THE RIGHT TO KNOW

Human rights and access to reproductive health information

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relationship, this study focuses on reproductive choice as an end in itself.) Information about fertility rates can provide some indication of the degree of reproductive choice when examined in conjunction with other information such as desired family size. This study includes data, where available, about the extent of "unmet need", that is, the percentage of women or couples who want to delay or prevent future births but are not using effective methods of contraception.

Figures are included about the percentage of the population that lives in rural areas because people in rural areas generally have far less access to family planning and other health services than do people in urban areas.

Information about literacy and educational levels is included for two reasons. First, education and literacy are key to the empowerment of women; in most countries covered in this book, a woman's educational level is the single most important variable contributing to the likelihood that she will be using an effective method of contraception if she desires to postpone or prevent future pregnancies. Second, in order to be able to make informed reproductive choices, women with low general educational levels require more information communicated with greater sensitivity than do women with higher educational levels. For both these reasons, low levels of education for girls and low literacy rates for women are significant indicators that a government may be failing in its obligation to ensure that women have adequate information to make informed choices about their health and that of their children.

Expenditure on Health

The World Health Organization (WHO) considers the percentage of GNP spent on health care by the public and private sectors to be a rough indicator of the government's commitment to health. Health expenditures are defined to include funding for hospitals, maternity and dental centres, and clinics with a major medical component; national health and medical insurance schemes; and preventive care and family planning. Five per cent of GNP has been set as a global target.[4]

In 1990, 7 per cent of Algeria's gross domestic product (GDP, which is roughly comparable to GNP) was spent on health care; 4.2 per cent of Brazil's (or approximately US$132 per person); 4.5 per cent of Chile's (approximately US$98 per person); 7.1 per cent of Ireland's; 4.3 per cent of Kenya's; 5 per cent of Malawi's; 3.4 per cent of Pakistan's; 2 per cent of the Philippines'; 5.1 per cent of Poland's; and 12.7 per cent of the United States'.[5]

Foreign governments (including, in particular, the US, Japan, Germany and the European Union) have granted a considerable amount of funding for health programmes to the governments of developing

countries examined in this book. Foreign donors provided funding for 22.3 per cent of Kenya's health care costs; 23.3 per cent of Malawi's; 5.4 per cent of Pakistan's; and 7.8 per cent of the Philippines'.[6] Foreign donors provided virtually no funding for health care in Algeria, Brazil and Chile.[7]

Family planning services currently account for less than half of 1 per cent of government budgets of developing countries, and less than 1.5 per cent of all foreign aid to developing countries.[8] The UN estimates that about US$6 billion is currently spent on population, family planning, and reproductive health programmes in developing countries, of which about $1 billion is spent by international donors (primarily the US, Japan and Europe), and the rest by the developing countries themselves.[9] The 1994 Programme of Action of the International Conference on Population and Development (ICPD) calls for world expenditures to increase annually to $17 billion (in 1993 US dollars) by the year 2000; these sums are required if the broad goals agreed upon by the ICPD are to be met, including in the areas of family planning ($10.2 billion), reproductive health ($5 billion), prevention of HIV/AIDS and sexually transmitted diseases ($1.3 billion), and data collection ($0.5 billion).[10] The ICPD calls on developing countries to meet about two-thirds of the costs themselves ($11.3 billion by the year 2000, or more than twice the sum they currently spend), and calls on donor governments to increase their contributions to meet the remaining one-third (up from $1 billion in 1994 to $5.7 billion annually by the year 2000).[11]

Fertility Rates

It is estimated that between 1960 and 1990 the total fertility rate in sub-Saharan Africa declined from 6.7 to 6.5 children per woman; in the Middle East and North Africa, from 7.0 to 5.1; in South Asia, from 6.0 to 4.4; in Latin America, from 5.9 to 3.2; in East Asia and the Pacific, from 5.8 to 2.6; and in developed countries, from 2.8 to 1.8.[12] A 1994 UN study of fertility rates for the period 1990-1995 projects a continuing decline, and estimates that the rate for "more developed regions" will be 1.7; for "less developed regions", 3.5; and for "least developed countries", 5.8.[13]

Infertility

An estimated 8 to 12 per cent of couples, 50 to 80 million people around the world, experience some form of infertility during their reproductive lives.[14] Over 55 per cent of cases of infertility are the result of sexually transmitted diseases (STDs) or of pregnancy or abortion-related complications, and are preventable.[15]

1970-1975: Africa's overall average infant mortality rate fell by 38 deaths per 1,000 live births during that time; and the rate in North Africa fell from 132 to 67 per 1,000.[37]

In both developing and developed countries, infant and child mortality is linked to patterns of childbearing. "Three aspects of childbearing influence child survival: birth spacing, maternal age, and birth order. Of these, birth spacing is the most powerful factor."[38] Children born less than two years after a previous birth are twice as likely to die in infancy as are children born after a longer interval, and they are 50 per cent more likely to die between the ages of 1 and 4 than are other children.[39] Children born at the start of a short birth interval are also two times more likely to die in early childhood than those born at the start of a longer birth interval. It has been estimated that 1 in 5 infant deaths could be averted through appropriate birth spacing.[40]

Women who use modern methods of contraception are more successful in spacing births than those who do not.[41] In countries where large percentages of women have adopted family planning, the resulting changes in childbearing patterns have contributed significantly to a reduction in infant and maternal mortality.

Maternal Mortality

The World Health Organization has estimated that 500,000 women die every year from avoidable pregnancy-related causes, 90 per cent of whom live in developing countries.[42] The maternal mortality rate in developing countries averages 13 times higher than in industrialized countries.[43] In many developing countries, over one-quarter of all deaths of women of reproductive age are pregnancy related.[44] In many of the least developed countries in sub-Saharan Africa and South Asia, the maternal mortality rates are 200 times higher than those in industrialized countries: the average lifetime risk for a woman in an industrialized country dying of pregnancy-related causes is between 1 in 4,000 and 1 in 10,000, compared with an average risk for women in developing countries of between 1 in 15 and 1 in 50.[45] A significant factor contributing to this disparity in maternal mortality—one of the greatest in any area of public health[46]—is the more restrictive abortion laws in developing countries.[47]

Maternal mortality in North America and western Europe has been quite low compared to the rest of the world; it is estimated that there were 3 maternal deaths for every 100,000 live births in 1988 in Ireland; 13 per 100,000 in the United States; and 15 per 100,000 in Poland.[48]

According to UNDP estimates, there were 210 maternal deaths in Algeria for every 100,000 live births in 1988; 230 per 100,000 in Brazil; 67 per 100,000 in Chile; 400 per 100,000 in Kenya; 500 per

100,000 in Malawi, 600 per 100,000 in Pakistan; and 250 per 100,000 in the Philippines.[49]

Childbearing is least safe for teenagers and women over the age of 35. Between 10 and 20 per cent of babies born in developing countries are to women in their teens.[50] One study in Nigeria found that women aged 15 had a maternal mortality rate 7 times that of women aged 20 to 24.[51] When pregnancy interrupts the normal course of development in teenagers, risks include anaemia and related illnesses (especially for girls who conceive within two years of menarche), toxaemia, miscarriage, stillbirths, foetal and infant deaths, haemorrhage, and prolonged labour.

A study conducted in Jamaica found that the risk of death was twice as high for women aged 30-34 as for women between 20 and 24, and that the risk for women aged over 40 was 5 times as high.[52] After the third birth, the risk of serious complications also increases steadily with each further birth.[53]

It has been estimated that by averting unwanted pregnancies through family planning, maternal deaths could be reduced by 35 per cent in Asia, 33 per cent in Latin America, and 17 per cent in Africa.[54]

Overall Impact of Spacing Children on the Health of Families

Spacing children, delaying the first pregnancy, having four or fewer children, and not having children after the age of 35 not only directly correlate to reduced maternal, infant and child mortality. In addition, family planning, especially among poorer women, improves the general health and well-being of families.[55] Because health, nutrition, education and augmentation of income are generally managed at the household level by mothers, these are most likely to be improved when mothers have more time and energy to devote to them.[56]

Contraceptive Use and Availability

It has been estimated that by 1993 about 75 per cent of couples of reproductive age in industrialized countries were using some form of contraception, of which 50 per cent used a modern method.[57] The percentage of married women in developing countries in Asia, Africa and Latin America who were using some form of family planning method increased from about 20 per cent in the period 1960-65 (10 per cent using a modern method, and 10 per cent, a traditional method) to approximately 55 per cent in 1990 (50 per cent using a modern method, and 5 per cent, a traditional method).[58]

There is, however, a wide variance among regions. UNICEF has estimated that in sub-Saharan Africa the percentage of married women using some form of contraception increased from 5 per cent in 1960-

Around the world, unsafe abortion is one of the five major causes of maternal death (along with haemorrhage, infection, hypertension and obstructed labour).[81] The World Bank estimated that at least 60,000 women die each year from unsafe abortion;[82] another expert estimated the figure at between 100,000 and 200,000.[83]

In addition to death, unsafe abortion also results in long-term health effects, many of them grave (such as gynaecological problems and infertility). In developing countries, up to 40 per cent of admissions to maternity hospitals are due to complications arising from unsafe abortion.[84] Unsafe abortions not only have severe negative health consequences for women: societies also suffer owing to the health care costs of treating abortion-related complications.[85]

Abortion is legal in most circumstances in most of the countries in Europe and North America. In Poland, changes in laws and regulations beginning in 1990 culminated in the passage of a restrictive law in March 1993, thereby placing Poland with Andorra, Ireland and Malta as the only countries in Europe where abortion is prohibited except for narrowly defined medical reasons.[86] Abortion rates in Eastern Europe are believed to be still among the highest in the world: in the mid-to-late 1970s, the abortion rate (number of abortions per woman on average) was slightly more than 2 in Bulgaria, Romania and Yugoslavia and as high as 5-7 in the former Soviet Union.[87] During the mid-1980s 18.1 per cent of women aged 15-44 in the former Soviet Union were estimated to have an induced abortion each year.[88] While those rates are dropping owing to improved access to contraceptives, the rates remain high. In western Europe and North America, abortion rates during the mid-1980s were quite low; in the Netherlands, 0.5 per cent of women had induced abortions; in Canada, 1.2 per cent; in England and Wales, 1.4 per cent; and in the United States, 2.7 per cent.[89]

In virtually all countries of western Europe and North America the mortality rate due to abortion is low; for instance, in the US in 1985, only 4 deaths occurred for every 1 million abortions performed,[90] or about 0.3 deaths per 100,000 women. In contrast, in Poland in 1991, the first year that abortion was not available free of cost, there were 18 abortion-related deaths per 100,000 women.[91]

In Pakistan and the Philippines, abortion is prohibited except to save the life of the woman. In Pakistan, there is very little data about abortion rates, but hospitals perform a high number of emergency abortions, and it is assumed that the abortion rate is high.[92] In the Philippines, it is estimated that 20 per cent of pregnancies are terminated annually by abortions, and that 24 per cent of all maternal deaths in 1985-86 were attributable to induced abortion.[93]

In Malawi a 1989 study found that 18 per cent of maternal deaths were caused by poorly performed abortions;[94] in Kenya, the figure is probably over 20 per cent.[95] In Algeria, the most significant cause of

maternal mortality is uterine perforation, of which half are estimated to be the result of poorly performed abortions.[96]

In all countries of Latin America except Cuba, abortion is legal only to save the life of the woman, and in some countries, in cases of rape or incest; nonetheless, abortion is common.[97] Some 4 million abortions are estimated to be induced each year throughout Latin America, of which about 800,000 require hospitalization.[98] It is estimated that 31 per cent of induced abortions in Chile in 1992 resulted in serious complications, and that 24 per cent of women who had abortions were hospitalized.[99] In Brazil, 42 per cent of women who had induced abortions were estimated to experience serious complications and 29 per cent were hospitalized.[100]

HIV/AIDS Infection and Sexually Transmitted Diseases

Although accurate data are difficult to obtain, an estimated 2.7 million people around the world had developed AIDS as of early 1992, 90 per cent of whom had already died.[101] In 1993, it was estimated that 14 to 18 million adults were infected with HIV, possibly double the 9 million people estimated to be infected in 1990.[102] Moreover, there are few indications that the policies and programmes designed to reduce the spread of HIV have had a significant impact.[103]

Cases of AIDS have been reported in 164 countries and HIV has been found in virtually every country in the world. Fifteen per cent of HIV-infected people live in North America or Western Europe; over 8 per cent live in Latin America, and 5 per cent live in Southeast Asia. Sub-Saharan Africa is by far the most severely affected: with 9 per cent of the world's adult population, the region accounts for 66 per cent of the world's HIV-infected adults.[104] Although current estimates suggest that AIDS will not have a significant effect on population growth rates at the country level, there is no doubt that in the communities hit hardest by the pandemic, AIDS will have serious health, social and economic consequences.[105]

Women are at higher risk than men of becoming infected with HIV: they exercise far less control over the use of condoms, run a higher risk of infection from their regular partners,[106] and become more susceptible to infection when they suffer from "conventional" STDs.[107] In North America and Eastern Europe there is currently a substantially higher rate of HIV-infection among men than among women; in Latin America, Northeast Asia and Western Europe, there are 4 to 5 times as many infected men as women; in sub-Saharan Africa, equal numbers of men and women are infected.[108] Globally, women's share of HIV infection has grown rapidly from 20 per cent in 1980 to 40 per cent in 1993.

[51] E Royston and S Armstrong (eds.), *Preventing Maternal Deaths* (Geneva: WHO, 1989), 47.

[52] Ibid. at 47.

[53] Ibid.

[54] D Maine, *Safe Motherhood Programs: Options and Issues* (New York: 1991), 22. These figures are based on the World Fertility Survey conducted between 1974 and 1982.

[55] CEDAW, General Recommendation 21 (equality in marriage and family relations (13th Sess., 1993), at para. 21 (re Article 16(1)(e)), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc. HRI/GEN/1/Rev.1, of 29 July 1994.

[56] Ibid.

[57] UNFPA, note 9 above, at 21.

[58] UNICEF, note 12 above, at 8 (figures supplied by WHO, Geneva, Aug. 1993).

[59] Ibid., at 9, citing J Ross, et al., *Family Planning and Child Survival Programs, 1991* (Population Council, 1992).

[60] Ibid., at 64-65, Table 1; and 76-77, Table 7.

[61] Ibid. See also UNFPA, note 9 above, at 24.

[62] *The World's Women*, note 50 above, at 61.

[63] UNFPA, note 9 above, at 28.

[64] *The Reproductive Revolution: New Survey Findings: Population Reports, Series M, No. 11* (Baltimore, Maryland: Population Information Program, Johns Hopkins University, 1992). See also Dr Nafis Sadik, ICPD Secretary-General, keynote address at a conference on "Perspectives from the Global South", Washington, DC, 30 Mar. 1994, sponsored by American University.

[65] UNICEF, note 12 above, at 47.

[66] The Alan Guttmacher Institute, *Clandestine Abortion: A Latin American Reality* (New York and Washington, DC: 1994), 8 and 10.

[67] UNICEF, note 12 above, at 50, citing a Demographic Health Survey (1989).

[68] Ibid., at 50. Demographic Health Surveys in Nigeria (1990) found an unmet need of 21 per cent; in Zimbabwe (1988-89) 22 per cent; in Mali, 23 per cent; in Burundi, 26 per cent; in both Botswana (1988) and Uganda (1988-89), 217 per cent; in Liberia, 32 per cent; in Ghana, 34 per cent. Only in Togo was the unmet need of 42 per cent higher than in Kenya. See also UNFPA, note 9 above, at 29.

[69] UNICEF, ibid., at 50 (citing a Demographic and Health Survey).

[70] A Tadiar and F Tadiar, "Reproductive Rights of Filipino Women: Legal Basis and Problems", at 62, in *Speaking Out: A Consultative Forum Toward a Legislative and Administrative Advocacy Program for Women* (Quezon City: Institute for Social Studies and Action, 1993).

[71] S Harlap, K Kost, and J D Forrest, *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States* (New York: The Alan Guttmacher Institute, 1991). Of the couples interviewed who did not want a pregnancy within the next two years, 84 per cent said they were using some modem form of contraception, and 4 per cent were using a traditional method.

[72] *World Bank Report*, note 4 above, at 201; and Grzegorz Mrugala (IPPF Programme Officer), *Family Planning in Poland and the Impact of the Roman Catholic Opposition* (1992).

[73] For instance, according to one study, some 80 per cent of women in the Dominican Republic who said that they knew how to use the pill did not in fact know how to use it correctly. In Colombia, 58 per cent of rural women using the pill used it incorrectly. In contrast, in Rio de Janeiro, even among low income women, only 23 per cent of pill users did not know how to use the pill correctly. In Brazil, Colombia, the Dominican Republic and Peru, almost 60 per cent of the women believed that the pill has serious side-effects, and about 40 per cent think that using an IUD leads to health complications. *Clandestine Abortion*, note 66 above, at 9.

[74] Ibid.

[75] UN Population Division, Department for Economic and Social Information and Policy Analysis, Population Division, *Wall Chart: World Abortion Policies, 1994* (New York and Geneva: UN, 1994). Abortion is officially illegal in 16 countries: Djibouti, Mauritius, Central African Republic, Sao Tome and Principe, Egypt, Bhutan, Nepal, the Philippines, Andorra, the Holy See, Malta, San Marino, Chile, Dominican Republic, Honduras, and Colombia. However, in several of these countries—including the Philippines, Chile, Dominican Republic and Colombia—emergency abortions are performed in hospitals to save the woman's life and prosecutions are rare despite a high number of abortions. There is no information about Micronesia.

[76] Ibid.

[77] Ibid.

[78] Ibid., and press release issued by the UN on 10 May 1994 (PR/Pop/540).

[79] *Clandestine Abortion*, note 66 above, at 3.

[80] Ibid.

[81] *Implementation of the Global Strategy for Health for All by the Year 2000 - Eighth Report on the World Health Situation: Volume 1, Global Review* (Geneva: World Health Organization, 1993), 105.

[82] *World Bank Report*, note 4 above, at 300. A UNFPA report similarly notes that at least 10 to 15 per cent of the 500,000 maternal deaths annually are the result of unsafe abotion. UNFPA, note 9 above, at 36.

[83] S K Henshaw, "Induced Abortion: A World Review: 1990", 22(2) *Family Planning Perspectives* (Mar.-Apr., 1990), 76-81.

[84] International Planned Parenthood Federation, *Planned Parenthood Challenges: Unsafe Abortion* (London: 1993).

[85] Ibid.

[86] H P David and A Titkow, "Commentary: Abortion and Women's Rights in Poland, 1994", 25(4) *Studies in Family Planning* (July/Aug. 1994), 239.

[87] S Sing and D Wulf, "Estimated Levels of Induced Abortion in Six Latin American Countries", 20 *International Family Planning Perspectives* (1994), 11-12, citing Henshaw, note 83 above, at 76-89.

[88] *Clandestine Abortion*, note 66 above, at 26.

[89] Ibid., at 22.

[90] Ibid., at 26.

[91] *World Health Statistics Annual Report 1992* (Geneva: WHO, 1993), at D-274.

[92] Pakistan chapter, section 6.

[93] M de la Rosa, II, "Induced Abortion: Is it Really a Problem?" in *National Conference on Safe Motherhood*, conference report, 3-4 Sept. 1987 (Manila: Dept of Health), at 38-40, citing the Philippine Obstetrical and Gynecological Society's *Routine Statistics for 1985-86*, a survey of 78 hospitals.

[94] E D Ndovi and C M Chawanje, *Status of Maternal Mortality in Malawi: Background Paper*, Task Force on Safe Motherhood Initiative, National Family Welfare Council of Malawi (Lilongwe), at 11, citing F Driessen, *Maternal Deaths in 12 Malawi Hospitals in 1989* (Geneva: WHO). This figure is consistent with a 1981 estimate that abortion was responsible for 17 per cent of maternal deaths, reported in a UN study. UN Department of Economic and Social Development, *Abortion Policies: A Global Review, Volume III* (New York: United Nations, 1994), 2.

[95] It has been estimated that abortion accounted for over 20 per cent of maternal deaths at Kenyatta National Hospital (KNH, where most abortions are performed) between 1978 and 1987. UN Department of Economic and Social Development, ibid., at 138. One study found that about 26 per cent of maternal deaths at KNH between 1972 and 1977 were abortion-related. A E Makhoha, "Maternal Mortality in Kenyatta National Hospital: 1972-77", 57 *East African Medical Journal*, at 451.