequate framework that reconciles the possibility to have an abortion with the fight against discrimination.

We need strong deterrents to eliminate this practice, which also reinforces and perpetuates a climate of violence against women. Sex-selective abortions must be criminalised.