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Interpreting and Implementing Existing Abortion Laws in Africa

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Foreword



The promotion of maternal, newborn and child health (MNCH) across the African continent is a priority of the African Union Commission. The continent has, no doubt, recorded significant improvement with regard to MNCH status. The economic growth being experienced across the continent provides a further window of opportunity to consolidate on those gains and cover more ground.

Maternal, Newborn and Child Health status is a very critical indicator that provides an insight into the quality of life of any nation's citizens. Women account for about fifty percent of the continent's population. Therefore sustainable economic growth cannot be engendered unless they are empowered and their overall quality of life is improved.

Unsafe abortion unfortunately continues to contribute to morbidity and mortality in Africa. Each AU member state has laws in place to regulate the practice within its sovereign responsibility to promote community wellbeing. Evidence has shown that if these laws, irrespective of their apparently liberal or restrictive nature, are implemented with a view to saving women's lives and improving their health, the contribution of unsafe abortion to maternal mortality will be significantly contained. Evidence further shows that restrictive laws result in higher levels of unsafe abortion.

Failure to implement the laws, as they are, stems from several factors which include ignorance of the provisions of the laws. Therefore the AUC, in collaboration with Ipas, has developed this publication to empower the broad range of stakeholders to identify their rights (for right holders) and responsibilities (for duty bearers) within the existing laws.

It is my hope that this publication will serve as a practical and effective tool to improve maternal health status in Africa by stemming the tide of morbidity and mortality.

H.E Dr Mustapha .S. Kaloko
Commissioner for Social Affairs

Executive Summary

Unsafe abortion is one of the largest causes of maternal mortality and morbidity globally. In Africa, of the 6.4 million abortions carried out in 2008, only 3 percent were performed under safe conditions. The World Health Organization (WHO) estimates that in 2008, 29,000 African women died from complications of unsafe abortion, constituting a full 13 percent of maternal deaths in the region. In some individual countries, unsafe abortion accounts for up to 30 to 40 percent of maternal mortality. Unsafe abortions occur primarily in countries with restrictive abortion laws or practice regimes.

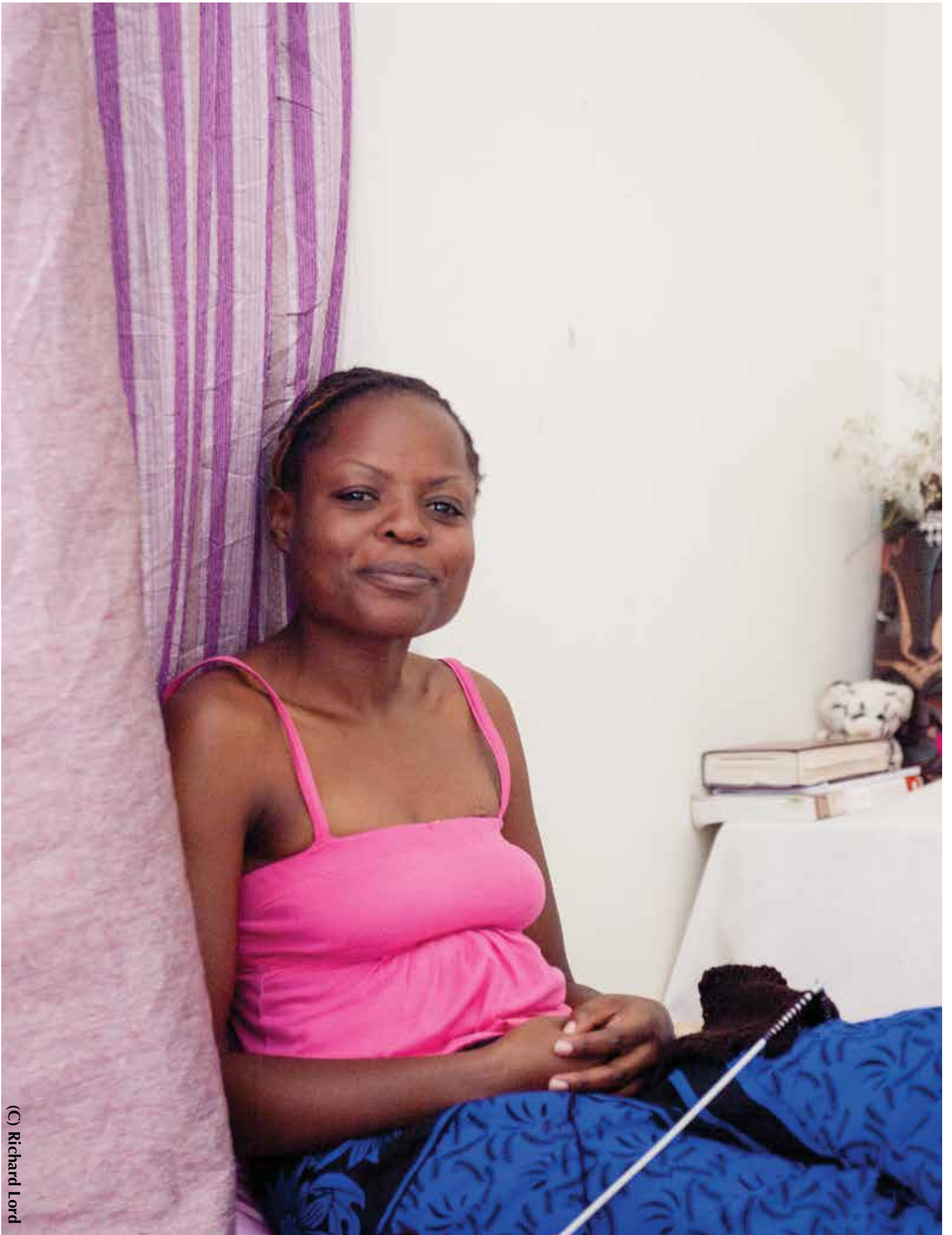
One of the reasons unsafe abortion occurs is because safe abortion services frequently are not available, even when they are legal, forcing women to undergo illegal and unsafe abortions. According to WHO, legal status and availability of lawful abortion do make a difference to the safety of abortions. While there are many steps that can be taken to prevent maternal mortality and morbidity, all African Union member states must take the important step of implementing current laws regulating abortion.

All African Union member states allow abortion at least to save a woman's life and many more permit it on broader grounds, including health grounds. However, few countries have taken positive steps towards ensuring women access to abortions they are entitled to under the law, causing women to seek unsafe abortions. World Health Organization standards and United Nations and regional commitments to reducing maternal mortality call upon states to take measures to ensure access to safe abortion, where legal, including by developing strategies and guidelines for providing safe abortion services.

International and regional human rights bodies and courts also have given increasing attention in recent years to abortion and its link to women's health and human rights. They have called on states to remove barriers to safe abortion services, including by implementing existing abortion laws. They require that laws, even when restrictive, are interpreted broadly and implemented to promote and protect women's health and human rights.

Examples from African Union member states show that when governments commit to ensuring that access to safe abortions is available within the law, incidence of unsafe abortions is reduced, as are maternal deaths from unsafe abortion. African Union member states must enact an enabling regulatory and policy environment, including development and dissemination of strategies and guidelines and training of providers, to ensure that every woman who is legally eligible has ready access to good-quality abortion services. South Africa, Ghana and Ethiopia are examples of countries where this is being done successfully.

This document offers guidance to African Union member states for effectively implementing existing abortion laws in ways consistent with prevailing human rights and public health guidance and to fulfill states' obligations to protect women's reproductive health and rights.



Introduction

There are approximately 22 million unsafe abortions annually worldwide, 98 percent of them in developing countries. Globally, unsafe abortion results in death for approximately 47,000 women and disabilities for an additional 5 million each year¹. This accounts for roughly 13 percent of maternal mortality, the third largest cause of maternal mortality, globally². African women bear the burden of more than half of these maternal deaths, with 29,000 deaths³. In many African Union member states, the percentage of maternal deaths resulting from unsafe abortion is much higher⁴. And young women are disproportionately impacted: more than 60 percent of all maternal deaths from unsafe abortion in Africa are among women under the age of 25⁵.

Restrictive abortion laws and policies are a major contributor to unsafe abortion. African Union member states have some of the most pervasive legal and practice restrictions in the world, resulting in high rates of maternal mortality and morbidity. In Eastern Africa, unsafe abortions are estimated to account for almost 1 out of 5 maternal deaths (18 percent), the highest rate in the world, while in Western Africa, it is 1 out of 8 (12 percent). The Southern Africa region has the lowest rate in the region, at about 1 out of 10 maternal deaths (9 percent). As explained in a recent report by the African Union Commission on Maternal Newborn and Child Health, Eastern Africa's poorer abortion indicators could be partly attributed to its more restrictive abortion laws compared with the other regions⁶.

World Health Organisation estimates confirm that the legal status of abortion does not reduce the number of induced abortions, as women will seek abortions if they need them, regardless of abortion's legal status. While abortion is a safe procedure when performed by skilled health care providers in sanitary conditions, clandestine and illegal abortions generally are unsafe and lead to high rates of complications and deaths⁷. According to the World Health Organization, the first steps for avoiding abortion-related maternal deaths are to ensure that women have access to

family planning and safe abortion. This will reduce unwanted pregnancies and unsafe abortions⁸.

International and regional human rights bodies and consensus documents also have consistently recognized that unsafe abortion leads to high rates of maternal mortality and have called on states to take measures to reduce such preventable deaths, by ensuring that abortion is available and safe. The problem is recognized as so acute in Africa that the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), ratified by the majority of African Union member states, expressly requires governments to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest" and when the pregnancy threatens the life or mental or physical health of the woman, and in cases where there is a threat to the life of the foetus.

All existing African national abortion laws, in fact, provide for legal abortion in some or all of the circumstances in the Protocol; no country in Africa has an absolute ban on abortion. Following global trends towards liberalising abortion laws—30 countries, including several in Africa, have liberalised their abortion laws over the past 20 years—a few countries in Africa also go beyond the minimal grounds of the Maputo Protocol and allow abortion also for socioeconomic reasons, or on request (Tunisia, South Africa, Cape Verde, Zambia and Ethiopia). Several other countries have taken positive steps towards effective implementation of existing abortion laws by issuing protocols and guidelines for the provision of safe abortion. In Ghana, for example, the current abortion law remained unimplemented for 25 years after it was enacted, although it allows abortion on grounds of physical and mental health. Recently, since 2005, the Ministry of Health is working to correct this situation by making safe, legal abortion accessible to women in Ghana.

Sadly, in many other African Union

According to the World Health Organization, the first steps for avoiding abortion-related maternal deaths are to ensure that women have access to family planning and safe abortion.



(C) Richard Lord

Lack of budgetary prioritization for reproductive health and maternal health services is also a significant barrier, especially for poor women.

member states there have been no steps to implement the law, resulting in preventable maternal deaths and disability. Several factors contribute to this failure. In many countries, providers, policymakers, women and other stakeholders wrongly believe that abortion is completely criminalized and not available under any circumstance under the law. This is usually due to lack of knowledge and information on the prevailing laws and an absence of standards and protocols for providing services within the law, leading to fear of criminal punishment and overall stigmatization of abortion. Thus, from country to country, similar laws are interpreted very differently, and women's access to safe legal abortion services can be very different.

It is not only the legal indications for abortion that are important. Economic status, geographical location and restrictive regulations are also significant obstacles to women seeking legal abortions. Limitations on types of health workers authorized to perform abortions and prohibitions on the use of medication abortion and other modern methods for safe abortion can have significant impact on accessibility, especially in rural locations. Lack of budgetary prioritization for reproductive health and maternal health services is also a significant barrier, especially for poor women. These factors contribute to high rates of maternal mortality and morbidity, which has been characterized by the World Health Organisation and the African Union as a major public health concern and by the United Nations as an infringement of women's human rights.

African Union member states must implement all legal indications for abortion to ensure improved access to safe, legal abortion. In order to achieve this, law and policymakers must make a concerted effort to review existing legislation on abortion and to take regulatory, budgetary, training and awareness-raising measures, including educating health-care workers, women and

communities on the lawfulness of abortion to ensure that all legal indications for abortion are implemented. Development and use of standards and protocols on safe, legal abortion will be an important step forward in reducing maternal deaths and disability, as shown by evidence around the world.

This document focuses on providing information to ministries of health and other relevant stakeholders to help interpret and implement existing abortion laws. It begins with a review of current laws on abortion in Africa and a brief overview of some barriers to implementation of these laws. While the barriers are many, due in part to deficiencies in drafting of the laws, this document does not attempt to address how to overcome them, but rather focuses on what African Union member states are obligated and committed to do and indeed can do in terms of implementing existing abortion laws. It then reviews international and regional consensus documents, with detailed information on human rights law presented in Annex II; World Health Organisation standards; and selected foreign laws, all with the aim of providing guidance on interpreting and implementing existing African abortion laws.

The chart in section IV provides a quick review of the legal indications in each country in Africa, with recommendations from WHO on implementing each indication. The brief case studies provided in Annex I reflect that while many laws governing abortion in Africa are similar, they are being implemented differently. A number of countries across Africa have increased access to safe abortion within the boundaries of their existing laws, resulting in fewer unsafe abortions. It is expected that this document will provide an indication of how African Union member states' ministries of health and other stakeholders can broadly interpret and implement existing laws, making abortion more readily accessible to women who need these services.

Summary of the Laws Guiding Abortion in Africa

African abortion laws came with colonisation, and these colonial laws have had and continue to constitute a significant influence on the restrictive features of African abortion laws. In pre-colonial times, abortion was generally treated as a private, not public, concern, to be resolved within the confines of the family or community. The imposition of colonial regimes significantly changed this, subjecting the regulation of abortion through replicas of laws in penal codes of colonial powers. Colonial abortion laws in Anglophone Africa are derived from the 1861 English Offences Against the Person Act and, in a more limited manner, subsequent English court interpretations. The abortion laws of the former colonies of Belgium, France, Italy, Portugal and Spain were heavily influenced by the Napoleonic Code of 1801 and still are largely retained by the former colonies of these countries. While all former colonial powers have liberalized their abortion laws, in furtherance of public health and human rights and to address abortion-related maternal mortality and morbidity, many African Union member states still adhere to these antiquated laws⁹.

Abortion laws in African countries still are generally found in the penal code and provide for a general prohibition on abortion with explicit exceptions—in most cases when pregnancy poses a threat to the life and health of the woman, and in some cases when pregnancy is a result of rape or incest or in cases of foetal impairment. Only the laws of Cape Verde, South Africa and Tunisia provide for abortion on request during the first twelve weeks of pregnancy and on other grounds, including socioeconomic circumstances, later in the gestational period. While Zambia does not allow abortion on request, it allows abortion on broad socioeconomic grounds. There is also a large bloc of countries that allow abortion for various indications, such as where a pregnancy puts a woman's health at risk or in cases of rape. A few countries have a mental health indication which is open to broad interpretation. The

remaining countries have more restrictive laws. However, no country on the continent has a complete ban on abortion¹⁰. Thus, all countries allow for abortion at least to save a woman's life. Twenty-nine (29) countries also permit abortion to preserve a woman's health¹¹, with nine (9) explicitly including mental health¹², and only one (1) explicitly limiting it to physical health¹³. Eighteen (18) countries also allow for abortion in cases of rape and/or incest¹⁴ and fifteen (15) allow in cases of foetal impairment¹⁵.

Postabortion care (emergency care for women who have experienced complications from an unsafe abortion)¹⁶, however, is required in all cases and in all countries, regardless of the legal status of abortion.

It is important to note that, in many instances, abortion is and can be permitted on broader grounds than currently available and still be within the bounds of the law. The challenge for African Union member states, in most cases, lies in the interpretation and implementation of the laws. As noted above, while some countries' laws may be almost identical, their interpretation and implementation may vary greatly. For example, even if there is no explicit recognition in the language of the law regarding mental health or rape, countries should allow for abortion on these grounds under the general health exceptions. In fact, international human rights law and the World Health Organisation's definition of health include mental health, and support this. For example, in the United Kingdom abortion law after which the Zambia law is fashioned, the health indication is considered enabling and an opening that provides broad access to most women seeking abortion.¹⁷ While ensuring that clinical judgments and services remain in the hands of a provider and his or her patient, clear guidelines and protocols by the Ministry of Health that interpret and provide guidance on existing abortion laws are critical to ensuring broad access to safe and lawful abortion services.

The challenge for African Union member states, in most cases, lies in the interpretation and implementation of the laws.



World Health Organisation Guidance on Safe Abortion Care

In the second edition of its ground-breaking 2003 publication *Safe abortion: technical and policy guidance for health systems*, the World Health Organisation presents recommendations for use by health ministries, program managers and providers around the world for providing safe abortion services within existing laws. The updated 2012 Guidance incorporates the evolving human rights rationale for providing safe, comprehensive abortion care, along with current clinical and public health evidence. The guidance is designed to help reduce the nearly 22 million unsafe abortions and the resulting almost 50,000 deaths that occur annually across the world.

The Guidance addresses legal and policy considerations recognizing the link between women's health and human rights and the need for laws that protect both. Using evidence-based and human rights standards, it recommends significant changes in the regulation of abortion. It advances evidence that legal restrictions on abortion do not result in fewer abortions. However, legal status and implementation of laws do impact the safety of abortions. WHO recognizes that even when abortion is legal, lack of clarity regarding the law and its implementation can prevent providers from offering services and women from accessing safe abortion services. WHO also notes that stigma surrounding abortion prevents women from accessing information about legal abortion and can deter women from seeking safe and legal abortion services or even postabortion

care when they face complications arising from unsafe abortions¹⁸.

WHO recommends that safe abortion services should be readily available for all legal indications and affordable to all women, including young women and adolescents. It recommends developing an enabling regulatory and policy environment to ensure that every woman who is legally eligible has access to safe abortion care. For example, it recognises that midlevel health professionals, such as midwives and clinical officers, can be trained to provide safe abortion services, increasing availability and accessibility without compromising safety, especially where doctors are few and not readily accessible to women. It also notes that since all countries that are members of WHO accept its constitutional definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"; laws that allow abortion to protect women's health should be interpreted in conformity with this broad definition¹⁹.

WHO recommends that national standards and guidelines for safe abortion services be developed to guide provision of safe services for the protection and promotion of the health and human rights of women²⁰. Since all African Union member states have some indication for legal abortion, all should of necessity have standards and guidelines to facilitate provision of services.

WHO recommends that safe abortion services should be readily available for all legal indications and affordable to all women, including young women and adolescents.

National Standards and Guidelines on Safe Abortion Care

Planning and managing safe, legal abortion care requires consideration of a number of health system issues, including the development of national standards and guidelines on safe abortion services. WHO recommends the establishment of national standards and guidelines facilitating access to and provision of safe abortion care to the full extent of the law. Standards and guidelines should address: types of abortion services; where and by whom they can be provided; essential equipment, instruments, medications, supplies and facility capabilities; referral mechanisms; respect for women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents; special provisions for women who have suffered rape; and conscientious objection by health-care providers. National standards and guidelines for safe abortion care should be evidence-based and periodically updated, to keep abreast with technological development and other new evidence. They apply whether services are public, private or not-for-profit.

-World Health Organization, Safe Abortion Guidance (2012)

How African Union Member States can implement current abortion laws, according to World Health Organisation recommendation

Legal Indication:	To save the woman's life	To preserve the woman's health- including mental health (also to save her life)	Rape or incest	Foetal impairment	Socioeconomic reasons	On request of the woman
Country:	All AU Member States	Algeria , Benin, Botswana , Burkina Faso, Burundi, Cameroon, Chad, Comoros, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia , Ghana , Guinea, Kenya, Lesotho, Liberia , Maldives, Morocco, Mozambique, Namibia , Niger, Rwanda, Seychelles , Sierra Leone , Swaziland , Togo, Zimbabwe	Benin, Botswana, Burkina Faso, Burundi, Cameroon, Ethiopia, Ghana, Guinea, Lesotho, Liberia, Mali, Namibia, Rwanda, Seychelles, Sudan, Swaziland, Togo and Zimbabwe	Benin, Botswana, Burkina Faso, Chad, Ethiopia, Ghana, Guinea, Lesotho, Liberia, Namibia, Niger, Seychelles, Swaziland, Togo and Zimbabwe	Zambia	Cape Verde, South Africa, Tunisia
Explanation:	While the majority of countries in Africa have laws explicitly allowing abortion to save the life of a woman, 13 do not, but the general criminal law defence of 'necessity' should apply in these countries, allowing abortion to be performed on the rationale that it was necessary to preserve the life of the woman.	Countries in bold additionally recognize an exception to preserve a woman's mental health. All other countries' laws permit abortion on grounds of 'health', with no limitations to physical health; only the Zimbabwean law limits grounds to physical health.			While Ethiopia and Rwanda, for example, do not allow on broad socio-economic grounds, they do allow on limited enumerated grounds relating to woman's age, capacity to care for a child, and financial status.	All three countries allow abortion on request during first 12 weeks of pregnancy and for other indications later in pregnancy.

<p>What all African Union member states can do, according to WHO:</p> <p>Establish evidence-based national standards and guidelines</p> <p>Ensure constellation of services</p> <p>Equip facilities and train health-care providers</p> <p>Finance abortion services</p> <p>Monitor, evaluate and improve quality of care</p> <p>Establish a process of planning and managing safe abortion care</p> <p>Ensure modern methods of abortion</p>	<p>All African Union member states should take steps to improve abortion access to save the life of the pregnant woman. This is consistent with the human right to life, which requires protection by law, including when pregnancy is life-threatening or a pregnant woman's life is otherwise endangered.</p> <p>African Union member states should not implement the life exception in a limited way to mean imminent death.</p> <p>Both medical and social conditions can constitute life-threatening conditions.</p> <p>African Union member states should not provide detailed lists of what they consider life-threatening medical conditions.</p> <p>Such lists may be interpreted restrictively or be considered exhaustive, when in fact they are meant to provide illustrations of situations that are considered life-threatening and do not preclude clinical judgment of what is life-threatening for a particular woman. In some cases, physicians argue that it is necessary to provide a safe abortion because, if they did not, the woman would risk her life by going to an unqualified practitioner (38).</p> <p>An example of a life-threatening social condition is a pregnancy that implicates so-called family 'honour'. For example, in some societies pregnancy out of wedlock may result in a woman being subjected to physical violence or even killed.</p> <p>Even where protecting a woman's life is the only allowable reason for abortion, it is essential that African Union member states take steps to ensure there are trained providers of abortion services, that services are available and known, and that treatment for complications of unsafe abortion is widely available. Saving a woman's life might be necessary at any point in the pregnancy and, when required, abortion should be undertaken as promptly as possible to minimize risks to a woman's health. All African Union member states should ensure treatment of complications from unsafe abortion is provided in ways that preserve women's dignity and equality.</p>	<p>African Union member states should fulfill human rights by ensuring that women can access safe abortion when it is indicated to protect their health.</p> <p>Physical health is widely understood to include conditions that aggravate pregnancy and those aggravated by pregnancy. It also includes mental health, which by WHO definition includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe foetal impairment. A woman's social circumstances are also taken into account to assess health risk.</p> <p>In many countries, the law does not specify the aspects of health that are concerned but merely states that abortion is permitted to avert risk of injury to the pregnant woman's health.</p> <p>Since all African Union member states that are members of WHO accept its constitutional description of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', African Union member states must use this description of complete health in the interpretation of laws that allow abortion to protect women's health.</p> <p>In addition, in some countries, no reference is made in the law to foetal impairment; rather, African Union member states should interpret health protection or social reasons to include distress of the pregnant woman caused by the diagnosis of foetal impairment.</p> <p>African Union member states must take steps to ensure that a woman is able to know the status of her pregnancy and to act on this information.</p>	<p>African Union member states must protect women from cruel, inhuman and degrading treatment by ensuring that those who have become pregnant as the result of coerced or forced sexual acts can lawfully access safe abortion services.</p> <p>Member states must take steps to ensure prompt, safe abortion services are provided on the basis of a woman's complaint rather than requiring forensic evidence or police examination or a judge's order.</p> <p>In addition, human rights standards note that African Union member states should interpret the rape provision in their laws to include all women and girls, including underage girls where sexual intercourse constitutes statutory rape.</p>	<p>African Union member states must read exceptions broadly to include serious foetal impairments, not simply fatal foetal impairment.</p>	<p>African Union member states that permit abortion for economic and social reasons should interpret the legal grounds with reference to whether continued pregnancy would affect the actual or foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health. Member states should also provide safe abortion for distress as a result of changed circumstance, for example, the distress of caring and providing for a child additional to existing family members.</p>	<p>The three AU member states have allowed abortion on request based on the recognition that women seek abortions on one, and often more than one grounds, and they accept all of these as legitimate, without requiring a specific reason. This legal provision recognizes the conditions for a woman's free choice. Most countries that allow abortion on request, however, set limitations for this ground based on duration of pregnancy.</p>
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Translating Health And Human Rights Standards Into Action: Brief Case Studies From Three Countries (Ghana, Ethiopia, Zambia)

A number of countries across Africa have increased access to safe abortion within their existing laws, taking steps to make safe services are widely accessible to women. The countries illustrated here were chosen to represent various sub-regions as well as legal systems. The case studies are intended to provide examples from countries that have made a concerted effort in recent years to implement abortion laws. They were also chosen, in part, based on information available to Ipas.

The approach taken by Ghana and Ethiopia is not only feasible but also urgently needed in other African Union member states, many of which have similar laws. These are two countries that, according to WHO, have made progress towards reducing maternal mortality. Zambia also offers evidence of recent progress. Even countries with restrictive laws have an obligation to make safe abortion available and accessible to the full extent permitted by such laws.

Ghana

The revised abortion law in Ghana, enacted in 1985, is fairly broad, allowing for abortion in cases of rape, where continuation of the pregnancy would risk the life of the woman or threaten her physical or mental health, or if there is substantial risk that child would suffer from a serious physical abnormality or disease. Yet despite these fairly broad grounds, this relatively enabling law, like similar laws in other countries such as Liberia, was for more than two decades not implemented effectively, resulting in unnecessarily high numbers of maternal deaths and disability.

To help reduce unwanted pregnancy and abortion-related maternal mortality and morbidity and to ensure high-quality, legal and safe and accessible abortion services to all women, in 2005 the Ghana Health Service and its partners developed and widely disseminated national standards, guidelines and protocols for comprehensive abortion services that include counselling, provision of contraceptives, and expanding the base of abortion providers²¹. Importantly, the guidelines define both physical and mental health broadly, using the WHO definition of health. For example, instead of focusing on mental illness, they emphasize ensuring that a woman's mental health would not be jeopardized.

Together with a number of partner

organisations, the Ghana Health Service implemented and is scaling up comprehensive abortion services in both the public and private sector. A number of key activities are being undertaken, including increasing awareness of the legal indications for abortion; training; monitoring and evaluation of abortion services; and expanding abortion and family planning services.

To inform policymakers, providers, women and communities that abortion is legal on fairly broad grounds in Ghana, sensitization and values clarification activities and education on the abortion law are being incorporated into implementation of abortion-care services. These educational activities include all hospital staff, even guards and other personnel who often direct women to the services ('whole-facility site sensitization'). Civil-society groups have conducted trainings for members of the media, lawyers, police officers and women in leadership roles on the incidence and impact of unsafe abortion, legal indications for abortion, and ways to prevent it. Community health nurses and local radio and television programs help disseminate accurate information about abortion to the wider community.

Training, monitoring and evaluation of abortion-related services have also been key.

Together with a number of partner organisations, the Ghana Health Service implemented and is scaling up comprehensive abortion services in both the public and private sector.

This includes training health-care providers to provide abortion using MVA (manual vacuum aspiration) up to 12 weeks gestation and expanding the base of abortion providers by authorizing midwives and nurses to perform first-trimester procedures. Peer monitoring and supervisory visits, mentoring, networking and other support systems have been implemented and are effective in improving quality of care and service providers' morale and confidence in the provision of lawful abortion services. In addition, although abortion is not yet cost-free, a fixed price for abortion services has been established in public facilities.

With the aim of ensuring wider access to safe and lawful abortion and reducing costs for the health-care system overall, medical abortion was included in the government-issued protocols and the Ministry of Health's essential drug list, and misoprostol was registered for obstetric and gynaecological use. These steps are in line with the WHO Safe Abortion Guidance, which recognizes that "medical methods of abortion have been proved to be safe and effective" and highlights that "registration and distribution of adequate supplies of drugs for medical abortion are essential for improving the quality of abortion services, for all legal indications"²². The MOH has revised the standards and guidelines to take care of certain gaps.

Efforts also have been made to improve access to family planning methods in order to reduce the number of unintended pregnancies, including improving the supply of contraceptives, reviewing relevant service protocols, and improving postabortion family planning services. In addition, Ghana's Strategic Plan for the Health and Development of Adolescents and Young Persons (2009 – 2015) specifically addresses comprehensive abortion care and family planning, including options counselling. Standards for adolescent- and youth-friendly services have been developed and are in use and training of regional resource teams to provide adolescent- and youth-friendly services is ongoing.

To date, comprehensive abortion services are being provided in 60 public and private health care facilities, including 12 hospitals and two main teaching hospitals. The ultimate goal is national coverage. It is expected that these measures to provide lawful safe services and respect the rights of Ghanaian women would soon manifest in reduced maternal deaths from unsafe abortions. Ghana has made significant progress towards improving maternal health, with a maternal mortality ratio of 350 to 100,000 live births.

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Ipas presentation by Dr Richard Turkson at workshop, Applying international and Regional Agreements to Reduce Maternal Mortality in Africa, a workshop for women leaders, 2007, on file with Ipas.

Ethiopia

Safe abortion services have not been available throughout much of Ethiopia's modern history. The penal code allowed abortions only to save the life or preserve the health of the woman. Combined with low rates of contraceptive supplies and use, and high rates of sexual violence, the restrictive law compelled many Ethiopian women to seek out the services of unskilled, back-street abortion providers, contributing to Ethiopia having one of the highest maternal mortality ratios in the world.

Recognizing the indisputable tragic impact of unsafe abortion and that ensuring women's access to safe abortion was consistent with existing government international commitments to women's reproductive health and rights and to gender equality, in 2004, the Ethiopian Parliament passed one of Africa's most progressive abortion laws. The new revised penal code allows abortions for rape, incest, foetal abnormality, and for physical or mental disability of the pregnant woman. The Parliament also approved abortion for minors physically or psychologically unable to care for a child.

In 2006, the Ethiopian Ministry of Health released guidelines for safe abortion services to implement the country's abortion law. The government has since worked with a range of development partners, including national and international NGOs, to make high-quality abortion care available at all levels of the public health care system. To date, comprehensive abortion care services are available at about 600 service delivery sites—aimed at ensuring that women throughout the country, especially poor, rural and young women, can obtain safe abortion care. In addition to developing evidence-based standards and guidelines based on WHO recommendations, related work has included:

- training doctors, midwives and other authorized midlevel and non-physician providers to provide abortion services (in the past five years, more than 5,000 health care workers have been trained);
- promoting access to safe and modern methods of abortion technologies, such as manual vacuum aspiration and approval and use of medication abortion drugs;
- integrating preventive contraception services, safe abortion and postabortion contraception into existing reproductive health care services;
- enabling private-sector providers to expand services; and
- strengthening supervision and monitoring and evaluation systems.

Limited knowledge of the legal status and availability of safe abortion among women, communities and health-care providers is an ongoing challenge that is being addressed. Strategies to overcome this challenge include cooperation with civil-society groups and community health workers to inform women of their legal rights and where to obtain safe abortion services; specific outreach to young women and adolescents through peer educators and university help points (adolescents make up more than 45 percent of those seeking abortion); values clarifications among health-care professionals; and sensitizing the media. These activities have been important not only in raising awareness about lawful abortion services but also in reducing pervasive abortion-related stigma and neutralising opposition to abortion.

Ethiopia's abortion law reforms and other efforts have begun to show results: the maternal mortality ratio has dropped by half in the past 10 years to 350 maternal deaths per 100,000 live births. In addition,

The new revised penal code allows abortions for rape, incest, foetal abnormality, and for physical or mental disability of the pregnant woman.

health-systems data show that many fewer women are seeking emergency treatment for complications of unsafe abortion or PAC, and senior obstetricians/gynaecologists attest to a dramatic decrease in mortality and morbidity from unsafe abortion. For example, the proportion of women seeking postabortion care at Ipas-supported service delivery sites has gradually declined, as women learn about the availability of safe legal abortion and resort less frequently to unsafe traditional abortion providers and methods. In 2008, half the women seeking abortion care at Ipas-supported health facilities required treatment for complications of previously induced unsafe abortion; in 2010 that proportion had shrunk to 15 percent, with 85 percent of women presenting at the facilities receiving safe induced abortion.



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African Union, Documenting Good Practices in Maternal, Newborn and Child Health Interventions, March 2013. <http://www.carmma.org/sites/default/files/PDF-uploads/MNCH%20Report%20on%20Good%20Practices.pdf>

Trends in Maternal Mortality, 1990 to 2010, WHO, UNICEF, UNFPA and the World Bank Estimates, 2012. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

Zambia

Since 1972, Zambia has had one of the most liberal abortion laws in Africa. Modelled on the law (1967) of the United Kingdom, it permits termination of pregnancy on health and socioeconomic grounds. However, safe, legal abortion remained largely inaccessible to women in Zambia until recent years. Numerous conditions contributed to this situation, notable among which are the lack of knowledge by providers, women and other stakeholders on the legal grounds for abortion and the availability of abortion services in public sector hospitals and clinics.

Growing concern over unsafe abortions and their impact on women's health and lives led the Ministry of Health to develop standards and guidelines for implementing the law, which were finalized and disseminated in 2009. The government is also working with development partners to expand access to safe abortion, including introducing comprehensive abortion care services at 25 sites over the past two years, serving thousands of women. Evidence shows that in communities where the law has been fully implemented through provision of these services, the proportion of women seeking postabortion care at these service delivery sites has declined.

Successful strategies include:

- Ministry of Health cooperation with a range of organizations to train providers in hospitals and health centres to provide safe and legal abortion and post-abortion care, including contraception
- increasing the availability of medication abortion, and
- working with community groups to raise awareness on the prevention of unplanned pregnancy, the dangers of unsafe abortion, the legal grounds for abortion and to decrease stigma around the issue.

Challenges, however, persist, and experts have suggested that Zambia could build on its achievements to date by considering WHO recommendations in areas such as ensuring the availability of needed equipment and supplies and improving supply chains; promoting use of the safest methods for first-trimester abortions, such as manual vacuum aspiration and medical abortion; allowing non-physician midlevel providers to perform abortions; and removing medically unnecessary legal barriers to abortion, such as requiring a number of doctors' signatures before an abortion can be performed.

The government is also working with development partners to expand access to safe abortion, including introducing comprehensive abortion care services at 25 sites over the past two years, serving thousands of women.

Sources:

Guttmacher Institute, Unsafe Abortion in Zambia, 2009

Namchana Mushabati, Abortion in Zambia, Open Society Initiative of Southern Africa, October 2012

United Nations Department of Economic and Social Affairs, Population Division, World Abortion Policies.

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Conclusion

Although many African Union member states still retain from their colonial legacies very restrictive laws on abortion, all allow abortion at least to save a woman's life, and many more permit it on broader grounds. International and regional consensus documents and human rights law affirm that all states have an obligation to make safe abortion available and accessible to women to the full extent of existing laws. African Union member states must take steps to fulfill that obligation, which include issuing standards and guidelines that encourage broad interpretation and implementation of existing laws; training health-care providers;

ensuring the availability of essential supplies and equipment; and informing health-care providers, women and communities about the legal status of abortion and where safe legal abortion services can be obtained. Guidance from the World Health Organisation guidelines on safe abortion and other sources supplement directives from human rights bodies to assist African Union member states in taking steps to ensure that women can access safe abortions to the extent permitted by law, and recent experience in several African Union member states offers further direction.



(C) Richard Lord

Annex I



Sources to Consider when interpreting and implementing Abortion laws

Numerous sources are available to help AU member states health ministries and other stakeholders to better interpret and implement their existing laws. African Union member states also are legally bound by provisions of major international and regional human rights treaties that are complemented by politically binding international consensus agreements which support a globally recognized right to access to abortion in certain circumstances, not least when abortion is lawful. World Health Organisation standards and guidelines

further support, at a minimum, the availability and accessibility of safe abortion within existing laws.

National laws and principles not only from domestic law but also foreign law can be useful and persuasive authority in this respect. Finally, case studies from other countries are sources that can provide significant guidance to African Union member states in developing measures to ensure women have access to safe and legal abortion services.

Select International and regional consensus documents and commitments

UN agreements: ICPD Programme of Action, Beijing Declaration

At the 1994 International Conference on Population and Development (ICPD), 179 countries agreed that population and reproductive health policies must be aimed at empowering couples and individuals—especially women—to make decisions about the size of their families, providing them with the information and resources to make such decisions. As such, States agreed that men and women have the right to access ‘methods of their choice for regulation of fertility which are not against the law’²³ and that where abortion is legal, it should be safe and accessible through the primary healthcare system²⁴. These standards were reinforced a year later at the World Conference on Women in Beijing which

also called for reviewing laws containing punitive measures against women who have undergone illegal abortions²⁵. During the five-year review of the ICPD Programme of Action, States agreed that health systems should increase women’s access to services where abortion is not against the law by training and equipping health-care providers and taking other measures to safeguard women’s health²⁶. States also agreed that “[i]n all cases, women should have access to quality services for the management of complications arising from unsafe abortion” and “post-abortion counseling, education and family-planning services should be offered promptly”²⁷.

National laws and principles not only from domestic law but also foreign law can be useful and persuasive authority in this respect.

The Maputo Plan of Action, CARMMA and UN Millennium Development Goal 5 in Africa

In 2005, the African Union adopted the Sexual and Reproductive Health and Rights Policy Framework as Africa’s road map for the implementation of the ICPD Programme of Action and the Millennium Development Goals (MDGs), including MDG 5 on reducing maternal mortality. The SRHR Policy Framework is aimed at ensuring universal access to sexual and reproductive health care by 2015. In 2006, African Union member states adopted the Maputo Plan of Action to implement the SRHR Framework and committed, as one of nine priorities, to reduce incidence of unsafe abortion through:

- Compiling and disseminating data on the

magnitude and consequence of unsafe abortion;

- Enacting appropriate policies and legal frameworks;

- Appropriately training providers on providing comprehensive abortion and postabortion care, and equipping facilities;

- Educating the public on availability of lawful abortion and, not least,

- Providing safe abortion services to the fullest extent of the law.

In 2010, the African Union Commission, in recognition of the daunting challenge of reducing maternal mortality in Africa, initiated the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). CARMMA serves as an advocacy platform for improvement of maternal and child health that has been launched by over 40 African Union member states. It recognizes that preventable maternal mortality and morbidity are pressing human rights issues and calls for the implementation of specific legal obligations. Also, the 2012 Annual Status Report of Maternal, Newborn and Child Health in Africa of the AU Commission addresses the impact that restrictive laws and lack of implementation of existing abortion laws have on poor

maternal mortality indicators. It recognizes that ensuring access to safe abortion services includes addressing service-level challenges and stigma that hinder access to services for women who legally qualify for abortion and for ensuring postabortion care. It also notes that countries with very restrictive laws should explore reforming such laws, considering that the “removal of legal restrictions and the provision of safe abortion services saves women’s lives”²⁸. The report recommends to member states that “abortion laws be reviewed to prevent maternal deaths from unsafe abortions and to provide post-abortion care”²⁹.

The report recommends to member states that ‘abortion laws be reviewed to prevent maternal deaths from unsafe abortions and to provide post-abortion care.’

International and regional human rights standards

A series of United Nations and regional human rights bodies and treaties have strengthened and broadened the consensus agreed upon in international and regional documents recognizing that failure to implement laws on abortion results in preventable deaths and ill-health. They have found restrictive abortion laws and lack of implementation of laws as incompatible with treaty obligations to respect, protect and fulfil human rights, including the right to life, health, privacy, information, freedom from cruel and

degrading treatment, and freedom from discrimination. They have recognized that these human rights commitments obligate states to ensure access to safe abortion, in certain circumstances (see Annex II), to implement existing abortion laws and to provide postabortion care. All African Union member states have ratified several or all of these international and regional human rights treaties and are bound to their provisions.

Human rights law framework

International and regional human rights law lay down minimum obligations which States are bound to respect. By becoming parties to international and regional treaties, African Union member states assume obligations and duties under international law to respect, to protect and to fulfill human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against

human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights.

Through ratification of international and regional human rights treaties, States undertake to put into place domestic measures and legislation compatible with their treaty obligations and duties. States can, however, protect rights beyond these minimum standards.

The Maputo Protocol

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) affirms women’s reproductive autonomy as a human right. While other human rights

instruments infer the right to abortion from broader fundamental rights, the Maputo Protocol is the only international or regional human rights treaty that explicitly articulates in the provisions of a treaty the

right to abortion for several indications (see box). This provision recognizes the critical benefits that ensuring access to abortion has for women, their families and communities, on a continent burdened by extremely high maternal mortality and morbidity. As described by African legal scholar Professor Charles Ngwena, "... by inscribing abortion in the Protocol, the drafters have ensured that unmet abortion needs are given voice at the highest regional, juridical level and that the violation of abortion rights by the nation-state cannot be insulated from human rights

scrutiny by the African Charter treaty bodies."

Forty-eight of the 54 African Union member states have signed the Maputo Protocol, and 36 countries have thus far ratified it and are bound by its provisions³⁰. Only two countries have placed reservations to Article 14. However, these reservations have no effect on existing legislation, do not create new legislation, nor do they preclude implementation or development of legislation to increase access to safe and legal abortion in the future³¹.

Article 14 of the Maputo

States Parties shall take all appropriate measures to: protect the reproductive rights of women by authorising 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.
-- Article 14[2][c] of the Maputo Protocol

United Nations Human Rights Bodies

Numerous United Nations human rights bodies tasked with interpreting the meaning and scope of human rights have linked maternal mortality and morbidity to various human rights, including the right to life. They have articulated that states

have a responsibility and legal obligation at an absolute minimum to ensure women have access to abortion where legal. (For information on the mandates of the various bodies presented below, see Annex II.)



The United Nations Human Rights Council

In recent historic resolutions, the UN Human Rights Council recognized that states must eliminate preventable maternal mortality and morbidity and encouraged states and other stakeholders at all levels to address the root causes of the problem, such as gender inequality, poverty, harmful practices, and lack of accessible and appropriate health care services³². As a follow up to these resolutions, the Office of the High Commissioner for Human Rights issued

technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal mortality and morbidity. The guidance includes recommendations that national plans for improving maternal health include access to safe abortion services where legal, and to ensure that appropriate protocols are issued and disseminated by the ministry of health to provide for abortion where it is legal³³.

The United Nations Special Rapporteurs

Several UN Special Rapporteurs have also raised serious concerns regarding lack of State implementation of existing abortion laws and prevailing restrictive laws. The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in a report to the UN General Assembly in 2011, recognized the severe physical and mental health consequences of unintended pregnancy and unsafe abortion. The Rapporteur's report recommended that States decriminalize abortion, ensure access to safe and legal abortion, and ensure that accurate information concerning the legal

availability of abortion is publicly available and that health-care providers are aware of the law related to abortion and what is allowed. Furthermore, he recommends ensuring access to essential medicines and services that make legal abortion safer and easier to access, especially in rural settings.³⁴ Another report, issued in 2013 by the UN Special Rapporteur on Torture, reiterated these concerns and further recommended that "States whose domestic laws authorize abortion under various circumstances should ensure that services are effectively available without adverse consequences to the woman or health professional"³⁵.

These bodies have noted the close link between the right to life and maternal mortality, recommending that impediments to women's access to life-saving services, such as safe abortion, be removed.

UN Treaty Monitoring Bodies

UN Treaty Monitoring Bodies have a mandate to provide interpretative guidance to states on fulfilling their specific human rights obligations under each of the treaties they have ratified. While not having abortion in the substantive texts, as does the Maputo Protocol, the treaty bodies have recognized abortion rights as integral to the realization of fundamental rights protected in treaties, including the rights to life, health, privacy, the right to be free from discrimination and even from torture and inhumane and degrading treatment. They have noted that these rights are violated when governments make abortion services inaccessible to women who need them. Under international law, governments can and have been held accountable for not ensuring that abortion

is accessible when it is legal and for having highly restrictive laws. States are responsible for deaths and disability when women are forced to resort to unsafe abortions. These bodies have noted the close link between the right to life and maternal mortality, recommending that impediments to women's access to life-saving services, such as safe abortion, be removed³⁶. The CEDAW Committee has explicitly stated, 'it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.'³⁷ (For specific information on recent recommendations to African Union member states from UN Treaty Monitoring Bodies and from African Commission on Human and Peoples' Rights, see Annex II).

a. States have an obligation to implement existing abortion laws

African Union member states have a general obligation to guarantee, under democratic principles and respect for the rule of law, that laws are being implemented. In the

area of abortion, these principles become even more imperative because of the loss of life resulting in non-implementation. In fact, UN and regional human rights bodies

have consistently called on states to ensure that abortion laws be implemented; where abortion is legal, it should be accessible. A recent judgment by the CEDAW Committee found that the absence of laws and regulations governing access to therapeutic abortion amounts to a violation of numerous human rights, including the right to be free from discrimination. It held that upon legalizing abortion, the state assumes the obligation to establish an appropriate legal framework to enable women to “exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals that must perform it”³⁸.

Significantly, the African Commission on Human and People’s Rights recently addressed this issue in relation to compliance with the African Charter on

Human and Peoples’ Rights, calling for measures to be taken to ensure reduction in unsafe, out of hospital, abortions (Nov 2011). The European Court of Human Rights has also declared, similar to the UN treaty bodies and the African Commission that, “once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it”³⁹. In these cases, women, including an adolescent in Poland, faced doctors’ unwillingness to provide legal abortions, even for rape, in part, due to the lack of standards and protocols that guide implementation of the law⁴⁰. In a case against Ireland, the Court also found a violation of the right to private life when the state failed to implement the existing right to abortion when a woman’s life is in danger. The Court called on Ireland to pass legislation doing so⁴¹.

b. States have an obligation to ensure access to an abortion when a pregnancy threatens a woman’s life or health

All UN treaty bodies have consistently noted that in order to prevent maternal mortality and morbidity, and guarantee the right to life and health of women, states must ensure access to safe and legal abortion when a woman’s life or health is in danger. As noted above, all African Union member states permit abortion when a pregnancy threatens the life of a woman and most African laws additionally entitle women to have an abortion when either their life or health is in danger. While many countries have explicit mental health exceptions, others do not specifically have a mental health indication as this is inferred in the health indication. The World Health

Organization defines health as “a state of complete physical, mental and social-well-being and not just the absence of disease or infirmity”⁴². In fact, many states around the globe interpret general health exceptions in their abortion regulation consistent with this definition. CEDAW and the Human Rights Committee, for example, have recommended that states read the health grounds in abortion regulation broadly to include mental health⁴³. This includes, but is not limited to, mental health implications of carrying a pregnancy as a result of rape and in cases of foetal impairment⁴⁴. (For detailed information on UN case law on this issue, see Annex II).

Right to life protections in international treaties do not apply before birth

Opponents to abortion have attempted to make the claim that right to life protections set forth in international and regional human rights treaties are accorded before birth, therefore prohibiting states from allowing abortions. In fact, no UN human rights treaty recognizes in its text the right to life prior to birth⁴⁵. As explained by noted African legal scholar, Prof. Charles Ngwena,

‘...drafters of international human rights

*instruments... have consciously desisted from using language that would have been incompatible with asserting abortion rights. It is particularly noteworthy that the drafters resisted calls to recognize in substantive texts of treaties, fundamental rights as attaching at conception rather than at birth. ...and [thus] leave open sufficient window of opportunity for the recognition of abortion rights as unenumerated rights*⁴⁶.

Accordingly, international human rights bodies have found restrictions on access to abortion in law or in practice as a violation of state obligations; **no human rights body has ever found allowing termination of pregnancy to be incompatible with the right to life or other human rights obligations**⁴⁷. At the regional level, both the

European Court of Human Rights and the Inter-American Court of Human Rights have also rejected claims asserting that right to life protections in their respective treaties apply prenatally⁴⁸. They have, however, like UN bodies, recognized that prenatal interests can be protected through promoting the health and well-being of pregnant women.

c. States have an obligation to ensure access to an abortion in cases of sexual assault, rape and incest.

Sixteen African Union member states entitle women to undergo abortion in instances of rape (see above). However, countries that do not have this explicit exception may allow abortion in these cases on health grounds, as the short- and long-term consequences of sexual violence on women's physical, mental and sexual and reproductive health can be devastating⁴⁹. As noted above, the Maputo Protocol obligates African Union member states to ensure access to abortion in cases when the pregnancy is a result of 'sexual assault, rape, incest.' UN treaty

monitoring bodies, including the Children's Rights Committee, have consistently urged countries to implement laws establishing rape and incest as grounds for abortion and have repeatedly urged countries that do not allow this to amend their laws to this effect⁵⁰. In addition, the Committee on Economic, Social and Cultural Rights has recently recommended a state to reform an abortion law which allows abortion only in cases of rape of a woman with a disability to expand it and allow for all women, regardless of disability⁵¹.

Sexual Violence in Africa

The link between sexual violence, unwanted pregnancy and unsafe abortion is clear. While comprehensive data are hard to come by, WHO has characterized sexual violence as a major public health problem and a violation of human rights. Around the world, including in Africa, girls and young women experience higher rates of sexual violence than adult women, contributing to their higher risk of unwanted pregnancy and unsafe abortion. For example, many girls and young women in several AU member states report having

forced sexual intercourse. Even where abortion is legal in these circumstances, women and girls who become pregnant as the result of sexual violence can face barriers to accessing safe abortion care.

International human rights treaties and documents support girls' and young women's right to comprehensive sexual and reproductive health including to safe abortion, if they so choose.⁵²

In two separate cases the Human Rights Committee and CEDAW Committee found that by failing to provide young women with a legal therapeutic abortion in cases of rape, governments had violated numerous rights, including the rights to equality and non-discrimination, the right to privacy and the right to be free from torture or cruel, inhuman and degrading treatment.

Both committees recognized the mental suffering of the young women who were raped, calling for a broad interpretation of health exception in accordance with the WHO definition of health and the issuance of standards and guidelines on preventing unsafe abortion⁵³. (For more information on these cases, see Annex II.)

d. States have an obligation to ensure access to abortion in cases of foetal impairment

A few African Union member states do have laws explicitly allowing abortion in cases of foetal impairment, in compliance with the Maputo Protocol and international human rights law. International human rights bodies, including most recently by the Committee on Economic Social and Cultural Rights, have

also called on states to amend laws to permit abortion on grounds of foetal impairment⁵⁴. And as noted in the cases above, a general health exception can also be understood to include foetal impairment grounds, in line with the WHO definition of health.

Constitutional Principles and Commonwealth Jurisprudence

Constitutions across Africa provide ample support to ensure women's access to safe abortion, in line with national and international human rights standards. In fact, countries across the globe have acknowledged in the ICPD Programme of Action that "reproductive rights embrace certain human rights that are already

recognized in national laws...⁵⁵". In addition, constitutional and high courts in Africa, as elsewhere in the world, have found it useful to look at foreign law when interpreting national laws⁵⁶. Moreover, jurisprudence from one Commonwealth country can have legal or persuasive authority in another Commonwealth country.⁵⁷

Constitutional provisions and applicability of international law

Like international and regional human rights conventions, constitutions protect rights that support an expansive interpretation of existing laws concerning access to abortion. These constitutional protections include the rights to dignity, life, health, privacy, the right to be free from inhumane and degrading treatment, and the rights to equality and non-discrimination.

The constitutions of most African Union member states recognize international treaties on an equal basis or higher than national law.⁵⁸ A state that ratifies an international convention 'establishes on the

international plane its consent to be bound by a treaty'⁵⁹ and thus, is obligated to protect the rights guaranteed by these instruments.

Constitutional and high courts as well as legislatures around the globe have often relied on international human rights law to interpret their laws governing abortion, overturning restrictive laws or upholding liberal laws based on international human rights obligations⁶⁰. Hence, in accordance with constitutional law principles, states should protect the rights guaranteed by the Maputo Protocol and other international human rights bodies on abortion.

African Constitutions Do Not Support Bans on Abortion

Almost all constitutions in Africa conform to international human rights law, guaranteeing the application of the right to life after birth (see above). Only five African Union member states directly address termination of pregnancy in their constitutions. The provisions in four of them clearly do not preclude access to abortion, but either stipulate when abortion is allowed or that

there is no right to terminate a pregnancy in the absence of a law permitting them to do so.⁶¹ And all these countries do in fact have such laws. The fifth country, whose constitution protects life before birth, would allow abortion in cases when a woman's life is in danger (see information on defense of necessity, above).⁶²

Select commonwealth Jurisprudence

Since the laws in Anglophone African countries have common derivation, the implications of decisions from Commonwealth countries are significant and are applicable in some African Union member states⁶³. Most former British colonies continue to have abortion provisions very similar to those at issue

in two landmark cases from England and Northern Ireland regarding interpretation and implementation of abortion laws. African Union member states can use these cases in court and at the ministry level to more broadly interpret existing abortion laws.

Rex v Bourne (1938)

Rex v Bourne was the first case to address the grounds on which an abortion could be legally provided in England. It is significant in that it set forth a general legal framework for permitting abortion to preserve a woman's

life or health, interpreting the life exception -- the only exception to abortion at the time in England -- to include mental and physical health, as well as rape. The case acquitted an abortion provider who performed an

abortion on a young girl who was raped. The judge reasoned in his instruction to the jury that the exception to the prohibition on abortion to 'preserving the life of the mother' should be understood not only as a duty to perform an abortion to save a woman from 'instant death' but also if the 'consequence of the continuation of the pregnancy will be to make the woman a physical or mental wreck,' that this is acting within the boundaries of the law. In doing so, he recognized both the physical harm that early pregnancy and childbirth can have on a girl as well as the mental health implications. The case is also significant in that it provided for access to legal abortion in cases of rape, stemming from the life exception. The judge stated that

"a girl who for nine months has to carry in her body the reminder of the dreadful scene and then go through the pangs of childbirth must suffer great mental anguish"⁶⁴.

Jurisprudence from courts across Commonwealth countries as well as legal scholars have recognized the distinguished place *Rex v Bourne* has in not only setting forth a general legal framework for permitting abortion to preserve a woman's life or health, but also on the general legal concept of the defense of necessity, which would allow abortion to be performed on the rationale that it was necessary to preserve the life of the woman⁶⁵.

Family Planning Association of Northern Ireland v Minister for Health Social Services and Public Safety (2004)

A 2004 judgment from a Northern Ireland domestic court is significant in addressing state obligations to clarify legal indications for abortion and for the ministry of health to issue guidance on the subject. In 2004, the Court of Appeal of Northern Ireland held that the Department of Health, Social Services and Public Safety failed to perform its duties to provide women seeking lawful abortions with satisfactory health services. The Court found the Department failed to investigate whether women were receiving satisfactory abortion services and to provide

guidance as to the availability of legal abortion services. As a consequence of the lack of guidelines, the Court found that health-care practitioners were confused as to the state of the law, and that some women were denied access to abortion services to which they were legally entitled⁶⁶. The Court held that ministries could be held liable for violations of national or international human rights duties when they fail to provide guidance for women to receive such services⁶⁷.

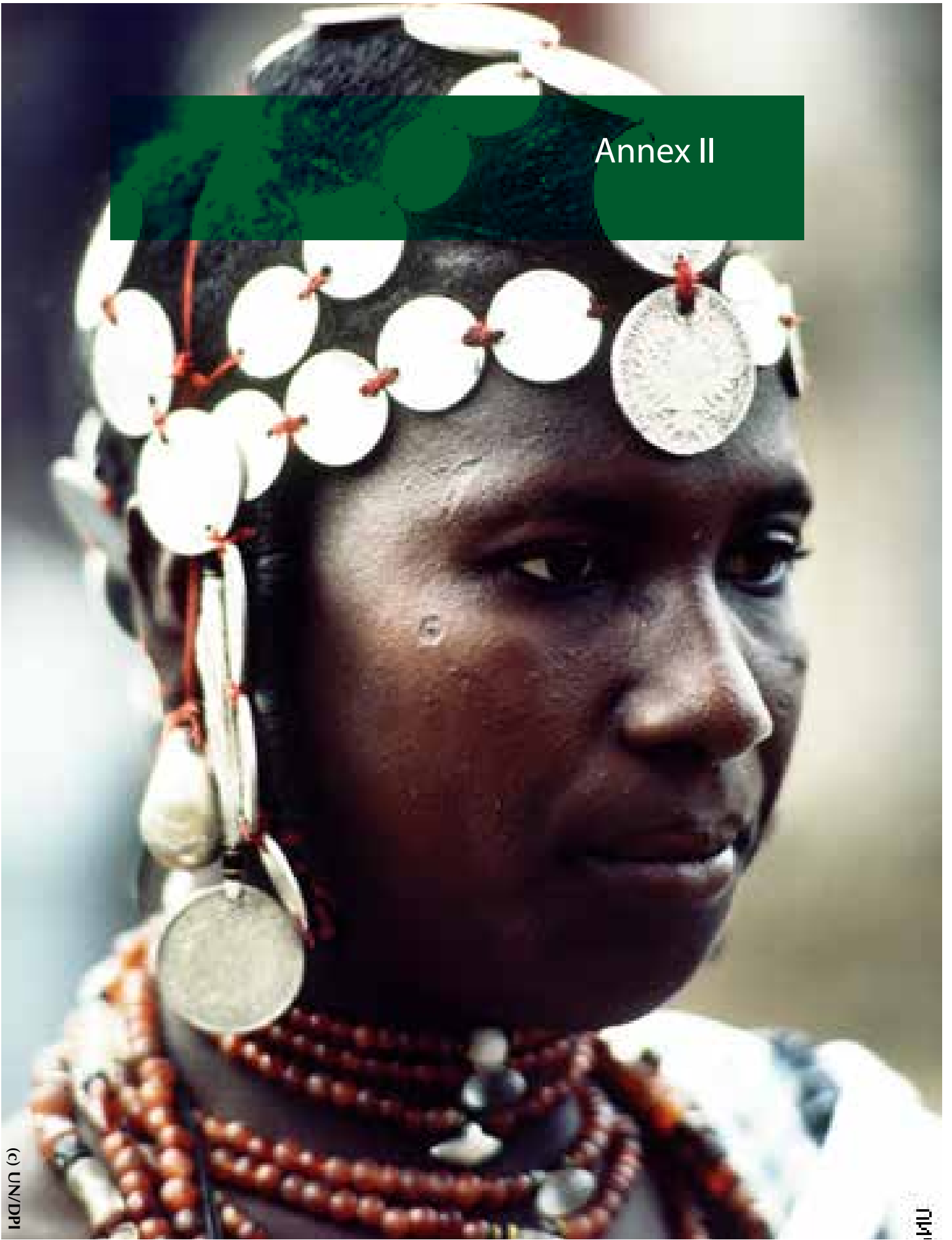
Christian Lawyers Association of South Africa and Others v Minister of Health and Others (1998) and Christian Lawyers Association v National Minister of Health and Others (2004)

Both of these decisions by High Courts upheld the constitutionality of the South African Choice on Termination of Pregnancy Act of 1996. In the first, a High Court agreed with the government that constitutional rights do not apply to fetuses and the Act could therefore stand⁶⁸. In the 2004 case, a High Court upheld the constitutional validity of Section 5 of the Choice on Termination

of Pregnancy Act of 1996, which permits a minor who has the capacity to give informed consent to terminate a pregnancy without parental approval or consultation. The court rejected the argument that Section 5 was contrary to Section 28 of the South African constitution which guarantees children's rights, including the rights to parental care⁶⁹.

The Court held that ministries could be held liable for violations of national or international human rights duties when they fail to provide guidance for women to receive such services.

Annex II



Further Information on Human Rights Law

Select International and regional consensus documents and commitments

UN Treaty Monitoring Bodies: Each of the major human rights treaties has a committee made up of individual experts whose mandate is to monitor and provide guidance to states to ensure their compliance with the treaties. They do this in several ways, including through a country reporting process, which requires states to report periodically on their efforts to respect, protect and fulfill human rights enshrined in a treaty. Following these reports and in-person dialogues with government representatives, they issue concluding observations on where countries have met their obligations and provide recommendations on measures to take where meeting obligations have fallen short.

Every year, these observations are compiled in a report and sent to the General Assembly of the UN. The committees also issue general comments and recommendations which are not country-specific, but which address measures that all countries can take to implement specific rights or issues covered by the treaty. Finally, most committees can also hear individual complaints against a specific country alleging violations of the treaty. Taken together, the concluding observations, general comments, and case decisions of the committees guide governments and advocates in further advancing human rights.

UN Special Rapporteurs are independent human rights experts with mandates to report and advise on human rights from a thematic perspective. There are currently 36 thematic mandates. They undertake country visits, send communications to states when

there are concerns of individual or structural human rights violations, conduct thematic studies, and engage in advocacy and raise public awareness. They report annually to the UN Human Rights Council.

The UN Human Rights Council is an intergovernmental body within the United Nations system responsible for strengthening the promotion and protection of human rights around the globe and for addressing situations of human rights violations and making recommendations on them. It has

the ability to discuss all thematic human rights issues and situations that require its attention throughout the year. The Council is made up of 47 United Nations Member States that are elected by the UN General Assembly on a rotating basis.

African Commission on Human and Peoples' Rights: The African Charter on Human and Peoples' Rights created the Commission to promote, protect and interpret the provisions of the Charter. The Commission ensures protection of human and peoples' rights through its communications procedure, friendly settlement of disputes, state reporting (including consideration of NGOs' shadow reports), urgent appeals and other activities

of special rapporteurs and working groups and missions. The Commission is mandated to interpret the provisions of the Charter upon a request by a state party, organs of the AU or individuals. The Commission also adopts resolutions expounding upon the provisions of the Charter. Additional activities include: sensitization, public mobilization and information dissemination through seminars, symposia, conferences and missions.

The African Court on Human and Peoples' Rights is a continental court established by African countries to ensure protection of human and peoples' rights in Africa. It

complements and reinforces the functions of the African Commission on Human and Peoples' Rights.

Key UN and African Human Rights treaties and their corresponding monitoring body

Human Rights Treaty	Monitoring Body
(UN) Convention on the Elimination of All Forms of Discrimination against Women	CEDAW Committee
(UN) Convention on the Rights of Persons with Disabilities	Committee on the Rights of Persons with Disabilities
(UN) Convention on the Rights of the Child	Committee on the Rights of the Child
(UN) International Covenant on Civil and Political Rights	Human Rights Committee
(UN) International Covenant on Economic, Social and Cultural Rights	Committee on Economic, Social and Cultural Rights
(UN) International Convention on the Elimination of All Forms of Racial Discrimination	Committee on the Elimination of Racial Discrimination
(UN) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment	Committee against Torture
(AU) African Charter on Human and Peoples' Rights	African Commission on Human and Peoples' Rights and African Court on Human and Peoples' Rights
(AU) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)	African Commission on Human and Peoples' Rights and African Court on Human and Peoples' Rights

Recent UN Treaty Monitoring Body recommendations to African Union member states

When reviewing state compliance with treaty provisions, treaty monitoring bodies have praised African Union member states for their participation in campaigns, such as CARMMA,⁷⁰ but they have consistently raised concern over the high rates of maternal mortality and morbidity, including those from unsafe abortions⁷¹. They have implored states to combat unsafe abortion by reviewing laws that are highly restrictive, which force women and adolescent girls to seek unsafe and illegal abortions with attendant risks to their life and health⁷². They have recommended states to ensure

implementation of existing laws and to amend and liberalize laws⁷³ at a minimum, in cases where the pregnancy poses a risk to the life or health of the pregnant woman, in cases of severe foetal impairment, or when a pregnancy is the result of rape or incest⁷⁴. UN treaty bodies have also praised countries that have liberalized their laws on these grounds⁷⁵ (which are also the minimum mandated to the Maputo Protocol) and have identified absolute bans on abortion and abortion as a punishable offense as being contrary to international human rights⁷⁶.

Recent recommendation from African Commission on Human and Peoples' Rights

In 2011, the African Commission issued ground-breaking concluding observations and recommendations to a member state during the periodic report to the Commission on its implementation of obligations under the African Charter on Human and Peoples' Rights. Recognizing high rates of maternal death and disability as a big problem in the

country, the Commission recommended to the government of the member state to further reduce maternal mortality and "provide adequate and comprehensive maternal health facilities for women, including ensuring that unsafe, out of hospital abortions are prevented"⁷⁷.

Case law from UN and regional human rights bodies

States have an obligation to ensure access to an abortion when a pregnancy threatens a woman's life or health

The UN Human Rights Committee in the case of *K.L. v Peru* articulated the important intersections between foetal impairment and women's mental and physical health when determining whether *K.L.* was entitled to a therapeutic abortion under the law. Like many abortion laws in African countries, the Peruvian abortion law only permits abortion in cases when a woman's health or life is in danger. *K.L.* was denied the abortion by physicians, in part, because the law did not have an explicit foetal impairment

exception. The Committee, however, applied WHO's holistic definition of health in determining that she was entitled to an abortion under the law. In doing so, the Committee recognized the mental distress to which she suffered when she was forced to carry the pregnancy of an impaired foetus to term. The Committee found that denying *K.L.* an abortion to which she was entitled violated her right to privacy and the right to be free from cruel, inhumane or degrading treatment, amongst other rights⁷⁸.

States have an obligation to ensure access to an abortion when a pregnancy threatens a woman's life or health

Peru's law only allows abortion when a pregnancy poses a risk to the life or health of a woman; there is no explicit rape indication. In a case before the CEDAW Committee, *L.C. v Peru*, the Committee found that the 13-year-old rape victim was entitled to an abortion under the health exception for both physical and mental health. In addition to finding violations of the Convention for failing to provide her with a lawful,

therapeutic abortion, the Committee also urged Peru to "review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse." The abortion law before the Human Rights Committee in the case of *L.M.R. v Argentina*, allowed for abortion on grounds of rape of a disabled woman, but due to stigmatization of the procedure, lack of knowledge of the law, and the chilling effect of criminal

sanctions, medical providers refused to perform the procedure, forcing the mentally disabled young woman to seek a clandestine abortion. The Human Rights Committee found a violation of numerous rights, including the right to be free from inhumane and degrading treatment, the right to private life and the right to an effective remedy.

While the African human rights system has yet to hear a case concerning access to abortion in cases of rape, both the European Court of Human Rights and the Inter-American Commission on Human Rights have done so. The case of *Paulina Ramirez v Mexico*, concerned a 13-year-old who became pregnant after being raped by a burglar. Despite being legally entitled to an abortion under the state's criminal code, she was repeatedly denied by state authorities and was forced to carry the pregnancy to term. Her case went to the Inter-American

Commission and was resolved through a formal settlement in which the Mexican Government acknowledged that she was entitled to an abortion under the law, and that by failing to ensure access to a legal abortion, it had violated her human rights. The state agreed to take measures to give effect to the law and to provide for damages and compensation to Ms. Ramirez, including psychological care. In a case concerning barriers a 14-year-old girl faced in accessing a lawful abortion in Poland on grounds of rape, the European Court of Human Rights held that states have an obligation to implement their abortion laws and that, in this case, state failure to properly implement in a timely manner abortion on grounds of rape led to a violation not only of privacy but also the right to be free from inhumane and degrading treatment.



¹World Health Organization. 2012. *Safe abortion: technical and policy guidance for health systems*. Second edition. Geneva:WHO, http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/ [hereinafter *WHO Safe Abortion Guidance*, 2012].

²World Health Organization, 2011. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed., Geneva: WHO. [hereinafter *WHO Unsafe Abortion*, 2011].

³According to WHO, 29,000 women die each year in Africa from complications of unsafe abortion. *WHO Unsafe Abortion*, 2011.

⁴Khalid S Khan, Daniel Wojdyla, Lale Say, A Metin Gülmezoglu, Paul F A Van Look, WHO: *Analysis and Causes of Maternal Death: a systematic review*, *Lancet* 2006; 367: 1066–74. Available at: https://centre.icddrb.org/images/WHO_Analysis_of_Causes_of_Maternal_Death_-_Khan_&_co..pdf

⁵WHO *Unsafe Abortion*, 2011.

⁶African Union, 2012 *Status report on Maternal, Newborn and Child Health, 2012* [hereinafter *African Union, Maternal Health Report, 2012*]; See also, Guttmacher Institute, *Facts on Abortion in Africa*, January 2012.

⁷WHO *Safe Abortion Guidance*, 2012, pages 23, 47-49. The World Health Organization defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both.

⁸WHO *Safe Abortion Guidance*, 2012.

⁹Ngwena, C., *Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa*, *Human Rights Quarterly* 32 (2010) 783-864; Cook, R. and Dickens, B., *Abortion Laws in Commonwealth Countries*, 25 *Journal of African Law* 60 (1981).

¹⁰While the majority of countries in Africa allow abortion to save the life of the woman, 13 do not (Angola, Central African Republic, Congo, Democratic Republic of Congo, Egypt, Gabon, Guineau-Bissau, Madagascar, Mauritania, Mauritius, Sao Tome & Principe, and Somalia) but the general criminal law of 'defense of necessity' would apply in these countries, allowing abortion to be performed on the rationale that it was necessary to preserve the life of the woman. In only four countries in the world would the applicability of the defense of necessity be highly unlikely; none are in Africa. These four countries are Chile, El Salvador, Malta and Nicaragua, countries whose legislation eventually made abortion illegal for all indications.

¹¹Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Maldives, Morocco, Mozambique, Namibia, Niger, Rwanda, Seychelles, Sierra Leone, Swaziland, Togo, Zimbabwe. See Center for Reproductive Rights, *World's Abortion Laws*, 2012.

¹²Algeria, Botswana, Gambia, Ghana, Liberia, Namibia, Seychelles, Sierra Leone and Swaziland. See Center for Reproductive Rights, *World's Abortion Laws*, 2012.

¹³Zimbabwe. See Center for Reproductive Rights, *World's Abortion Laws*, 2012.

¹⁴Benin, Botswana, Burkina Faso, Burundi, Cameroon, Ethiopia, Ghana, Guinea, Lesotho, Liberia, Mali, Namibia, Seychelles, Rwanda, Sudan, Swaziland, Togo and Zimbabwe. See Center for Reproductive Rights, *World's Abortion Laws* 2012.

¹⁵Benin, Botswana, Burkina Faso, Chad, Ethiopia, Ghana, Guinea, Lesotho, Liberia, Namibia, Niger, Seychelles, Swaziland, Togo and Zimbabwe. See Center for Reproductive Rights, *World's Abortion Laws* 2012.

¹⁶Postabortion care (PAC) is the management or treatment of women who have had an incomplete abortion either spontaneously or from an unsafe abortion. Postabortion care is an integral component of Comprehensive Abortion Care (CAC) and includes five essential elements: treatment of incomplete and unsafe abortion and complications; counseling to identify and respond to women's emotional and physical health needs; contraceptive and family-planning services to help women prevent future unwanted pregnancies and abortions; reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities; community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs. Ipas, *Postabortion Care*. Available at: <http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Elements-of-Comprehensive-Abortion-Care/Postabortion-Care.aspx>.

¹⁷United Kingdom Department of Health, 2012, *Abortion statistics, England and Wales: 2011*, p. 8.

¹⁸See WHO *Safe Abortion Guidance*, 2012, pp. 23 & 95; Erdman, J., DePiñeres, T., Kismödi, E. *Updated WHO Guidance on Safe Abortion: Health and Human Rights*, *International Journal on Gynecology and Obstetrics*, 120 (2013) 200-203.

¹⁹ See WHO Safe Abortion Guidance, 2012, p. 92.

²⁰ WHO Safe Abortion Guidance, 2012, pages 63-85; Erdman, J., DePiñeres, T., Kismödi, E. Updated WHO Guidance on Safe Abortion: Health and Human Rights, *International Journal on Gynecology and Obstetrics*, 120 (2013) 200-203.

²¹ Ghana Health Services, *Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services Standards and Protocols*, 2012, 2nd edition.

²² WHO Safe Abortion Guidance, 2012, pages 42-44. 76-78

²³ International Conference on Population and Development-Programme of Action, Cairo, 1994, para 7.2 [hereinafter ICPD]

²⁴ ICPD, para. 7.6, 8.19. '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... abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion'- ICPD, para. 7.6

²⁵ Fourth World Conference on Women, Platform for Action. Beijing, 1995, paras. 106(j) and (k) and BFAI 72(o).

²⁶ Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development. New York, United Nations, 1999, para 63(i) [hereinafter ICPD+5].

²⁷ ICPD, para. 8.25.

²⁸ African Union, *Maternal Health Report*, 2012, p. 29.

²⁹ African Union, *Maternal Health Report*, 2012 p. 40.

³⁰ African Union, *List of Countries which have signed, ratified, acceded to the Protocol to the African Charter on Human and Peoples' rights on the Rights of Women in Africa (February 21, 2013)*.

³¹ A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Uganda, Center for Reproductive Rights, 2012, p. 10.

³² UN Human Rights Council resolutions on 'Preventable maternal mortality and morbidity and human rights', 18/2 (2011), 15/17 (2010), 11/8 (2009) .

³³ Human Rights Council, 2 July 2012. *Report of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights- based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*, para 33. Available at http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

³⁴ UN Human Rights Council. 3 August 2011. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Anand Grover, A/66/254. Available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement>

³⁵ UN Human Rights Council. 1 February 2013. *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Juan E. Méndez, A/HRC/22/53, para. 90. Available at http://www.ohchr.org/Documents/HRBodies/HR-Council/RegularSession/Session22/A.HRC.22.53_English.pdf

³⁶ Committee on the Elimination of Discrimination against Women. 1999. *General Recommendation 24: Women and health (Art. 12)*, para 14; See also, Human Rights Committee. 2000. *General Comment no. 28: equality of rights between men and women (Art. 3)*, para 3.

³⁷ CEDAW General Recommendation 24: Women and health, para 11.

³⁸ Committee on the Elimination of Discrimination against Women. *L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011, para 8.1. CEDAW also noted that it is essential for this legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible risk to the health of the pregnant (woman), that her opinion be taken into account, that the decision be well-founded and there be a right to appeal, para.8.17.

³⁹ European Court of Human Rights. *Tysiac v. Poland*, 2007 (App. no. 5410/03), para. 116; European Court of Human Rights, *R.R. v. Poland*, 2011 (App. no. 27617/04); European Court of Human Rights, *P and S v Poland*, 2012 (App. no. 57375/08).

⁴⁰ The Court noted that the state has an obligation to regulate the availability of lawful abortion to alleviate the chilling effect the legal restrictions on abortion and risk of criminal responsibility can have on doctors when deciding whether requirements of legal abortion are met. The Court also called on the State to establish a mechanism so that women can effectively appeal, in a timely manner, denial of abortions by providers.

⁴¹European Court of Human Rights. *A.B. and C. v Ireland*, 2010 (App.no. 25579/05), paras 267-268. The European Court of Human Rights found that Ireland has a positive obligation to implement the existing constitutional right to a lawful abortion when a woman's life is in danger and failing to do so violated the European Convention's guarantees of the right to respect for private life.

⁴²World Health Organization, *Constitution of the World Health Organization*, entered into force 7 April 1948. Available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

⁴³Committee on the Elimination of Discrimination against Women. *L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011; Human Rights Committee. *K.L. v. Peru*, Communication no. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003, 2005.

⁴⁴Human Rights Committee. *K.L. v. Peru*, Communication no. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003, 2005; Committee on the Elimination of Discrimination against Women. *L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011.

⁴⁵Skuster, P. 2011, *Ipas, How to Protect Abortion Access During Constitutional Reform*; Copelon R., Zampas, C, Brusie E, deVore J. 2006, *Human Rights Begin at Birth: International law and the claim of fetal rights*, *Reproductive Health Matters* 13(26):120-129.

⁴⁶Ngwena, C., *Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa*, *Human Rights Quarterly* 32 (2010) 788.

⁴⁷Zampas, C. & Gher, J.M. *Abortion as a Human Right —International and Regional Standards*, 8 *Human Rights Law Review* (2008).

⁴⁸European Court of Human Rights, *Vo v. France*, 2004, (App. No. 53924/00); Inter American Court of Human Rights, *Ana Victoria Sánchez Villalobos and others v. Costa Rica*, December 2012.

⁴⁹See generally, World Health Organization, *Sexual Violence Research Initiative*. Available at <http://www.svri.org>.

⁵⁰See, e.g., Committee on Economic, Social and Cultural Rights, *Concluding Observations: Kenya*, para. 33, (2008) ('The Committee recommends that the State party ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by ... decriminalizing abortion in certain situations, including rape and incest.') For more information on recommendations to African countries, see Annex II.

⁵¹Committee on Economic, Social and Cultrual Rights. *Concluding observations: Ecuador*, 2012, para. 29.

⁵²*Sexual Violence and Unwanted Pregnancy: Protecting the human rights of adolescent girls and young women, Ipas*, 2013; *Pre-venting intimate partner and sexual violence against women*, World Health Organization 2010, Geneva.

⁵³Committee on the Elimination of Discrimination against Women. *L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011; Human Rights Committee, *L.M.R. v Argentina*, CCPR/C/101/D/1608/2007, 2011.

⁵⁴Committee on Economic, Social and Cultrual Rights. *Concluding observations: Ecuador*, 2012, para. 29.

⁵⁵ICPD, para. 7.3

⁵⁶*A Technical Guide to Understanding the Legal and Policy Framework of Terminaiton of Pregnancy in Mainland Tanzania*, Center for Reproductive Righs, 2012, p 22; Center for Reproductive Rights and University of Toronto, Faculty of Law, *International Reproductive and Sexual Health Law Program*, Amicus brief to European Court of Human Rights in the case of *ABC v Ireland*, 31 October 2008.

⁵⁷*Legal Grounds, Reproductive and Sexual Rights in African Commonwealth Courts*. Center for Reproductive Rights, *International Programme on Reproductive and Sexual Health*, University of Toronto Faculty of Law, University of the Free State, volume II, January 2010. Available at: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_legalgrounds_vol2_2.10.pdf

⁵⁸In addition, constitutions generally recognize international treaties as part of domestic law. While some constitutions provide for domestication of international treaties upon ratification (self-executing), others require legislative or other approval before a treaty is domesticated. It is also generally understood that international law prevails over inconsistent domestic law.

⁵⁹*Vienna Convention on the Law of Treaties*, article 2.1(b) (1969).

⁶⁰See for example, decision of the Constitutional Court of Colombia ruling that women's human rights require that abortion must be permitted when a pregnancy threatens a woman's life or health, in cases of rape, incest and in cases where the fetus has malformations incompatible with life outside the womb. C-355/2006, May 10, 2006; Decision of the Constitutional Court of the Slovak Republic, upholding its liberal abortion law in accordance with international human rights and constitutional law principles. No.) PL. ÚS 12/01-297, December 4, 2007.

⁶¹These four countries are Kenya, Swaziland, Uganda and Zambia. Skuster, *Ipas*, 2011.

⁶²Madagascar.

⁶³Cook, R. and Dickens, B. , *Abortion Laws in Commonwealth Countries*, 25 *Journal of African Law* 60 (1981).

⁶⁴*Rex v Bourne*, 1 K.B. at 694 (1938).

⁶⁵*Mehar Singh Basel v R*, (1959) *East African Court of Appeal*; Cook, R. and Dickens, B. , *Abortion Laws in Commonwealth Countries*, 25 *Journal of African Law* 60 (1981).

⁶⁶*Family Planning Association of N. Ir. v Minister for Health, Soc. Services and Pub. Safety*, (8 October 2004) NICA 27-39, 42, 44, 115.

⁶⁷Cook & Ngwena 'Women's access to health care: The legal framework' (2006) 94 *International Journal of Gynecology and Obstetrics* 220-221.

⁶⁸*Christian Lawyers Association of South Africa and Others v Minister of Health and Others* 1998 (4) SA 1113 (T)

⁶⁹*Christian Lawyers Association v National Minister of Health and Others* 2004 (10) BCLR 1086 (T).

⁷⁰CEDAW to Lesotho, 2011; CEDAW to Zimbabwe, 2012.

⁷¹*Children's Rights Committee to Chad*, 2009; *Human Rights Committee to Cameroon*, 2010; CEDAW to Lesotho, 2011; CEDAW to Nigeria, 2008; CEDAW to Rwanda, 2009; CEDAW to Zambia, 2011; CEDAW to Burundi, 2008; CEDAW to Zimbabwe, 2012.

⁷²*Human Rights Committee to Cameroon*, 2010; CEDAW to Côte d'Ivoire, 2011; CEDAW to Kenya, 2011; *Children's Rights Committee to Burkina Faso*, 2010; CEDAW to Zimbabwe, 2012; *Children's Rights Committee to Namibia*, 2012; *Committee on Economic, Social and Cultural Rights to Cameroon*, 2012.

⁷³*Committee on Economic, Social and Cultural Rights to Kenya*, 2008; *Committee on Economic, Social and Cultural Rights to Mauritius*, 2010; *Children's Rights Committee to Nigeria*, 2010; *Children's Rights Committee to Namibia*, 2012.

⁷⁴*Committee on Economic, Social and Cultural Rights to United Kingdom of Great Britain and Northern Ireland*, 2009; *Committee on Economic, Social and Cultural Rights to Kenya*, 2008; *Committee on Economic, Social and Cultural Rights to Mauritius*, 2010.

⁷⁵See e.g., *Human Rights Committee to Colombia*, 2010.

⁷⁶*Human Rights Committee to Nicaragua*, 2008; *Children's Rights Committee to El Salvador*, 2010.

⁷⁷*African Union, African Commission on Human and Peoples' Rights. Concluding Observations and Recommendations on the Fourth Periodic Report of the Federal Republic of Nigeria*, paras. 62, 93, 97. 50th Ordinary Session of the African Commission, Banjul, 25 October-5 November, 2011.

⁷⁸*Human Rights Committee. K.L. v. Peru*, Communication no. 1153/2003, UN Doc. CCPR/C/85/D/1153/2003, 2005.

⁷⁹*Committee on the Elimination of Discrimination against Women. L.C. v. Peru*, CEDAW/C/50/D/22/2009, 2011; *Human Rights Committee, L.M.R. v Argentina*, CCPR/C/101/D/1608/2007, 2011.

⁸⁰*Paulina Ramirez v. Mexico (Inter-American Commission on Human Rights)*, settlement in 2006.

⁸¹*European Court of Human Rights, P and S v Poland*, 2012 (App. no. 57375/08).

Ipas Africa Alliance for Women's Reproductive Health and Rights

P.O Box 1192- 00200
Nairobi
Kenya

www.ipas.org | www.ipas.org/facebook | www.ipas.org/twitter

African Union Commission

P.O. Box 3243, Roosevelt Street
(Old Airport Area), W21k19
Addis Ababa, Ethiopia

www.au.int