WOMEN'S REPRODUCTIVE HEALTH RIGHT

BY ELLEN ALEM
AND
MELLESE DAMTIE

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Women's Reproductive Health Rights in the Ethiopian Context

I. Introduction

Today, the world is moving forward towards improving the situation of women, who make up more than half of the world's population. Efforts are being made at different levels to recognize and facilitate the exercise of the inherent rights of women. Among the rights of women that have been the subject of current discourse is that of reproductive health.

Reproductive health rights (RHR), include access to family planning, protection from diseases of the reproductive system including HIV/AIDS and other sexually transmitted diseases (STDs). They include, among others, the prevention of involuntary sterility, and prevention of and management of complications from abortion. These rights are relevant to both men and women, but particularly significant to women, who are more prone to the social, physical, physiological and psychological changes resulting from reproduction. The guarantee of women's reproductive health rights is also critical to ensuring women's rights to equal participation in the economic, social and political fields at all levels.

A number of international agreements and consensus documents have established that reproductive health rights are fundamental and central to the advancement of women. These include the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), a well known and legally binding instrument that, among others, asserts the right of women to reproductive health and therefore, to family planning. At the national level, the Constitution of the Federal Democratic Republic of Ethiopia guarantees the right of women to family planning. Various other laws and policies have also incorporated different aspects of reproductive health rights.

The present paper examines the meaning and relevance of reproductive health rights, their definition and concepts, starting with the premise that, as a matter of principle, the termination of pregnancy should be considered as a reproductive health right of women. It reviews the national and international framework of women's reproductive health rights, the experiences of several countries and current international trends. It further examines the realities of the exercise of reproductive human rights in Ethiopia and existing gaps between law and practice, particularly as concerns abortion, and makes specific recommendations with respect to needed changes in law and practice.

II. Conceptual Framework

Human reproduction is the process resulting in the birth of human offspring, beginning from fertilization of an egg by a sperm cell, the implantation and growth of the fertilized egg in the mother's womb. The parts of the human body involved in this process are referred to as reproductive organs. This is the basic fact of procreation on which concepts of reproductive health and reproductive health rights primarily rest.

Paragraph 7(2) of the Program of Action of The International Conference on Population and Development (ICPD), (Cairo 5-13 September, 1994) defines reproductive health and the corresponding right as follows:

> "Reproduction health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant…"

This definition provides for the right of people to be free from, not only disease or infirmity, but from any impediment to their mental, physical and social well being in matters pertaining to the reproductive system. More specifically, people are entitled to a safe and satisfying sex life as well as control over their fertility. The basic requirements for this include, among others, freedom from the risk of sexually transmitted diseases and unwanted pregnancy, as well as safe pregnancy and childbirth and having a healthy infant. In this respect, the different forms of violence such as rape, female genital mutilation and forced prostitution are particularly grave as threats to both the reproductive health rights of women and other fundamental freedoms.

Controlling fertility means freely deciding the number, timing and spacing of children by making use of the different methods of birth control. As far as the means for the regulation of fertility is concerned the definition uses the qualification *not against the law*. It appears that the definition does not commend any specific form of birth control other than indicating that its legality is to be determined at the national level. Birth can be controlled by contraception or by abortion. Contraception is generally understood as any process designed to prevent pregnancy while abortion is that designed to end an established pregnancy.[1]

When reproductive health is conceived in terms of a right, the correlative duty is basically on the government. Concerning the beneficiaries of the right, paragraph 7(3) of the ICPD refers to individuals and couples. Some previous instruments like the World Population-Plan of Action of 1974 employ the same terminology while others use terms like parents and persons especially in relation to the family planning right.[2] The term parents is used to show that their wish prevails over the wishes of other members of the family.[3] Later, the term couples was introduced instead of parents, in view of the fact that

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[1] B.R. Furrow et.al. Health Law: Cases, Materials and Problems (2nd ed.), 1991. P. 938
[2] Philip M. Hauser (ed), World Population and Development: Challenges and Prospects, Syracuse University Press. (1970) PP. 513-514
[3] Ibid.

partners may choose not to have children.[4] In recognition of the right of unmarried mothers to free choice the word persons has also been used.[5] This indicates that all individuals, irrespective of sex and marital status have the right to security of well being in the reproductive process, and the right to regulate their fertility.

Components of Reproductive Health Rights

In light of the earlier definition, reproductive health rights require: a) that governments refrain from interfering in individual freedoms to promote other social, economical or political goals. The international standard expressed in the recent Program of Action of the International Conference on Population and Development (para7 (3)) and other previous and later UN documents is for individuals to freely and responsibly determine the number and spacing of their children. In this respect, nothing positive is expected from governments except that they should avoid unreasonably limiting individual freedoms by obliging people to practice family planning or by prohibiting or restricting it. Government has the duty to enable access to this right, through providing resources for reproductive health care. Paragraph 7(6) of the Program of Action of the International Conference on Population and Development provides:

Reproductive health has many dimensions including the family planning right, which primarily needs access to the relevant information and education. In reproductive health as well as other areas, what matters is not the ability to make a decision, but to make an informed decision. The relevant information and education should be available and accessible to family planning clients.[6] Aside from understanding the benefits of family planning, people should have adequate knowledge to the wide range of methods of fertility regulation and the means of access to those methods.[7]

For a satisfying and safe sex life, which is part of the reproductive health right, individuals need to be aware of STDs including HIV/AIDS and other diseases of the reproductive system, how they are transmitted and how they can protect themselves from such diseases. Women need information on how to care for themselves during pregnancy and for their infants after birth. Information on the prevention of infertility and treatment of infertile couples is also vital as this directly affects reproductive capacity. Government is expected to ensure access to such information, either directly or through collaboration with non-governmental actors.

Access to the necessary information and knowledge needs to be accompanied by available and affordable services. This requires an integrated approach to service delivery. Individuals and couples also need access to different kinds of medical and counseling services besides those directly related to fertility regulation. Within the

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[4] Ibid.
[5] Ibid.
[6] C.M. Huezo, and C.S. Carigan, Medical and Service Delivery Guidelines for Family Planning, 2nd ed., IPPF Medical Publications, (1997) P.2
[7] I. Evans, Family Planning Handbook For Health Professionals: The Sexual and Reproductive Health Approach, IPPF Medical Publications (1997) P.5

means available, services should be accessible to all individuals regardless of their social status, economic situation, religion, political belief, ethnic origin, marital status, geographical location or any other characteristics, which may place individuals in certain groups.[8]

The links between reproductive health rights and other human rights

The most important aspect of reproductive health rights is that of fertility regulation. Unless a woman can enjoy the right to regulate her fertility, she has little possibility of exercising her other fundamental rights. A woman's control over her own fertility has been called "the freedom from which other freedoms flow."[9] Therefore, reproductive human rights are a prerequisite for many other rights.

The following rights appear in international human rights instruments including the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; and the Convention on the Rights of the Child.

- *The right to life: and to liberty and security of person: Control over fertility in the sexual life promotes the exercise of the right to liberty and security of women;*
- *The right to information and education: women have the right to be able to make informed decisions on matters related to their reproductive health. Any barrier to information and education is considered to be a violation of reproductive health rights, because one cannot choose between alternatives one does not know about;*
- *The right to choose whether or not to marry and to found and plan a family: The exercise of this right requires the full consent of a woman. Consent is considered to be free, inter alia, when it is given after attaining the age of maturity, when all individuals are assumed to start making a reasoned decision. States are expected to enact laws by specifying a minimum age for marriage that fulfills at least the majority age requirement. Arranged marriage, marriage by abduction and related practices shall collide with this right;*
- *The right to be free from torture and other cruel, inhuman or degrading treatment: Torture and other ill treatments are to be widely interpreted to incorporate treatments which are inflicted on the reproductive health rights of all females;*
- *The right to freedom of assembly and political participation: This right has a bearing on reproductive health right in that: [all women] have the right to assemble and canvass for sexual and reproductive health rights; they have the right to form an association which aims to promote sexual and reproductive health and well-being and they have*

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[8] Op.Cit. Note 31, P.3
[9] Op.Cit. Note 8. P.4.

the right to seek to influence governments to place a priority on sexual and reproductive health rights.[10]

- *The right to development: The right to development is a universal and inalienable right, to which all persons are entitled. Reproductive health rights are particularly significant in this respect as they enhance the exercise of the right to development;*
- *The right to the benefits of scientific progress: The recognition and exercise of RHR depends on the utilization of the results of progress in science and technology, which are safe and acceptable. The following are considered to be reproductive health rights in relation to the right to the benefits of scientific progress;*
- *The right of the benefit and access to available reproductive health care technology, including that related to infertility, contraception and abortion, where to withhold access to such technology would have harmful effects on health and well-being;*
- *The right of protection from and information on any harmful effects of reproductive health care technology on their health and well-being.*[11]

The above discussion demonstrates the relationship between reproductive human rights and other core human rights, as prescribed in various international instruments. It is indicative of the fact that the status of reproductive human rights directly affects the exercise of other human rights and vice versa.

States parties to the relevant international instruments are obliged to enforce these human rights that are linked to reproductive human rights. International support for national efforts is essential to enhance the recognition, respect for and exercise of reproductive human rights, particularly in the case of developing countries. This assistance must be made in conformity with the Charter of the UN and principles of international law as well as the Declaration on Principles of International Law Concerning Friendly Relations and Cooperation among States.

Abortion as a Reproductive Health Right of Women

Abortion is one of the most controversial and sensitive issues of our time. Positions on the abortion issue tend to be heavily influenced by a number of factors such as culture, diverse religious opinions, views on women's rights to control over their own lives and bodies, and views on the right of the fetus to life.

However, even religions have held different conceptions of abortion at different points in time. Abortion assumed different conceptions at different times, even by different religious organizations. Until the late 19th century, religious scholars did not consider abortion as taking a human life until the soul had "animated" the body sometime during the fourth or fifth month of pregnancy. It was only in 1869 that Pope Pius IX suppressed the distinction between abortion during the first phase of embryo development and later

[10] Ibid. P.24
[11] Ibid. P.23.

stages. There are diverse opinions among religious groups. The traditional tenets of Islam only forbid abortion after animation of the fetus and Judaism does not consider the embryo as a human being independent of its mother until it is at the point of birth.[12] The Catholic doctrine prohibiting abortion from the moment of conception is contested by many theologians. They believe that it is possible to interrupt pregnancy when the circumstances of birth make the new life a calamity rather than a blessing.[13]

In England, prior to the 19th century, the common law considered abortion as a misdemeanor if performed after "quickening", or around the 16th week of gestation,[14] before which, it was not considered an offence. Midwives and lay practitioners employed strategies such as herbal potions and rigorous, physical activities to induce abortion.[15] The first laws restricting abortion aimed at protection of the woman's health, as surgical medicine was still backward and one surgical intervention in three ended in death.[16] Consequently in the mid-19th century, several Western nations made laws prohibiting abortion.[17] But the state of modern medicine makes this reason no longer valid.

Increasing recognition of the rights of the pregnant woman has also had its impact. In 1973 in the USA, abortion became an issue of "personal privacy and liberty". The US Supreme in its landmark decision in Roe vs. Wade overturned a state law allowing abortion only to save the mother's life.[18] It held the state law to be in violation of the Due Process clause of the Fourteenth Amendment.[19] Thus the Court's view was essentially that during the first six months of pregnancy, prior to the stage of viability of the fetus, decision on abortion were essentially the right of the mother, limiting the state to regulating the abortion procedure only in ways reasonably related to maternal health.[20]

This was a 'watershed decision' and during the following decade, the status of abortion in the US, changed from being a crime to being widely perceived as a "constitutional right" and "fundamental freedom".[21]

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[12] Annie-Mare Dourlen-Rollier, Legal Problems Related to Abortion and Menstrual Regulation, the Symposium on Law and Population Proceedings, Background Papers and Recommendations (19-1975), PP.122, 123
[13] Ibid. p. 123
[14] Women's Health Series, Vol.4, World Health Organization Regional Office for the Western Pacific, Manila, (1995), p.3.
[15] Ibid.
[16] Sahlu Haile, "Illegal and Unsafe Abortion in Africa", Proceedings of the VII Annual Conference of the Ethiopian Society of Obstetricians and Gynecologists (May 17-18 1999), p. 18
[17] Op. Cit. Note 27, p.3
[18] Judith Areen et al, Law, Science and Medicine, The Foundation Press, Inc Mineola, (1984), PP. 1241-2
[19] Ibid
[20] Ibid
[21] Clark D. Forsythe, "Is Abortion the "First Right" for women: Some Consequences of Legal Abortion". Abortion, Medicine and the Law, Facts on File, N.Y. (1992), P.101

The Present Situation

There is still fierce contention between the pro-life (anti-abortion) and pro-choice (pro-abortion) groups. But it is widely recognized that restrictive laws on abortion have little effect on reducing the rate of abortion. They commonly lead to the performance of abortions in unsafe conditions, and to increased maternal mortality and morbidity by denying women access to safe services. Each year, an estimated 80,000 women world wide die due to unsafe abortion.[22] Africa contains only 10 percent of the world's female population, but accounts for over 25 percent of abortion cases and over 40% of maternal deaths.[23]

The experience of Romania, among others, demonstrates the failure of restrictive abortion laws to limit abortion. In Romania, first trimester abortions were available on request from 1957 until 1966.[24] In 1966, the government imposed severe restrictions on abortion, which were followed by an upsurge in illegal abortions.[25] Abortion-related mortality in Romania rose from 21 per 100,000 live births in 1965 to 128 per 100,000 in 1984.[26] In 1984 alone, the WHO reported 449 deaths in Romania.[27] Only after abortion was again legalized in 1989 did abortion-related deaths drop to around 60 per 100,000 live births.[28] Between 10-50 percent of women who undergo unsafe abortions require medical attention as a result of such complications.[29]

Worldwide, abortion laws can be classified in five major groups:

i. Those that totally prohibit abortion. A notable example is Chile's law, which prohibits abortion even to save the pregnant woman's life.[30]
ii. Those that allow abortion to save a woman's life. Examples – Angola, Iran, Ireland, Mexico.[31]
iii. Those that allow abortion to save a woman's life and on other maternal health reasons. Examples – Algeria, Ethiopia, Saudi Arabia, Argentina. Some countries such as Cameroon, Ghana, Liberia, Namibia, and Zimbabwe have allowed abortion on additional grounds such as rape and incest.[32]

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[22] Reproductive Rights 2000: Moving Forward, The Center for Reproductive Law and Policy, N.Y. (2000) P.27.
[23] Op. Cit. Note 29. P. 19
[24] Stanley K. Henshaw, "Induced Abortion: A World review, 1990," Abortion, Medicine, and the Law. (4th ed.), Facts or file, NY (1992) PP411, 419
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Ibid.
[29] Id. P.26
[30] Abortion Policies- A Global Review, UN Department of Economic and Social Development, NY, (1992) P.7.
[31] Op.Cit. Note 38, p.408.
[32] Ibid.

iv. Those allowing abortion on the additional grounds of social and economic reasons. Examples – Burundi, Zambia, Australia.[33]

v. Those allowing abortion on request during the first 12 weeks of pregnancy. Examples – Togo, Tunisia, South Africa, Vietnam.[34]

Today, about 41% of the world's population living in 50 countries, have access to abortion without restriction as to reason; a further 21% live in 14 countries that permit abortion on broad social and economic grounds; about 13% live in 53 countries where abortion is available for maternal health reasons, and an estimated 26% live in 74 nations that either permit abortion only to save a woman's life or prohibit the procedure altogether.[35] Thus, more than half of the human population lives in countries where abortion laws are liberalized.

The prevailing international view is that abortion should be considered as a right of women. The woman who is burdened with carrying the pregnancy to term, going through childbirth and taking the major responsibility for child rearing should have the right to decide.

Even the most cautious woman may be faced with an unwanted pregnancy in the case of method failure.[36] From a medical point of view, abortion during the first 12 weeks of pregnancy is safer than normal childbirth with respect to the risk of death from such procedures.[37] Abortion entails almost no risk if it is performed before the 12th week of pregnancy and can be provided as an out patient service.[38]

Rationale of Reproductive Human Rights

Human Rights Rationale

A number of international human rights documents, including the Tehran Proclamation of 1968, the Vienna Declaration and Program of Action of 1993 and the Beijing Platform for Action of 1995 have recognized the family planning aspect of RHR as a human right. Their aim is to make alternatives available to individuals, especially women, to empower them to plan their lives. "Without the ability to plan her fertility and determine when and how many children she should have, it is not likely that a woman would be able to plan and control any other activity well enough and take active steps to improve her own living conditions…[39] The respect and recognition of RHR for women should not be taken as a means to an end, but as an end in itself. It is important to stress that women are much more than mothers and that child bearing is only a part of women's lives.[40]

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[33] Ibid.
[34] Ibid.
[35] Op. Cit. Note 37
[36] Op. Ct. Note 29, P.20
[37] An Interview with Dr. Mekonnen Bekele, gynecologist at Brass MCH center, 4 Oct. 2000
[38] Ibid.
[39] Family Planning in the 1980's: Challenges and Opportunities (Report of the International Conference on Family Planning in the 1980's Jakarta Indonesia 26-30 April, 1981). P. 42
[40] Hellen Ware, Women, Demography and Development, The Austrian National University 1981. P.18

Demographic and Economic Rationale

Uncontrolled population growth is a major threat to sustainable development. Recognition and facilitation of the reproductive health rights of women has an important role in addressing this problem. Experience has shown that as women become more informed, educated and participatory, they tend to choose smaller family size.

Health Rationale

The exercise of reproductive health rights has important implications for women's health. Every pregnancy poses risks, and some pre-existing medical conditions make pregnancy especially risky. These include high blood pressure, vascular heart disease, diabetes with vascular disease and hepatitis.[41] Fertility regulation enables women to reduce their risk through fewer pregnancies and limiting them to the lower risk reproductive ages.

Women's access to contraception also helps to avoid unsafe abortion. In the developing countries, deaths related to unsafe abortion are estimated as high as 100-600 deaths per 100,000 abortions.[42]For survivors of unsafe abortion, post abortion complications can cause disability and infertility. Providing for safe abortion as an integral part of reproductive health services will help to secure women's rights to health and life.

III. The Global Perspective

Women's rights are human rights and hence, the inherent and inalienable rights of all human beings, that need to be recognized and enforced, as such, rather than granted by governments. Most of these rights are enshrined in international instruments and the states party to such instruments are both legally and morally obliged to respect them. Nevertheless, the degree to which reproductive human rights are enjoyed and exercised depends largely on the improvement of the general status, i.e. empowerment and advancement of women. This requires improving women's economic, social and political status and eliminating discrimination, to enable them to make and effect informed choices in all aspects of life, including reproductive life. Several international instruments, including the UDHR, ICCPR, ICESCR, and CEDAW, proscribe discrimination on the basis of sex, while the Vienna Declaration of 1993 and the Beijing Declaration of 1995 seek the general improvement of the status of women.

Such international instruments as the Convention on the Elimination of Violence Against Women have much to contribute to the enjoyment of reproductive human rights. Specific areas, directly relevant to the full realization of reproductive human rights, such as the elimination of FGM and the fixing of a minimum age of marriage are addressed in various international instruments. The practices that they address have serious consequences for RHR. Such violence as rape or genital mutilation may cause a woman

[41] Population Reports of the Johns Hopkins University School of Public Health, VolXXVII, No. 2, July 1999, p.7
[42] Ibid.

long lasting physical and psychological harm. Globally, the physical consequences of rape and sexual violence, account for some 5 percent of disease affecting women.[43]

The Proclamation of Teheran (1968) has made an important contribution. The Proclamation, arising from the international conference on human rights held at Teheran on May 13th, 1968, is not legally binding, but has assisted in the articulation of reproductive health rights and the formulation of an ethical standard. In its Paragraph 16, it states that parents have a basic human right to determine freely and responsibly the number and spacing of their children. This s the first international instrument in which family planning is specifically incorporated as a basic human right. It also affirms the right to freedom of choice in family planning with the restriction that it should be practiced responsibly. This may imply "the collective right of society to achieve a balance between population size and resources."[44] However, it appears to affirm that use of coercion in the practice of family planning is a human rights violation.

The World Population Plan of Action (1974), adopted at the Bucharest Conference (August 19-30, 1974), was another landmark. In its Paragraph 14 (f) it recognizes the basic right of couples and individuals to determine freely and responsibly the number and spacing of their children and to have the information, education and means to do so. In Paragraph 29(a) it further recommends that that all countries respect and ensure, regardless of their overall demographic goals, the right of persons to determine, in a free informed and responsible manner, the number and spacing of their children. Paragraph 29(c) indicates the need to address, not only the prevention of pregnancy but also the elimination of involuntary sterility to allow couples to have their desired number of children. In its paragraph 30, it further states that family planning policy should promote psychosocial harmony and mental and physical well being of couples.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) is particularly important, first of all because it has treaty status, giving rise to legal rights and obligations. It provides in its Article 12 that health care services including services for family planning should be accessible to both men and women on an equal basis. With respect to maternity, Article 12 provides that states shall ensure that women have access to health care services, and where necessary, free services, including adequate nutrition during pregnancy, confinement and lactation. Article 16(e) further provides that, on a basis of equality with men, women shall have the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

CEDAW is particularly important as it directly addresses the issue of women's rights in decisions on family size and in making use of health care services in relation to family planning. For this purpose, taking appropriate measures may include creating awareness, economic capability and availability of services for women. Aside from equality of

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[43] *File: llC://WINDOWS/Desktop/Report of the Special Rapporteur on violence. Htm as visited on 1/3/00
[44] Philip M. Hauser (ed), World Population and Development: Challenges and Prospects, Syracuse University Press (1979)

treatment between the sexes, special treatment of mothers is also called for by the Convention.

Other relevant issues include Article 11(2), which requires states to prevent discrimination against women on grounds of marriage or maternity and to guarantee their effective right to work through measures including maternity leave with pay or comparable social benefits; prohibiting dismissal on the grounds of maternity leave; providing support systems to enable parents to effectively discharge their work responsibilities and family obligations; and protecting pregnant women from exposure to harmful working conditions. The protection thus afforded to working women contributes towards the exercise of their rights to reproductive health.

Article 16(2) of the Convention, deals with early marriage and requires states to enact legislation that specifies a minimum age for marriage. Early marriage means a potential for pregnancy at an earlier age, an important cause of maternal and infant mortality and morbidity.

Finally, the Committee on the Elimination of Discrimination Against Women, the UN body that monitors compliance with the above convention, has stated in its recommendation on health that "…barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo these procedures."[45] Although vague, these 'barriers' are interpreted to include "laws that prohibit abortion, restrict advertising of contraception, require a spouse's consent to obtain contraception, and criminalize voluntary sterilization."[46]

The Vienna Declaration and Program of Action (1993) arising from the World Conference on Human Rights (Vienna, June 14-25, 1993), reaffirm that women's rights are human rights and should be among the top concerns of UN Programs and strategies. Although, not legally binding, it assists in the development of customary international law around this point. It urges Governments and UN bodies to focus on, inter alia, integration of women in the development process, and elimination of violence and eradication of discrimination against women (Paras. 36, 38 & 39 respectively). It notes the importance of enjoyment by women of the highest standard of physical and mental health – and thus reproductive health – throughout their life span, and women's right to accessible and adequate health care and the widest range of family planning services.

The Cairo Declaration and Program of Action (1994) provides the most extensive and comprehensive treatment of reproductive human rights. The primary purpose of the Conference, which led to the adoption of the Declaration and Program of Action, was to deal with the problem of uncontrolled population growth. In this context a whole chapter is devoted to reproductive health rights. The detailed treatment of the subject matter and the focus on the 'right' aspect makes the Cairo document a milestone for the development

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[45] Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24 on Women and Health, para 29, February 2, 1999 cited in Reproductive Rights 2000: Moving Forward, the Center for Reproductive Law and Policy, P. 9

[46] Reproductive Right 2000: Moving Forward, the Center for Reproductive Law and Policy, p.9

of an international legal standard on the topic. However as the instrument does not have treaty status, states have only a moral obligation to commit themselves to reproductive health rights.

As concerns the positive obligation of states, Paragraph 7(6) of the Program of Action outlines the scope of RHR in an exhaustive manner and obligates states to the progressive fulfillment of such care by the year 2015. Actions that should be taken by governments in this context include designing programs which will meet the needs of women, men and adolescents; promoting community participation; putting prevention and treatment of STDs and other reproductive tract infections among reproductive health care programs; removing barriers to affordability, adequacy and quality of services; and securing conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services.

The Beijing Platform For Action (1995) adopted at the Fourth World Conference on Women (4-15 September 1995) was a major step forward for women's rights. It encapsulates states' commitments to women's issues including reproductive health and rights. Paragraphs 94 and 95 define reproductive health and rights in a similar manner to that of the Program of Action of the Cairo Conference. Paragraph 97 specifically mentions that the problems and means relating to reproductive health are to be addressed on the basis of the report of the International Conference on Population and Development. The conference treats the subject matter from the perspective of women's rights, and thus, human rights.

The Beijing Platform for Action clearly recognizes that "[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." (Para. 96) It also addresses other areas affecting reproductive health and rights such as HIV/AIDS and other sexually transmitted diseases (Para. 98); sexual and gender based violence (Para.99); inequality of access to health care services between men and women (Para. 105); and harmful traditional, customary and modern practices (Para.224). These issues are central to women's rights to reproductive and sexual health. The AIDS pandemic and other STDs that affect both men and women also need to be seen from a gender perspective, particularly as women have little power in controlling the spread of such diseases. The unequal relationships between women and men make women afraid to demand protection during sexual contact. They also lack access to vital information and services for prevention and treatment (Para. 98).

In this respect, the required governmental actions include reaffirming the right of women and girls to the enjoyment of the highest attainable standards of physical and mental health – and thus reproductive health, through national legislation (Para. 106(b)) and providing more accessible, available and affordable service for sexual and reproductive health care. (Para. 106 (e)). The Beijing instrument takes the same stand on birth control methods including abortion with that of the ICPD in that their legality is to be judged at the national level. (Paras. 94, 106 (k)). On abortion, Para. 106 (k) provides: "In light of the Paragraph 8.25 of the Programme of Action of the International Conference on

Population and Development…[states should] consider reviewing laws containing punitive measures against women who have undergone illegal abortions."

In summary, there are indications of a global consensus that Reproductive Human Rights are fundamental human right of all individuals and couples. The full exercise of such rights needs to be guaranteed by governments through their national legislation and policies. Moreover, states should commit themselves to a progressive fulfillment of the provision of adequate, affordable and accessible services for reproductive health, including family planning. Finally, the legality of the different methods of birth control is left to be determined at the national level. This includes the controversial issue of abortion, which, not as a family planning method, but as a huge problem needs to be addressed. While abortion cannot be encouraged as a birth control method, the international community acknowledges the importance of addressing the reality that thousands of women resort to the procedure every year and that where abortion is illegal or where adequate services are lacking, women undergo unsafe abortion, often leading to loss of life. Therefore all countries are required to develop mechanisms to change the existing situation.

Country Experience

This section deals with experiences of a selection of countries of diverse socioeconomic and political backgrounds with respect to matters related to RHR. The focus is on the most important dimensions of RHR, seen here as family planning, abortion and sterilization practices.

South Africa

South Africa's constitution guarantees to everyone the right to make decisions concerning reproduction and the control over his or her body.[47] The South African government has produced a discussion document that acknowledged that a development and population policy should deal not only with population trends but also with the environment, resources, production and patterns of consumption[48]. It further raises issues for public comment on whether South Africa should decide the average number of children a woman or man should have, and what mechanisms should be available for coordinating activities aimed at women's empowerment.[49]

Since 1974, family planning services have been provided free of charge in government facilities.[50] Oral contraceptives containing progestogen are sold only by pharmacists and may not be sold to a person of under 16 years of age unless prescribed by a medical practitioner. But contraceptives, which do not contain progestogen, may be sold on the

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[47] Women of the World: Laws and Policies Affecting their Reproductive Lives. Anglophone Africa, The Center for Reproductive Law and Policy. N.Y. 1997, P.99
[48] Ministry for Welfare and Population Development, A Green Paper for Public Discussion: Population Policy for South Africa. (1995) P.14
[49] Ibid. pp.27, 32
[50] Women's Health Project, Women's Health Conference Policy on Contraception (1994).

written prescription or oral instructions of a medical practitioner, regardless of the age of the purchaser.[51] Advertisements of contraception are legal although advertisements on educational publications that contain explicit sexual content are subject to age restrictions.[52]

Family planning services have been identified among the services to be provided by District Health Authorities in community hospitals, clinics and community health centers, which should substantially increase the accessibility of these services.[53] Nevertheless, the distribution of the services is usually equitable. For example, services in predominantly white areas were better than services in predominantly black areas.[54] Moreover, all types of contraceptives are not equally available. For instance, rural clinics lacked IUDs.[55]

On November 12, 1996 South Africa enacted the Choice on Termination of Pregnancy Act, 1996, repealing the restrictive provisions on abortion contained in the Abortion and Sterilization Act, 1975[*].

Under Section 2(1) of the Choice Act, pregnancies may be lawfully terminated in the following circumstances[56]:

a) Upon request of a woman (woman defined in sec.1 of the choice Act to mean "any Female person of any age.") during the first 12 weeks of the gestation period (the choice Act sec.1 defines gestation period as "the period of pregnancy of woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last") of her pregnancy.
b) From the 13th week up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –
    i. The continued pregnancy would post a risk of injury to the woman's physical or mental health; or
    ii. There exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

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[51] Medicines and Related Substances Act. No. 101 of 1965.
[52] Films and Publications Act No.65 of 1996
[53] Department of Health (South Africa), Towards a National Health System, (1995), pp. 7-10
[54] Op. Cit. Note9.
[55] Ibid.
[*] The Abortion and Sterilization Act No. 2 of 1975, sec. 3 severely restricted access to abortion by prescribing detailed procedural requirements which had to be met before abortion could be performed, and by emitting the grounds for legal abortions to situations where pregnancy: endangered the life of the pregnant woman or constituted a serious threat to her physical or mental health; posed a serious risk that the child to be born would be seriously disabled; or was the result of "illegitimate carnal intercourse" with a woman with permanent mental disability.
[56]

iii. The pregnancy resulted from rape and incest; or
iv. The continued pregnancy would significantly affect the social and economic circumstances of the woman; or

c) After the 20th week of the gestation period if a medical practitioner, after Consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy:
   i. Would endanger the woman's life;
   ii. Would result in severe malformation of the fetus; or
   iii. Would pose a risk of injury to the fetus.

The Choice Act also provides that the identity of women who have requested or obtained a termination of pregnancy must remain confidential at all times.[57]

In brief, during the first trimester (12 weeks) a pregnancy can be terminated on the request of the pregnant woman, without further conditions. In the second trimester, the 13th to the 24th week, there are further conditions, but which may be broadly interpreted in favor of termination of pregnancy. For instance, a woman is allowed to terminate her pregnancy if the continuation of such pregnancy will put her in difficult social and economic circumstances. This condition appears sufficiently broad to allow for the termination of almost all unwanted pregnancies of the specified gestation age.

As there is no specific law on sterilization, it appears that any mentally competent consenting adult may freely choose sterilization as his/her preferred method of contraception.[58] While there might be controversy over whether spousal consent is required, it appears that the constitutional provision guaranteeing everyone the right to make decisions concerning reproduction and control over his or her body, removes any previous right of persons to refuse consent to the sterilization of their spouses.[59]

Where a person is legally incompetent to consent to sterilization, it may only be performed on him/her after meeting three requirements.[60] First, two medical practitioners must certify that the person's hereditary condition would cause his/her child to suffer from serious physical or mental disability, or that the person concerned is unable, due to permanent physical or mental disability, to comprehend the consequences of, or bear permanent responsibility for, "the fruit of coitus". Secondly, a magistrate or the person

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[57] Ibid. sec.7(5)
[58] Stephen Harrison, Review and Perform of South Africa Health Legislation (1995). (Unpublished LL.M dissertation. University of Cape Town). P.116.
[59] Op. Cit note 6, p.99
[60] Abortion and Sterilization Act, No.2 of 1975

normally entitled to consent to an operation upon the person concerned – for example, the parent or guardian of a minor, or the curator of a mentally ill person under curatorship must consent to the operation. Thirdly, the Minister of Health, or a medical officer of the Department of Health so authorized by the Minister of Health, must grant written authority for the sterilization.

Zimbabwe

In Zimbabwe, the government has associated population issues with development concerns and has given national priority to family planning activities since 1985. The overall goal of the government is the reduction of the total fertility rate through the increased use of modern methods of contraception.[61]

The Zimbabwe National Family Planning Council (ZNFPC), established in 1985, has from its inception, made services broadly accessible. The ZNFPC maintains that, "all individuals in the community have a right to information on the benefits of family planning for themselves and their families. They also have the right to know where and how to obtain more information and services for planning their families.[62]

Although contraceptive rates in Zimbabwe are among the highest in Sub-Saharan Africa, they vary by region.[63] The national government supports more than half the cost of national family planning programming.[64] It subsidizes up to 90% of the cost of contraceptives, and contraceptives are free of charge to low-income families. However, following introduction of the government cost-recovery program in 1991, fees for all health services have increased and distribution of some contraceptives declined.[65]

Campaigns specifically targeting men and youth promote joint decision-making of couples regarding contraception and family size.[66] The quality and effectiveness of modern contraceptives are regulated by the Drugs Control Council, (DCC), established by the 1988 Drugs Control Act. In Zimbabwe there is no legislation specifically addressing the advertisement of contraceptives.[67]

Abortion is legally permissible in limited circumstances in Zimbabwe under the 1977 Termination of Pregnancy Act, irrespective of the duration of pregnancy. The 1977 Act sets forth four circumstances under which abortion may be performed legally:[68]

1. When the pregnancy endangers the life of the woman;

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[61] Second Five-Year National Development Plan, 1991-1995, p68
[62] Zimbabwe National Family Planning Council, Statement of Client Rights, (1994)
[63] "Women in Law & Development in Africa (WILDAF)". Reproductive Health Rights in Zimbabwe (1995), p.5.
[64] "Bill Keller, Zimbabwe taking a Lead in Promoting Birth Control". N.Y. TIMES, Sept. 4, 1994, P.16
[65] Op. Cit. note 22, p.6
[66] Phyllis T. Piotrow et.al Changing Men's Behavior: The Zimbabwe Male Motivation Project, (1992), pp.366
[67] Drugs and Allied Substances Control Act. Ch.320 Sec.3 &23
[68] Termination of Pregnancy Act. Ch. 15:10, sec. 2(1)

2. When the pregnancy represents “a serious threat of permanent impairment of her physical health”;
3. When there is a severe risk that the child to be born would suffer from a permanent, serious physical or mental handicap;
4. When the pregnancy was the probably result of “unlawful intercourse”.

The 1977 Act defines “unlawful intercourse” to be rape, incest, or intercourse with a mentally handicapped woman or girl.[69]Abortion may only be performed by a “registered medical practitioner”.[70]

No legislation in Zimbabwe directly addresses sterilization. However, sterilization for health purposes is legally permissible, provided that the operation is performed by a registered medical practitioner with the consent of the patient.[71]

The legality of non-therapeutic sterilization, commonly for contraceptive purposes, is implicit in Zimbabwe’s family planning legislation. Non-therapeutic sterilization must be performed with the free and informed consent of the patient after counseling all clients considering sterilization.[72] Spousal consent is not a legal requirement for sterilization.[73]

Netherlands

The Netherlands opposed family planning prior to the 1960s. It was forbidden to sell or advertise contraceptives, with the result that, the Netherlands had one of the highest birth rates in Europe up to 1965. This changed dramatically in the decade from 1965 to 1975, reflecting a fundamental shift in the social, cultural and political climate.

The influential Dutch Association for Sexual Reform launched a vigorous campaign for new family planning legislation, aimed to persuade the government to introduce sex education in schools, exercise an influence on the media, and establish family planning centers throughout the country. The women’s movement, also conducted a major family planning campaign.

The government lifted the statutory prohibition on contraceptives in 1969 and in 1971 made certain forms of contraceptive available under the national health insurance scheme. In addition, small family planning clinics run by an organization called the Rutgers Foundation were entitled to government subsidies.

Abortion became the subject of public debate in the second half of the 1960’s in relation to several wider issues. It was legalized in 1984 by the Termination of Pregnancy Act

[69] Ibid.
[70] Ibid. sec. 5(1)
[71] Op. Cit. note 22, p.8
[72] Ibid.
[73] Ibid.
* These notes on the Netherlands were taken from a fact sheet entitled “Abortion in the Netherlands”. Published by the Ministry of Foreign Affairs in association with the Ministry of Health, Welfare and Sports, in October 1998.

which is designed to balance two potentially conflicting interests: protection of the life of the unborn child on the one hand, recognition of a woman's right to terminate an unwanted pregnancy on the other. The purpose of the Act is to ensure that any decision to terminate a pregnancy is given careful consideration, and that a termination is performed only if the woman's circumstance leave no alternative.

The law contains a set of rules designed to ensure that a pregnancy is never terminated without careful consideration. For instance, the doctor must discuss alternative solutions to the problem. If the woman decides to terminate the pregnancy, he must establish that she has reached her decision after careful consideration and of her own free will.

Abortion is prohibited once the fetus is viable. Viability is deemed to begin at the 22nd week from the beginning of the last menstruation. Hence, voluntary termination of pregnancy is authorized up to the end of 21st week.

Both the woman and the doctor are responsible for the process of reaching a decision, although the decision is ultimately made by the woman.

In the Netherlands there is no specific law governing sterilization. It is, however, regulated by general laws such as the constitution and contracts for medical treatment. Before the patient undergoes sterilization operation, he has to give his consent since involuntary sterilization is not allowed, in principle. As individual autonomy is the prime principle, spousal consent is not a required condition for sterilization. For sterilization of minors, the consent of parents or other representatives is required.

China

China is the most populous country in the world, until the 1970s the Chinese government regarded a growing population as beneficial to swift economic development. It decided in the 1970's to control population growth, with a strategy introduced in 1982, based on a radical family planning program to encourage couples to restrict their family size to just one child.[74]

Since 1982, detailed annual population plans have been drawn up for all provinces and cities. Birth targets or quotas have been set and controlled and all pregnancies are supposed to be planned and authorized.[75] Because the One Child Policy is implemented and monitored by local and provincial authorities, it has been applied differently across the nation. For example, there has been stricter enforcement of the policy in urban areas than in rural areas.[76]

The Chinese government supplies incentives to families who abide by the One Child Policy and penalties for disobedience.

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[74] http://www.altavista.com/as visited on August 26, 2000
[75] Ibid.b
[76] Ibid.

The incentives include:[77]

- Salary bonus (urban areas);
- Bigger land allocation (rural area);
- Extended maternity leave;
- Medical and hospital expenses;
- Priority access to housing, employment and schooling for the child.

Disobeying the policy entails penalties including:[78]

- Withdrawal of family allowance and medical benefits;
- Fines;
- Demotion of discharge from government job.

However, there are exceptions from the One Child Policy for people in particular circumstances including:[79]

- Members of a minority ethnic group (may be allowed to have two or more children);
- Having a first child with a disability that is likely to result in inability to work;
- Pregnancy after adopting a child;
- Risk of 'losing the family line' without a second child (the first child being a girl)
- Rural families with real difficulties (all children so far being girls)

These facts seem to infer that family planning is a duty rather than a right in China.

China's One-Child Policy has been modified based on certain conditions. The modification leaves specific measures to the judgment of localities after making a thorough study of local conditions and undertaking surveys and pilot projects. It also prohibits methods of "coercion and command" and suggests "three priorities" for family planning: regular work instead of shock treatment, contraception instead of economic penalties.[80]

In China the use of contraception as birth control is mandatory. The Marriage and Family Relations Law of 1, January, 1991 under Article 12 provides that "[H]usband and wife are duty bound to practice family planning." This means that the government has to make sure that the duty will not be evaded for lack of family planning services. Thus there could not possibly be shortage of facilities although there is still a question on the quality of such facilities.

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[77] Ibid.
[78] Ibid.
[79] Ibid.
[80] Annual Review of Population Law, 1985, Vol. 12, P.14

Abortion is legal in China. Termination of pregnancy may be performed on various grounds. It is also available at the request of a pregnant woman. However, sometimes the consent of the husband is required to terminate a pregnancy.

According to the Eugenic Protection Law of 1984, a pregnant woman with one of the following conditions may undergo an induced abortion at her own will[81] (i.e. without the consent of her husband):

- Where a woman or her husband is affected with genetic, infections, or psychiatric disease with eugenic effects;
- Where a woman or her husband with a genetic disease within the fourth degree of relationship in his/her family;
- Where a pregnancy or childbirth will endanger the woman's health or life;
- Where a fetus is diagnosed to be congenitally abnormal;
- Where a pregnancy is due to incest;
- Where a pregnancy or childbirth will affect the woman's mental health or her family life.

Abortion can also be performed on socio-economic grounds. In such case, however, a married woman must have the consent of her husband, except if he is not confirmed alive or unless he is not in a position to manifest his will.[82]

An unmarried minor or a person who is not allowed to manage her own property wishing to undergo an induced abortion based on the eugenic grounds must have the consent of an authorized guardian.[83]

If a woman becomes pregnant for the second time and if she is not the beneficiary of the exceptions, she is forced to terminate the pregnancy. Forced abortion is a standard measure for pregnancies not approved by authorities.[84]

Spousal consent is required for the sterilization of a married person, except when such spouse is not alive or he/she is not in position to manifest his/her will.[85] However, in the case of genetic illness, or when a pregnancy or childbirth would endanger the health of the mother, a person may undergo sterilization at his/her own will,[86] even if he/she is a married person.

An unmarried male or female with one of the above conditions may undergo sterilization at his/her own will. An unmarried minor or a person who is not allowed to manage his/her own property wishing to undergo sterilization must have the consent of an

[81] Ibid. vole. 111, P.346
[82] Ibid.
[83] Ibid.
[84] Op. Cit. note 33
[85] Op. Cit. note 39, P.347
[86] Ibid.

authorized guardian.[87] There is also a compulsory practice of sterilization of women after their first child.[88] It has been taken as measure to implement the One-Child Policy.

To summarize, the practice of family planning and hence reproductive health is a right of all individuals and couples in the three of the four foreign systems considered above. China's experience is unique in that the practice of family planning is compulsory on all individuals but most of all on women. To implement its One-Child Policy, the government of China forces women to undergo forced sterilization or abortion. The other three countries promote and implement the practice of family planning without the use of coercion. However, their reason for promoting family planning is to reduce population growth, rather than to enhance reproductive health. Governments need to be discouraged from using coercion in support of their population objectives. It is important that reproductive human rights are recognized and facilitated for their own sake.

[87] Ibid.
[88] Op. Cit. note33

III. Ethiopian Laws and Policies on Reproductive Health Rights

In this respect it is relevant that all international instruments dealing with this area that Ethiopia has ratified or become party to, are laws and principles of the land as per Articles 9 and 13 of the FDRE Constitution. Accordingly, the World Population Plan of Action (Bucharest, 1974) CEDAW, ICPD, and Beijing Platform have national application since Ethiopia has ratified CEDAW and was a party to the adoption of the other documents. However, this does not necessarily ensure national application. States need to commit themselves to the international principles by formulating national strategies. The impact of these international legal documents on RHR is discussed in the preceding chapter.

Reproductive health

The Constitution of the Federal Democratic Republic of Ethiopia, organic laws and different policies of the country deal with varied issues related to reproductive health. The discussion of these laws and policies in relation to family planning, abortion and AIDS/STDs is taken separately.

In Ethiopia, a country with deeply rooted customs and traditions, there are various traditional practices that pose serious threats to the reproductive health of women. These include female genital mutilation (FGM) a practice that prevails in most parts of the country.[89] While not specifically attacking FGM, Art 35(4) of the Constitution which provides that "…Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited." This is directly relevant to FGM as a practice which causes such harm. In view of the gravity of the problem of harmful traditions practices in general and FGM in particular, the 1993 women's policy has among its strategies the creation of awareness aimed at elimination of this harmful practice of "female circumcision".[90]

A further significant measure, was the establishment in 1987 of the National Committee on the Traditional Practices in Ethiopia (NCTPE), with the basic objective of eliminating harmful traditional practices (HTPs) affecting mostly women and children. The strategy adopted by the committee for this purpose, focuses on creating public awareness of "the harm caused and sensitizing decision makes on the need to eradicate HTPs." A more recent development FGM was the criminalization of FGM in the draft amendment of the Penal Code of 1957 proposed by the Ministry of Justice.[91]However, the penalty provided, is only six months' imprisonment.[92] This is inadequate as compared to the harm cause to the victim of FGM, and the need to deter its practitioners.

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[89] National Committee on Traditional Practices in Ethiopia (NCTPE): Baseline Survey on Harmful Traditional Practices in Ethiopia (1998) – according to this survey conducted in 1997, 73% of the studied group (44, 181 people from the 10 regional states of Ethiopia) responded 'yes' to the occurrence of FGM.
[90] National Policy on Ethiopian Women, Transitional Government of Ethiopia (1993), p.30
[91] Draft Amendment of the Penal Code of Ethiopia, Ministry of Justice (2000), Art544 (A)
[92] Ibid.

A further area of concern is that of early marriage which, poses a direct threat to the RHR of women. Art. 34 of the Federal Constitution refers to a marriageable age, specified as 18 years of age by the current Ethiopian family law. This results from the amendment of the previous family law, which set the minimum age of marriage at 15.[93] The current Ethiopian policies on women, and on population discourage early marriage.[94] It is identified as a harmful traditional practice.[95] The age requirement is sanctioned by civil and criminal penalties.

Article 35(5) of the Federal Constitution Article 35(3) of the Federal Constitution guarantees the right to adequate maternity leave, which contributes to safe pregnancy, and thus, to reproductive health. Under this Article, "women have the right to maternity leave with full pay" while "the duration of [the] maternity leave shall be determined by law, taking into account the nature of the work, the health of the mother and the well being of the child and [the] family." The maternity leave may include 'prenatal leave with full pay'. The existing Ethiopian labor legislation addresses this issue by both prohibiting discrimination on the basis of sex as regards employment and payment and providing different forms of protection for pregnant women.[96] Article 87 prohibits employment of pregnant women in types of work identified by the Minister as 'arduous or harmful to their health'; 'an assignment to night work between 10 p.m. and 6 a.m. or employment on overtime work'.[97] A pregnant woman cannot also be transferred from her permanent place of work, unless required by her health condition as per the advice of a medical doctor, nor can her employment be discontinued during her pregnancy and until four months of her confinement.[98]As regards maternity leave, "a woman worker shall be granted a period of 30 consecutive days of leave with pay preceding the presumed date of her confinement and a period of 60 consecutive days of leave after her confinement".[99] A pregnant woman is also entitled to leave with pay for examination in connection with her pregnancy and at other times as recommended by a medical doctor.[100] A pregnant civil servant is entitled to a similar maternity leave and leave for medical examination in accordance with a doctor's recommendation.[101]

A more or less comprehensive approach to reproductive health care is manifested in the health policy of 1993, which deals with it in the context of family health. Among others, the health policy provides that "Family health services shall be promoted by: assuring adequate maternal health care and referral facilities for high risk pregnancies;

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[93] This amending legislation has not been issued in the Negarit Gazeta which procedure is necessary for the enforcement of the new family law.
[94] National Policy on Ethiopian Women (1993), pp. 18,30 and National Population Policy of Ethiopia (1993), p 16 respectively.
[95] Op. Cit. note 17 – the prevalence rate of early marriage in Ethiopia in 1997 was 54.5%
[96] Labor Proclamation 42/1993, 27 Negarit Gazeta 268 (Jan 20, 1993)
[97] Ibid. Art.87 (2-5)
[98] Ibid.
[99] Ibid. Art. 88(33)
[100] Ibid. Art. 88 (2)
[101] Public Service Regulations Amendment Council of Ministers Regulations 32/1998, 24 Negarit Gazeta 695 (Feb 27, 1998), Articles 1-4

intensifying family planning for the optimal health of the mother, child and family, addressing the special health problems and related needs of adolescents…and identifying and discouraging harmful traditional practices…”.[102] As concerns access to and affordability of health care, and thus reproductive health, the health policy aims to assure accessibility for all segments of the population and to provide health care under a scheme of payment according to ability; with special mechanisms to assist those who cannot pay.[103]

Family Planning

Pursuant to Art 35(9) of the Constitution, women are entitled to family planning education, information and capacity the rationale of, which is stated to be ‘to prevent harm arising from pregnancy and childbirth and to safeguard their health.’ This constitutional guarantee puts an obligation on the state not to interfere with a woman’s choice to control her fertility. Moreover, the state is duty bound to make family planning education, information and capacity accessible to women. Capacity seems to refer to affordability of services. The Constitutional guarantee of the right to family planning can be meaningful only when this positive obligation of the state is fulfilled.

Although from a different rationale i.e., a demographic one, the population policy also shows the state’s commitment to reproductive health in general and family planning in particular. The policy has general and special objectives that impact on RHR. The general objectives include “closing the gap between high population growth and low economic productivity through planned reduction of population growth…” and, “raising the economic and social status of women.”[104]In this respect, the specific objectives include: reducing the current total fertility rate of 7.7 children per woman to approximately 4.0 by the year 2015; increasing the prevalence of contraceptive use from the current 4.0% to 44.0% by the year 2015; reducing maternal, infant and child morbidity and mortality rates as well as promoting the level of general welfare of the population; significantly increasing female participation at all levels of the educational system; and mounting an effective country wide population information and education program addressing issues pertaining to small family size and its relationship with human welfare and environmental security.[105]

The strategies through, which the above objectives could be attained, include expanding clinical and community based contraceptive distribution services by mobilizing public and private resources; promoting breast-feeding as a means of dealing with the problem of childhood malnutrition and increasing the time span between earlier and subsequent pregnancies through information, education and communication (IEC); raising the minimum age of marriage for girls from the current lower age limit of 15 to, at least, 18 years;…amending all laws, impeding, in anyway the access of women to all social, economic and cultural resources; amending relevant articles and sections of the civil

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[102] Health Policy of the Transitional Government of Ethiopia (1993), p34
[103] Ibid. p25.
[104] National Population Policy of Ethiopia (1993), pp14-15
[105] Ibid p.15

code[sic] in order to remove unnecessary restrictions pertaining to the advertisement, propagation and popularization of diverse conception control methods…establishing teenage and youth counseling centers in reproductive health; facilitating research program development in reproductive health; developing IEC programs specially designed to promote male involvement in family planning; and diversifying methods of contraception with particular attention to increasing the availability of male oriented methods.[106]The population policy also addresses the issue of service delivery through the diversification of contraceptive methods and expansion of services by informal health centers at the community level.[107]It also encourages the participation of non-governmental organizations in the delivery of population and family planning related services.[108]

The population policy manifests commitment to capacity building, providing that more resources will be made available to institutions involving themselves in the training of experts in demography and population studies.[109] Integration of training of family planning into the curricula of medical and other schools is seen as a means of strengthening domestic capacity.[110] Finally, the significance of IEC in population and development issues is acknowledged to bring about behavioral change on, inter alia, reproductive decisions.[111]IEC is to be facilitated through different groups including interest groups, political bodies, women and youth groups, NGO's and through formal education centers and agricultural extension workers as well as informal community leaders.[112]

A National Population Council (NPC) and an office of population are established[113] to ensure the implementation of the population policy. The members of the NPC include the Ministers of Planning and Economic Development, Health, Education Information, Labor and Social Affairs, Natural Resources Development and Environmental Protection.[114]

Contraception

Contraception is the basic method of family planning. As indicated above, the Ethiopian Government has committed itself to promoting contraception use by increasing accessibility and availability of information and services. In conformity with this, art 802 of the Penal Code of the country which provides "Whosoever, (a) advertises or displays in public, or sends to persons who did not solicit them or are not, by reason of their

[106] Ibid. p. 16
[107] Ibid. p. 17
[108] Ibid.
[109] Ibid. p. 18
[110] Ibid.
[111] Ibid. p.19
[112] Ibid.
[113] Ibid. p. 20
[114] Ibid.

profession, interested therein, contraceptive publications, contraceptive samples…is punishable with fine of arrest not exceeding one month" has been repealed as of 1998.[115]

The sale and distribution of contraception are regulated in the same manner as the sale and distribution of other pharmaceuticals.[116]

Sterilization

There are no specific laws on sterilization which is a method that has been used to control birth by family planning clients in Ethiopia. However, the legality of the procedure can be challenged based on the Penal Code articles 537 and 538, which prohibit the maiming and disabling of essential organs.[117]Nevertheless, the procedure is widely performed in the country mainly by the Family Guidance Association of Ethiopia, a national Ngo involved in family planning and related activities.[118]

Abortion

Under the 1957 Penal Code of Ethiopia, abortion is a criminal act if performed intentionally. That is, if the abortion resulted from negligence of the woman or another person, it is not punishable.[119] If performed intentionally, it is punishable regardless of the stage of pregnancy. The Ethiopian Penal Code prohibits any intentional act of termination of pregnancy from the time of conception.

Moreover, advertisement or offering for sale means or products designed to cause abortion, or public offering of services to perform abortion are punishable under the petty offenses.[120]If an attempt of abortion is performed on a woman who is not pregnant, but wrongly supposed to be pregnant, such attempt is punishable by applying the general provisions concerning offenses impossible of completion.[121]

The law reduces punishment if abortion is performed on account of an exceptionally grave state of physical or mental distress, especially following rape or incest, or because of extreme poverty.[122]The only exception to the prohibition of termination of pregnancy is, its termination to save the life of the pregnant woman or to protect her health from grave and permanent danger.[123] However, termination of pregnancy on this basis requires

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[115] 1957 Penal Code (Amendment), 21 Negarit Gazeta 923 (Dec 15, 1998) Proclamation No 141/1998
[116] Women of the World: Laws and Policies Affecting Their Reproductive Lives, The Center for Reproductive Law and Policy, (1997), p 20.
[117] Id p. 21
[118] Statistical Abstract (1997), Family Guidance Association of Ethiopia, Research and Evaluation Unit, Number 15, Addis Ababa, p
[119] Penal Code of Ethiopia (1957), Art. 528
[120] Ibid. Art. 528(2), 802(b)
[121] Ibid. Art. 532
[122] Ibid. Art. 533
[123] Ibid. Art. 534 (1).

the fulfillment of certain conditions, whose non-observance would result in the liability of the involved medical personnel. The conditions are:[124]

- A concurrent opinion of a second doctor qualified as a specialist in the alleged defect of health from which the pregnant woman is suffering, and empowered by the competent authority; and
- Consent of the pregnant woman or if she is incapable, the consent of her next of kin or legal representative.

If these conditions are fulfilled, pregnancy may be terminated at whatever stage of its development. Persons subject to punishment are:[125]

- The pregnant woman who procures her own abortion;
- Those who assist her, or provide her with the means to do so; and
- Those who perform the abortion or those who assist them.

Abortion is considered as an aggravated offense where the offender has acted for gain or habitually performs abortion.[126] Moreover, if the offender is a doctor, a pharmacist, a midwife or a nurse, the penalty may include prohibition from practicing the profession for a limited period, or even for life if the offense is repeated.[127]

Ethiopia has a restrictive abortion law, which allows termination of pregnancy only to save the life of the pregnant woman or to protect her health from grave and permanent danger. Other grounds such as eugenic grounds or social and economic grounds have been disregarded.

The draft amendment to the Penal Code, however, is relatively less restrictive since it allows termination of pregnancy, resulting from rape or incest; provided that the legal safeguards are observed. It seems that the termination of pregnancy on such grounds is possible during the entire period of gestation. However, the interpretation of 'legal safeguards' will be of key importance. Clearly, if a criminal conviction of rape or incest is a required condition, the pregnant woman is unlikely to benefit form this liberalization given the delays prevailing in the Ethiopian justice system.

The National Population Policy of Ethiopia notes that many Ethiopian women are faced with unwanted pregnancy and that many resort to unsafe abortion for the termination of their pregnancy.[128]The Policy recognizes that illegal/unsafe abortion is a serious social health problem in the country.[129] In the face of the outright prohibition of abortion by the Penal Code, the fact that the Population Policy recognizes the problem of illegal and thus unsafe abortion shows a tendency to deal with this issue openly.

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[124] Ibid. Art. 534 (3) (a), (b).
[125] Ibid. Arts. 529(1), (2); 530(1).
[126] Ibid. Art. 531(1).
[127] Ibid. Art. 531(2).
[128] Op Cit. Note 16, p10
[129] Ibid.

HIV/AIDS and STD's

The rapid spread of HIV/AIDS and other sexually transmitted diseases throughout Ethiopia, poses a serious threat to the physical and social well being of the people. The impact of these diseases on economic growth and development should also not be underestimated. From low adult prevalence rate in the early 1980's, HIV has been spreading rapidly in Ethiopia increasing by 3.2% by the early 1993[130]. By 1997, adult HIV prevalence had increased to 7.4 percent.[131] One study estimates that by 2014, expenditure for AIDS care could amount to one third of the entire budget of the Ministry of Health.[132]

Intervention for the prevention and control of AIDS has been made since 1985 by the establishment of National Task Force and later in 1987 by the creation of a National AIDS Control Program at a Departmental level within the MOH.[133]Further, in 1998 the National Government showed its commitment by issuing a National Policy on AIDS. The factors informing the issuance and shaping of the policy include recognition of:

- The "contribution of gender inequality in the further spread of HIV/AIDS in the country", and
- "the need for women, including women living with HIV/AIDS, to have access to information and services regarding HIV/AIDS and family planning that help them make reproductive choices and services regarding HIV/AIDS and family planning that help them to make reproductive choices and decisions".[134]

The general objective of the policy is to prevent and control HIV/AIDS in the country.[135] Its specific objectives include:

- Promoting a broad multi-sectoral response to HIV/AIDS epidemic;
- Coordination of the activities of different sectors and the mobilization of resources for the control of the epidemic;
- Encouraging government sectors, non-governmental organizations private sectors and communities to take measures in order to alleviate the social and economic impact of HIV/AIDS;
- Safeguarding the human rights of people living with HIV/AIDS and avoiding discrimination against them; and
- Empowering women, youth and other vulnerable groups to take action to protect themselves against HIV/AIDS.[136]

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[130] AIDS in Ethiopia, Background, Projections, Impacts, Interventions; Epidemiology and AIDS Department, MOH (1998) 2nd ed., p5
[131] Ibid.
[132] Ibid p.23
[133] Ibid p.37
[134] Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia (1998) p.23
[135] Id.
[136] Id. P24-25

The first strategy for the implementation of the policy is the provision of IEC through various outlets.[137]In this regard the policy states that emphasis shall be given to women and that women shall be empowered to decide and negotiate for safer sex and use of condoms when necessary.[138]The policy also deals with STD prevention and control by, among other things, providing for education and counseling to patients on risk reduction, treatment compliance, condom instruction, distribution, notification and treatment of partners.[139]Other strategies touch upon different areas such as HIV testing and screening, sterilization and disinfecting, HIV surveillance, notification and reporting and medical care and psychosocial support.[140]

The policy, if fully implemented, has potential to greatly improve the social and health conditions of women.

IV. Practical Implementation of Reproductive Human Rights in Ethiopia

As discussed earlier, reproductive health rights center on having the number of children wanted, when they are wanted. This has been recognized by the international community as a fundamental human right, since the adoption of the Tehran Proclamation in 1968. The subject was comprehensively approached by the ICPD (1994), which can be said to be the first global conference to take a board view of women's sexual and reproductive rights. Later, the Beijing Conference has also confirmed the centrality of reproductive rights for the advancement of women. In these latter influential international conferences and the resulting documents, besides family planning, RHR includes prevention of treatment of AIDS and other STDs, safe pregnancy and childbirth, and management of complications arising from unsafe abortion. In this regard, obligation of states is to remove legal and policy barriers to such rights on the one hand, and to create suitable economic and social circumstances for the exercise of the right on the other. In as much as possible, such services should be integrated in the primary health care, the accessibility and affordability of which should be ensured to the whole population. Beautiful laws and policies accomplish nothing unless they are accompanied by IEC, availability, accessibility and affordability of services.

In light of what has been mentioned above, the preceding chapter has attempted to assess the relevant Ethiopian laws and policies. This has been done with the purpose of disclosing gaps, if there are any, between international legal and ethical standards and national laws and policies. It seems that there is no significant gap except in the area of termination of pregnancy. As shown in chapter II, even though there is no specific international standard on abortion, there is a tendency for liberalization. The international community has noted the consequences of unsafe and illegal abortion and has urged states to take due consideration of the matter. That the current Ethiopian law (Penal Law) allows abortion on strict grounds is already discussed.

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[137] Id. p.26
[138] Id p.27-28
[139] Id. P.28
[140] Id. P.29-31

As regards the actual exercise of reproductive human rights in Ethiopia, services for maternal and reproductive health are very limited and only 46% of the people have access to any form of health service.[141]In the coming sections, we will focus on the knowledge and use of FP methods, availability of FP services and the practice of abortions.

Knowledge and use of family planning

Contraception

A recent nationally representative survey conducted by the Central Statistical Authority of 15,367 women of age 15-49 and 2,607 men of age 15-59 indicated that knowledge of family planning (FP) is high in Ethiopia, with four in five women (82 percent) and nine in ten men (86 percent) in the reproductive age group being aware of a method.[142] Knowledge is slightly higher among currently married women (86 women) than among all women.[143] However, the use of contraception is generally low although there is variation between urban and rural areas and between the educated and uneducated groups.[144] The most commonly known and used modern method of contraception in the country is the pill followed by injectables and condom.[145] Current use of these modern methods by urban women is nine times higher (28 percent) than rural women (3 percent).[146] Education plays a significant role with 45 percent of women with secondary education or higher reporting use of family planning method, as compared with 16 percent of women with primary education and 5 percent of women with no education.[147]

Overall, contraceptive use among women in the reproductive age group increased from 4% to 6% in the decade from 1990-2000.[148] One UNFPA publication reports that clinic services increased by 26 percent when family planning service providers in Ethiopia stopped requiring spousal consent.[149]As concerns service delivery, 78% of current contraceptive users obtained service from the public sector; 7% from non-governmental organization, 9% from private facilities and 6% obtained a method from drug vendors, shops, friends/relatives or others.[150] Within the public sector, government health centers are the principal source, supplying one in three users of modern methods while in the private sector pharmacies are the most important source.[151] Of the NGO's providing family planning and related reproductive health care services, the Family Guidance Association of Ethiopia (FGAE) is the most active, with 7 branch offices in different parts of the country, which themselves encompass different service delivery outless such

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[141] "Unsafe/Illegal Abortion in Ethiopia," African Journal of Fertility, Sexuality and Reproductive Health, Vol 1 Number 1 (1996) p.69
[142] Ethiopia Demographic and Health Survey, Central Statistical Authority, Macro International Inc., Calverton, (2000), p.7
[143] Ibid.
[144] Ibid. p11
[145] Ibid. pp7
[146] Ibid. P(vii)
[147] Ibid. p11
[148] Ibid.
[149] Population Issues, Briefing Kit 2000, UNFPA, p.7
[150] Op. Cit Note 2 p.11
[151] Ibid.

as clinics and community based distribution (CBD)[152]. By 1997, FGAE had over 400 service delivery outlets, which catered for about 300 thousand FP clients.[153]

In the assessment of fertility preferences, many Ethiopian men and women expressed a desire to control their fertility. The above mentioned survey reports that one in three women and men stated that they did not want more children.[154] The need is high as compared to actual use. For instance where around 30% of women desire to control their fertility, only 6% of women in the reproductive age group reported use of contraception in 2000. This discrepancy indicates an unmet need, the cause of which is not reported in the survey. Elsewhere, there are indications of a lack of IEC and sevices with respect to modern contraceptive methods.[155]

Sterilization

Female and male sterilization as a method of fertility regulation is less well known than the pill, injectables and condom.[156]Actual use is also insignificant as the demographic survey referred above shows that only 0.2% of all women and 0.3% of currently married women have undergone sterilization.[157] The FGAE which provides this permanent method of voluntary surgical contraception (VSC) has given the service to 54 men and 4424 women form 1987 to 1997.[158]Because of the fact that the method is irreversible, most women who required the operation were those whose life or health would be put at risk by a further pregnancy or childbirth.[159] For instance women who had three births through caesarian section, those with heart problem, or women who are hypersensitive are usually advised not to have more children in which case the medical personnel propose the sterilization operation.[160]

Like any other operation, the sterilization operation needs the consent of the patient. Since it is a procedure which disables the reproductive function of the person on whom the operation is to be performed, consent is crucial. Implicit in this condition is the necessity of attaining the age of consent to undergo the treatment on the basis of one's own decision. However, health institutions do not require spousal consent.[161]

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[152] Statistical Abstract (1997), Family Guidance Association of Ethiopia, Research and Evaluation Unit, Number 15, Addis Ababa, p.4
[153] Ibid. pp16, 17.
[154] Op. Cit Note 2, p.12
[155] Op. Cit. Note 1 P.69
[156] Op. Ct. Note 2, pp 7, 8
[157] Ibid. P.8
[158] Op Cit. Note 12, p.27
[159] An Interview with Dr. Ashebir Getachew, Medical Director at Ghandi Hospital, 2 Oct. 2000
[160] Ibid.
[161] An Interview with W/ro Hiwot Mengistu, Family Health Department, MOH, cited at Women of the World: Laws and Policies Affecting their Reproductive Lives, The Center for Reproductive Law and Policy (1997), p.21

The Practice of Abortion

As indicated above, Ethiopia has a restrictive abortion legislation allowing termination of pregnancy only to save the 'life' or 'health' of the mother. This is expected to prevent abortion from taking place. However, it has been mentioned time and again that restrictive abortion laws are seen when succeeding not in limiting the practice but in preventing women from having access to safe abortion services and thus promoting back-street abortions. Ethiopia is no exception to this situation. Despite the prohibitive law, the practice is increasing at an alarming rate and it is estimated that unsafe/illegal abortion account for 54% of all direct obstetric death[162]. More than half of these are poor and unemployed young women under the age of 20 years.[163] One study has indicated that of registered 9712 pregnancies during the study, 51.3% were stated as "unwanted pregnancies" and that out of the studied abortion cases 92% were performed in unsafe conditions.[164] This shows that the problem is serious and affects large numbers of women.

The Ethiopian law that proscribes abortion is commonly defied, firstly by the woman who has her pregnancy terminated on non-medical grounds. If this woman who is the 'carrier' of life wants to end it, she must be in a very desperate situation.[165]She is also the principal victim in the process, so if the law subjects her to penal sanctions, it victimizes her for the second time. However, such punishment of women in this situation is not common. Experience shows that the law enforcement agencies hesitate to apply the full force of the law, and also face difficulty in obtaining evidence.[166] Thus, many of the convictions that are obtained, are not based solely on the ground of abortion, but also on the death or bodily injury of the woman.[167] Therefore, the law is not commonly enforced, and therefore cannot regulate social behavior because it lacks a normative character. Women with unwanted pregnancies who have decided on abortion will obtain it despite the law. For those with sufficient money, there are places with relatively good facilities and skilled personnel. For instance, it has been reported that the Dejazmatch Balcha Hospital provides such service.[168] The poor, who represent the majority of the Ethiopian women risk their health and lives by turning to unskilled persons who perform the procedure in unsterile conditions. In the end, the law merely discriminates against the poor.

The consequences of unsafe abortion are not limited to jeopardizing maternal health and life. As a result of incomplete abortions or other complications, many women are

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[162] Op Cit. Note 1, p. 68
[163] Ibid.
[164] Ibid.
[165] Original Wolde Giorgis, "Legal Issues Concerning Unsafe and Illegal Abortion in Ethiopia", Proceedings of the VII Annual Conference of the Ethiopian Society of Obstetricians and Gynacologists, (May 17-18, 1999), Addis Ababa, p.53
[166] Interviews with Ato Amha Mekonnen, Prosecutor at Federal High Court (4. Oct. 2000); Ato Tekeste Berhan Taye, Judge at First Instance Court?
[167] Op Cit Note 25, pp 61, 62
[168] Seyoum GebreSelassie (PhD), "The Social Impact of Illegal and Unsafe Abortion," Proceedings of the VII Annual Conference of the Ethiopian Society of Obstetricians and Gynacologist

admitted to hospitals gynecological wards. Such cases consume a disproportionate share of the limited health care resources such as hospital beds, medication and medical specialists.[169] In a study on unsafe abortion conducted in five hospitals in Addis Abeba over a period of 6 months, there were 180.2 induced abortions per 1000 deliveries.[170] The mean stay in hospital of such patients was 2.96 days.[171] This is an unnecessary burden on already scarce health resources.

One of the reasons that the Ethiopian National Population Policy did not consider abortion in its package of reproductive health services was the fact that health service delivery was already over burdened.[172]However, it seems that this objective is defeated, not only because women are not deterred from seeking services at the hospitals but also because they come after undergoing an unsafe procedure. In this case, their treatment is more costly or they may have already suffered permanent damage, if not death.

Besides the fact that the abortion legislation's purpose of deterring induced abortions is not served, the purpose itself is questionable. When safe abortion services are lacking, due to the prohibitive law, a woman may be forced to carry the pregnancy to term for fear of risking her health and life through unsafe places abortion. Even if it can be said that the woman could and should have avoided the pregnancy, forcing her to have the child is not sensible when she is neither interested nor ready to be a mother. In the case of an adolescent, she may have to discontinue her education, jeopardize her opportunity to improve herself and thus become a burden to her guardians and the society at large.

Currently, Ethiopian society appears to be favorably disposed towards liberalization. The issue has become an area of public discussion and some groups of the society are openly suggesting liberalization. For instance, the Ethiopian Society of Obstetricians and Gynecologists held a conference on "Illegal and Unsafe Abortion in Ethiopia" from May 17-18, 1999 which has attended by different bodies including the National Population Office.[173] Among the recommendation forwarded by the conference participants, one is the revisions of the law on abortion to "accommodate safe abortion services for vulnerable groups at selected institutions.[174]

A small survey in which 60 women and 25 men were asked to state their opinion on the liberalization of the Ethiopian abortion law, found that 42 of the women and 14 of the men were in favor of liberalization. While this does not attempt to be a representative survey, it helps to give some insight on people's attitudes on the subject.

Overall, it may be seen that the provisions of the Ethiopian Penal Code provision aimed at regulating the practice of abortion, have failed to do so. They need to be revised with a

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[169] Seyoum Yoseph (MD) "Unsafe Abortion in Addis Abeba" Proceedings of the VII Annual Conference of the Ethiopian Society of Obstetricians and Gynecologists, May 17-18, 1999 (Addis Abeba) P.28
[170] Ibid. P.29
[171] Ibid. P.30
[172] Op. Cit Note 28, p.51
[173] Proceedings of the VII Annual Conference of the Ethiopian Society of Obstetricians and Gynecologists (May 17-18, 1999), "Illegal and Unsafe Abortion in Ethiopia." P.64
[174] Ibid.

view to providing a concrete solution to this serious social problem. Turning a blind eye to the problem will not make it disappear.

Conclusion and Recommendations

Conclusion

Reproductive human rights are a basic human right of all individuals. However, they are especially significant to women whom nature makes responsible to carry and nurture new life. These rights are largely manifested by the ability to have a safe and satisfying sexual life as well as control over one's fertility. These would lead individuals to freely decide the number, timing and spacing of their children and enjoy their sexual life without fear of STDs including HIV/AIDS and/or unwanted pregnancies.

There are a number of international instruments, which recognize reproductive health rights (RHR) as basic human rights, beginning with the Teheran of 1968. This was followed by the 1974 World Population Plan of Action, adopted by the Bucharest Conference. Both instruments underline the right of individuals to decide, freely but in a responsible manner, the number and spacing of their children. Subsequently, various other international conferences have dealt with the subject matter. The 1994 Cairo Conference on Population and Development was the first conference to take a broad view of reproductive health rights, declaring that reproductive health is not just the absence of disease or infirmity but complete physical, mental and social well being in matters pertaining to the reproductive system.

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and others such as the Vienna Declaration and the Beijing Platform for action have immensely contributed to the development of women's reproductive health rights. With the exception of CEDAW, these instruments are consensus documents with no building force, but they require states to duly consider and make every endeavor to facilitate the enjoyment and exercise of RHR by women. The general understanding is that states should forbear from interfering in individuals' freedoms and that they should, to the extent possible, allocate ever increasing resources for reproductive health care. They should make comprehensive RH services available, accessible and affordable to the public at large.

In accordance with these conditions, states should remove legal and policy barriers. This includes considering the reviewing of laws containing punitive measures against women who have undergone illegal abortions.

If any decision is to be made by individuals and couples with respect to reproductive health rights, such decision must be based on information and education. It is believed that the availability of up to date information and perpetual education play a key role in the exercise of reproductive health right. As far as the method for birth control is concerned, there is no definite international standard. The same goes for the practice of abortion. However, the international community has agreed that abortion should in no

way be considered as a family planning method. Nevertheless, services should be made available to treat complications arising from unsafe/illegal abortions. Furthermore, the Committee on the Elimination of Discrimination Against Women, a very influential UN body that monitors compliance with the CEDAW has stated that barriers to reproductive health rights include criminalizing medical procedures only needed by women. Such medical procedures could be interpreted to include abortion.

Reproductive health rights have a well established link with rights that are prescribed in the UDHR, ICCPR and other international treaties and documents. These rights include: the right to life, the right to privacy, the right to liberty and security of the person, etc. The enjoyment and exercise of these reproductive health rights would pave the way for the enjoyment and exercise of these fundamental freedoms and rights. This is particularly true for a woman, since her ability to control her reproductive life would enable her to keep her health and save her time, energy and money so that she could strive for her advancement and empowerment. Hence, it is said that the reproductive health right is a right from which many other rights spring.

The practice of most countries shows that they have recognized and taken various measures for the implementation of reproductive health rights. A country with a unique experience is China where family planning is an obligation rather than a right. China has a One-Child-Policy where generally couples are constrained to restrict their family size to just one child.

Abortion laws of several countries have also been assessed to show the current trends on this issue. At present, the majority of the world's population lives in countries where abortion laws are liberalized. It is known that restrictive abortion laws do not limit the practice. Such laws are widely violated as a result of which many women with unwanted pregnancies resort to unskilled abortions, thereby putting their lives and health at risk. It has been found that criminalizing the abortion procedure contributes highly to maternal mortality and morbidity. Cost-wise, resources are unnecessarily wasted in treating the complications arising from unsafe/illegal abortions while it is possible to provide services for the termination of unwanted pregnancies through simple and safe procedures at minimal cost. It is also worthy of note that due to advancements in medical science, abortions that take place during the first trimester are less risky than normal childbirth.

In the Ethiopian context the different dimensions of reproductive health rights are recognized by various laws including, the Constitution of the FDRE, which guarantees the family planning right of women. Policies on Women, Health, Population and AIDS has also prescribed the reproductive health rights of women. Among these, the National Population Policy gives a wide coverage to the reproductive health rights of women by focusing on both quantitative and qualitative objectives. All the policies have the improvement of the status of women among their objectives. However, Ethiopia is among the countries with restrictive abortion laws allowing termination of pregnancy only to save the woman's life and health.

The use of family planning in Ethiopia is low, although knowledge of it is high. As regards service delivery, there are private and public service providers. Within the public sector, government health centers are the most important source.

There is also a high incidence of unwanted pregnancies most of which result in abortions. Because of the restrictive law, there are no safe and affordable services of termination of unwanted pregnancies. Therefore clandestine abortion, which is very common in the country, contributes to 54% of all direct obstetric deaths.

Recommendations:

It is clear that the full guarantee of reproductive health rights by governments requires the removal of legal barriers and the provision of IEC and services pertaining to reproductive health. In this respect, the Penal Law that criminalizes abortion should be reviewed. It is recommended that:

1. In the following circumstances and conditions, abortion should be considered as the right of women:

    - That a pregnancy may be terminated during the first 12 weeks of pregnancy:

        a. If the continued pregnancy would, in the opinion of a medical practitioner, risk the life of health of the mother;
        b. If a medical practitioner is of the opinion that there is a risk of injury or malformation of the fetus;
        c. If the pregnancy resulted from rape or incest;
        d. If the economic and social circumstances of the woman justify it.

    - A pregnancy may be terminated from the first 12 weeks up to the 20th week if, in the opinion of a medical practitioner, the continued pregnancy would:

        a. Risk the life of health of the mother;
        b. If a medical practitioner is of the opinion that there is a risk of injury or malformation of the fetus;

    - After the 20th week of the gestation period, a pregnancy may be terminated only to save the pregnant woman's life.
    - That the termination of a pregnancy may only be carried out by a licensed medical practitioner;
    - That the termination of a pregnancy may take place only at a place designated by the Ministry of Health;
    - Informed consent of the woman who has attained the age of capacity is necessary

- A pregnant minor shall be advised to consult with her parents, relatives or other family members before consenting to the termination, provided that the termination to the pregnancy shall not be defined because such minor chooses not to consult them.

2. That FGM should be specifically criminalized. As the practice seriously jeopardizes RHR of women, the penalty should be sufficiently proportional to deter the practice.

   - That the government should take action to:

- Facilitate informed choice by making IEC available and accessible;
- Disseminate family planning information and education through the mass media, and the curricula of schools;
- Make the utmost effort to ensure the availability, accessibility and affordability of integrated reproductive health services to all individuals of reproductive age.
- To ensure that reproductive health information and services are not conditioned to age, marital status or spousal consent;
- Such services should include family planning information and services, prenatal, safe delivery and postnatal care, prevention and treatment of infertility and STDs including HIV/AIDS and services for safe abortion;
- Regulate quality, efficacy and safety of contraceptive methods;
- Encourage NGO involvement in the provision of reproductive health care services including safe abortion, to overcome the problem of the already scarce health resource of the country;
- Develop programs, in collaboration with NGOs, aimed at proliferating service delivery sites for simpler contraceptive methods, in order to reduce unwanted pregnancies and thus recourse to abortion. Such services can be provided by health officers with simple training. Clients needing more complicated services could be referred to clinics or hospitals with better facilities.

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