

**Submission to Parliamentary Group on Population and Development
Roundtable discussion, Monday 11 September**

**Theme: Sexual and Reproductive Health and the Millennium Development
Goals in the Australian Aid program- the way forward**

Post-abortion Care and Family Planning

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Introduction

The purpose of this presentation is to situate abortion, post-abortion care (PAC) and family planning (FP) in a rights framework and consider how the Australian Government can meet its international obligations framed within international conventions, as well as address the Millennium Development Goal 5 which originates from global concern about the deaths of millions of young women. I will present as much factual information as possible and provide evidence where it exists. I will address the following:

- Rights and laws
- Unwanted pregnancy and unsafe abortion in the Asia-Pacific region
- AusAID, White Paper and the Guidelines
- How parliamentarians can initiate and support work towards reducing maternal mortality and morbidity

Rights and laws

In Australia the majority of people consider it their right to choose the number and timing of children, to use family planning methods and to consider terminating an unwanted or unplanned pregnancy, many women in Australia also decide to have an abortion. Australians embody and actively live the rights promulgated within the Convention on Elimination of all Forms of Discrimination Against Women (hereafter CEDAW). CEDAW is the only human rights treaty which affirms the reproductive rights of women and Australia became a signatory in 1983¹. CEDAW states:

Article 12 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

And further,

Article 16 1. (e) 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.

This treaty is widely endorsed globally and as of 2006, 184 countries are signatories. In the Asia-Pacific region most of our neighbours including Burma (1997), Cambodia (1992), Cook Islands (2006), Fiji (1995), Indonesia (1984), Laos (1981), Malaysia (1985), Nepal (1991), Papua New Guinea (1995), Samoa (1995), Timore-Leste (2003) and many others, have signed and ratified this international convention¹. My colleagues Elizabeth Bennett and Maxine Whittaker have already given information on other human rights conventions and global consensus statements that underpin sexual and reproductive health which Australia also endorses. The Honourable MPs will understand that by signing these international treaties, governments are then required to implement them with actions. Governments should also not promote laws which conflict with international obligations and laws should be reformed if they directly conflict with international treaties.

The Harvard Annual Law Review contains a summary of country's laws regulating access to abortion². A cursory glance shows that some laws are rudimentary and only contain the provision to save the woman's life or not even that. Laws regulating access to abortion are often not based on health evidence or women's human rights³. However, the global trend regarding laws pertaining to abortion shows a liberalising pattern and since 1984 (when the 'Gag Rule' came about) 30 countries have liberalised and reformed their abortion laws^{4,5}.

'A global trend toward liberalization of abortion laws observed before 1985 appears to have continued in more recent years. Nevertheless, women's ability to obtain abortion services is affected not just by the laws in force in a particular country, but also by how these laws are

interpreted, how they are enforced and what the attitude of the medical community is toward abortion.’⁶

The table below shows that several countries in our region have chosen this path. My argument is that human rights and good quality public health evidence should underpin abortion law⁷. Another example comes out of the Philippines which has a number of laws which restrict and add unnecessary complexity to the provision of family planning⁸. The White Paper “Helping health systems deliver: A policy for Australian Development Assistance in Health” fails to recognise that a health system may be functional but laws can prohibit practitioners to deliver certain services.

Table 1. The shift towards human rights and evidence based law and abortion since 1984 the year the ‘Gag Rule’ was introduced.

Albania (1991)	Greece (1986)
Algeria (1985)	Malaysia (1989)
Belgium (1990)	Mongolia (1989)
Botswana (1991)	Nepal (2002)
Bulgaria (1990)	Pakistan (1990)
Burkina Faso (1996)	Romania (1989)
Cambodia (1997)	Slovakia (1986)
Canada (1988)	South Africa (1996)
Czech Republic (1986)	Spain (1985)
Ghana (1985)	Thailand (2006)

Source: <http://www.guttmacher.org/pubs/tgr/04/3/gr040301.html> [Access 21 August 2006]⁵

From this small sample and with general knowledge, the parliamentarians can see that the highlighted countries share neither a similar stage of development, common religion, nor similar social or economic values. The question is why would a nation make access to safer abortion easier for women?

Action: Parliamentarians are in a unique position to foster inter-country dialogue on laws which regulate access to safe abortion and family planning with MP colleagues in the region.

Question: Is AusAID aware of the law in each recipient country and those willing to consider reforming law or attending fora which promote a wider interpretation to terminate a pregnancy other than to save the life of the woman?

Unwanted pregnancy and unsafe abortion in the Asia-Pacific region

Some of the realities of the situation of maternal health and family planning

- Many indicators of reproductive health are simply not known or recorded in many Asian and Pacific countries
- The maternal death rate in Burma, Cambodia, Laos, Nepal, Papua New Guinea and Timor-Leste is high
- Globally 13% of all maternal death is caused by unsafe abortion and in many countries it is simply not recorded especially where abortion is illegal⁹
- Unsafe abortion is a common way to manage fertility and women often view it as a form of menstrual regulation
- There is an unmet demand for family planning in Burma, Cambodia, Laos, Nepal and in Samoa, Fiji and Vanuatu it is not even recorded¹⁰

We now have the knowledge of why women die and how to prevent maternal death¹¹ and this is evidenced by the extremely low levels of maternal death in Australia. Global research indicates that unsafe abortion is underreported and often remains undetected so this figure is potentially higher than 13%. Some studies report that unsafe abortion causes a quarter of all maternal deaths and congests acute health care services which could be better used for other purposes¹². To seriously address the Fifth Millennium Goal we need to re-think how to reduce the personal, social, and economic harm from unwanted pregnancy and unsafe abortion and re-consider Australia's aid policy regarding programs which deliver these types of information, training or services. We cannot continue to cordon off abortion as though it does not happen.

The following questions are important:

- What are the realities for women who have had an unsafe or incomplete abortion?
- What does the research tell us?
- What are the recommendations to ensure that women have access to safer abortion, post-abortion care and family planning?

Women need to manage their fertility and they choose multiple methods to achieve their goals. Access to modern methods of contraception is erratic and riddled with barriers¹³. Traditional and modern methods are used in many countries and the termination of an early pregnancy is often considered a form of normal menstrual regulation not abortion^{14 15}. In areas where there is no antenatal care, no special protection for pregnant women and no tests for detecting a pregnancy, women are the ultimate arbiters of whether their period is late or whether they are pregnant with a wanted child¹⁶. Despite religious sanction, social taboo, flawed law, hazardous abortion methods women continue to terminate their unwanted pregnancies.

Post-abortion care (PAC) means the suite of treatments that occur *after* a pregnancy loss and we need to consider *preventing* the complications arising from unsafe abortion. Post-abortion care¹⁷ is an end point intervention. Women can have an early pregnancy loss from either a miscarriage or self-induced abortion; both can be life threatening from haemorrhage, infection, shock, and blood clotting changes. In countries where technology is limited, health workers stretched to capacity, and elective abortion impossible, it is extremely difficult to tell the difference between the two. In some ways it is not important as the treatment, evacuation of the remaining contents of the uterus, antibiotics, fluid replacement and counselling require similar skills, technology and resources. While it is not yet possible to prevent a miscarriage, clearly the aim of preventative health care is to reduce the number of women presenting with 'botched abortions'. One surprising finding in the research is the lack of good quality post-abortion care, so for example women are treated without any pain relief or risky methods such as sharp curette are still used¹⁸. Even more extraordinary is that after a pregnancy loss women are not given the FP information or supplies to space their next pregnancy¹⁹.

After any type of pregnancy loss it is recommended that women wait a short period of time to recuperate emotionally and physically. In cases where women have not wanted to have a child it is very hard to understand why they are not given the tools to prevent the next pregnancy. Unfortunately this is the reality and women then face the repeated dangers of poor quality fertility management and unsafe abortion. The evidence shows that women are very receptive to the idea of contraception if it is given at this time. Providing FP counselling **before the woman leaves a hospital** that provided post-abortion care can increase the proportion of women agreeing to use a contraceptive method before leaving the health facility.

So to conclude, PAC interventions need to make a deliberate effort to strengthen the post-abortion family planning component. PAC programs should emphasise training of service providers in post-abortion family planning to improve access and counteract attrition. PAC

service providers and managers should advocate for reliable contraceptive distribution mechanisms to ensure that women who are counselled and who want a method are able to get it and FP programs should give priority to women receiving PAC treatment.

A strong preventative strategy to reduce the disability and death of women is affordable, accessible, culturally appropriate birth spacing and birth limiting projects that include educational messages about unsafe abortion and access to safe abortion. These strategies need to include men and communities as well.

Questions: Does AusAID fund these types of programs? How will AusAID funding build the capacity of health systems to accurately monitor maternal deaths and injury with the recognition that many women will not be admitted to or die in a hospital?

Policy issue

In order to reduce maternal mortality unwanted and mistimed pregnancies Australian aid money should focus on the prevention of unwanted and mistimed pregnancies and access to high quality post-abortion care and safe abortion.

AusAID, White Paper and Guidelines

AusAID's Annual Report 2004-2005 states that 11% of aid money is spent on health and 7% of this is in the area of reproductive health. The previous annual reports for the past 5 years show similar percentages of funding. Unfortunately the reports are not detailed enough to know how this money is spent. A question to the Budget Estimates Committee 2006-07 by Senator Moore initiated a coded funding tracking for HIV/AIDS money at least. This was subsequently followed up by Senator Allison. This lack of transparency is annoying for those trying to analyse foreign aid but must also raise questions of accountability for MPs. The following table provides an analysis of AusAID expenditure for the years 2001-2004.

Table.1 AusAID expenditure on population policies/ programs and reproductive health 2001-2004

(current prices \$'000)

	2001-2002	2002-2003	2003-2004
Population Policy & Administrative Management	2,230	2,554	5,825
Reproductive Health Care	7,006	13,867	10,839
Family Planning	1,701	2,010	2,003
STD Control Including HIV/AIDS	24,871	26,572	52,220
Personnel dev for Population & Reproductive Health	--	92	77
Population Policies/Programs & Repro Health Total	35,808	45,096	70,964

Source: AusAID, *Statistical Summary 2003-2004*, p 18, accessible at http://www.ausaid.gov.au/publications/green-book/green_book_0304.pdf

The globally accepted definition of 'reproductive health' care is a very broad term which includes a) 'Safe Motherhood' such as hygienic delivery and emergency obstetrics, b) family planning, c) safe abortion, d) gender based violence, e) HIV/AIDS and e) other sexual health issues. The categories currently used by AusAID to report RH activities do not reflect this. I am left wondering what exactly is meant by reproductive health care. The 'Family Planning Guidelines'²⁰ suggest that post-abortion care is funded by AusAID and the question remains what were the abortion related programs or services funded during the past few years? Many of us are aware that the 'Family Planning Guidelines' are an anachronism from a particular

political past which align us with the United States and the Mexico City Policy a unilateral move that is not supported by European donors²¹.

Questions: – Which countries received funding, who implemented them, what was delivered and what were the outcomes? Why are there not coded tracking systems for all of the elements of reproductive health? My research suggests that AusAID has not supported PAC programs in the past five years which would mean an incomplete approach to Millennium Development Goal 5.

Action: Ask NGOs if the Guidelines are a help or a hindrance in providing reproductive health programmes or projects in the Asia-Pacific region – if they are a disincentive they should be retracted.

Policy issue: The Family Planning Guidelines need to reflect support for the Fifth Millennium Goal.

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