THE RIGHT TO KNOW

Human rights and access to reproductive health information

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GLOBAL OVERVIEW

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In the 1960s, India's population explosion was a concern for governments and the international community. The United Nations' Special Programme of Family Planning (UNFPA) was established to address this issue. India, along with other developing countries, was identified as a priority area for family planning interventions. The United Nations' 1994 Conference on Population and Development (UNCPD) outlined the need for improved reproductive health services and highlighted the importance of integrating reproductive health and family planning services into maternal and child health programs. The conference called for the establishment of national and subnational Family Planning Councils to oversee the implementation of family planning programs. India, along with other developing countries, was urged to take concrete steps to improve access to reproductive health services, including contraception and sexually transmitted infection (STI) prevention. The conference also emphasized the need for a multidisciplinary approach to reproductive health, involving the involvement of various stakeholders, including governments, civil society, and the private sector. The 1994 conference marked a turning point in reproductive health policy, with many countries adopting comprehensive policies that included family planning as part of their national development strategies. The conference also highlighted the importance of addressing the needs of marginalized and vulnerable populations, including women, adolescents, and rural communities. Over the years, India has made significant progress in improving its reproductive health indicators, including a reduction in the fertility rate and an increase in contraceptive prevalence. However, challenges remain, particularly in rural areas and among certain socioeconomic groups. The Indian government and international partners are working together to address these challenges and ensure that all women have access to the reproductive health services they need.
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—is the more restrictive abortion laws in developing countries.46 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.47

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 2,700 per 100,000 in the Philippines.48

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.49 One study in Nigeria found that women aged 15 had a maternal mortality rate 7 times that of women aged 20 to 24.50 When pregnancy interrupts the normal course of development in teenagers, risks include anemia and related illnesses (especially for girls who conceive within two years of menarche), toxemia, miscarriage, stillbirth, 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.51 After the third birth, the risk of serious complications also increases steadily with each further birth.52 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.53

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.54 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.55

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.56 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).57 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). The World Bank estimated that at least 60,000 women die each year from unsafe abortion; another expert estimated the figure at between 100,000 and 200,000. 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. 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.

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. 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. 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. 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.

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, 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.

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. 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.

In Malawi a 1989 study found that 18 per cent of maternal deaths were caused by poorly performed abortions; in Kenya, the figure is probably over 20 per cent. In Algeria, the most significant cause of maternal mortality is uterine perforation, of which 80-90 per cent are estimated to be the result of poorly performed abortions.

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. Some 4 million abortions are estimated to be induced each year throughout Latin America, of which about 800,000 require hospitalization. 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. In Brazil, 42 per cent of women who had induced abortions were estimated to experience serious complications and 29 per cent were hospitalized.

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. 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. Moreover, there are few indications that the policies and programmes designed to reduce the spread of HIV have had a significant impact. 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. 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.

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, and become more susceptible to infection when they suffer from "conventional" STDs. 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. Globally, women's share of HIV infection has grown rapidly from 20 per cent in 1980 to 40 per cent in 1993.