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THE INJUSTICE OF UNSAFE MOTHERHOOD

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ABSTRACT

This paper presents an overview of the dimensions of unsafe motherhood, contrasting data from economically developed countries with some from developing countries. It addresses many common factors that shape unsafe motherhood, identifying medical, health system and societal causes, including women's powerlessness over their reproductive lives in particular as a feature of their dependent status in general. Drawing on perceptions of Jonathan Mann, it focuses on public health dimensions of maternity risks, and equates the role of bioethics in conscientious medical care to that of human rights in public health care. The microethics of medical care translate into the macroethics of public health, but the transition compels some compromise of personal autonomy, a key feature of Western bioethics, in favour of societal analysis. Religiously-based morality is seen to have shaped laws that contribute to unsafe motherhood. Now reformed in former colonizing countries of Europe, many such laws remain in effect in countries that emerged from colonial domination. UN conferences have defined the concept of 'reproductive health' as one that supports women's reproductive self-determination, but restrictive abortion laws and practices epitomize the unjust constraints to which many women remain subject, resulting in their unsafe motherhood. Pregnant women can be legally compelled to give the resources of their bodies to the support of others, while fathers are not legally compellable to provide, for instance, bone-marrow or blood donations for their children's survival. Women's unjust legal, political, economic and social powerlessness explains much unsafe motherhood and maternal mortality and morbidity.

DIMENSIONS AND CAUSES OF UNSAFE MOTHERHOOD

The differential incidence of unsafe motherhood has been described as marking the greatest discrepancy in any health statistic between developed and developing countries of the world.[1] The most recent World Health Organization and associated agencies' estimate is that every year worldwide, about 515,000 women die of complications of pregnancy and childbirth,[2] a rate of over 1,400 maternal deaths each day. Further, at least 7 million women suffer serious health problems when they survive childbirth, and an additional estimated 50 million women suffer adverse health effects after childbirth.[3] Statistics are incomplete because many countries lack vital statistics registries and systematic examinations of causes of maternal deaths, and many women are unattended by healthcare professionals or other adequately skilled personnel during pregnancy, labour, childbirth and their resulting death or morbidity. Nevertheless, it is estimated that almost 99% of these tragic and often preventable consequences of unsafe motherhood occur in developing countries. It has been observed that 'Almost 90% of these deaths occur in sub-Saharan Africa and Asia' alone.[4]

The ends of the spectrum of maternal mortality and morbidity are not easily determined, but representative figures are that the estimated probability of pregnancy-related death faced by an average woman over her reproductive life-span is 1 in 8,700 in Canada, and 1 in 7 in Ethiopia, 1 in 6 in Rwanda and Sierra Leone.[5] Canadian statistics may conceal different rates between aboriginal and non-aboriginal women, in the same way that the United States of America's rate of 1 in 3,500 conceals differences between black, white and hispanic women and members of rural and urban populations.[6] By way of general contrast and

[1] A. Starrs. 1998. *The Safe Motherhood Action Agenda: Priorities for the Next Decade*. New York. Family Care International: 1.

[2] World Health Organization, United Nations Children's Fund and United Nations Population Fund. 2001. *Maternal Mortality in 1995. Estimates Developed by WHO, UNICEF, and UNFPA*. Geneva. World Health Organization (WHO/RHR/01.9).

[3] United Nations Population Fund. 1999. *The State of the World Population 1999, 6 Billion: A Time for Choices*. New York. UNFPA: 30.

[4] A. Starrs, *op. cit.* note 1, p. 1.

[5] See World Health Organization *op. cit.* note 2, and R.J. Cook et al. 2001. *Advancing Safe Motherhood Through Human Rights*. Geneva. World Health Organization: Appendix I, pp. 93–95.

[6] In the US the black population has a relative risk of maternal death 4.3 times higher than the nonblack population: H.K. Atrash et al. Maternal Mortality in Developed Countries: Not Just a Concern of the Past. *Obstetrics and Gynecology* 1995; 86: 700–705.

comparison, however, the average rate in sub-Saharan Africa is 1 in 14 but 1 in 70 in South Africa, the average rate in South-East Asia is 1 in 47 but 1 in 1,100 in Thailand, 1 in 60 in the Eastern Mediterranean but 1 in 430 in Tunisia and 1 in 1,300 in Europe, ranging from 1 in 4,600 in the United Kingdom to 1 in 1,000 in Romania and 1 in 450 in Kazakhstan.[7]

Causes of unsafe motherhood may in theory be separated into medical, health system, social and other causes, but in practice they often overlap. For instance, many pregnant women in developing countries suffer from anemia, which compromises their survival and health status associated with pregnancy and childbearing in general, and particularly when heavy blood loss occurs. Where food resources are inadequate due, for instance, to regional drought and famine or family poverty, the nutritional disadvantages of girl children may be aggravated by their devaluation in their homes and cultures. Food allocation practices within families that give priority to feeding husbands and sons before wives, then other family dependents such as elderly parents and lastly daughters,[8] may condemn girl children to malnutrition in the form of undernourishment, with associated anemia.

Similarly, early marriage, perhaps when adolescents are below the minimum age for marriage prescribed by law,[9] followed by premature and repeated pregnancy, create medical circumstances inimical to survival and health. These are conditioned, however, by social forces that favour or even require girls' early marriage, and fecundity. Conditioning factors include families' concerns regarding dowry payments, fears of family dishonour due to daughters' premarital loss of virginity, whether by their sexual adventure or victimization by rape, and husbands' requirement of births of sons and of evidence of their virility.

Infections such as malaria, that may be more associated with geographical rather than social considerations, pose a medical risk in pregnancy, endangering health and life itself. Equally, women with the genetic sickle-cell trait may face health hazards

[7] See World Health Organization and RJ Cook et al., *op. cit.* note 5.

[8] See e.g. J. Kabeberi-Macharia. 1998. Reconstructing the Image of the Girl-Child. In *Law, Culture, Tradition and Children's Rights in Eastern and Southern Africa*. W. Ncube, ed. Aldershot. Ashgate/Dartmouth: 47–56 at 47.

[9] For instance the Child Marriage Restraint Act in India sets the minimum age of marriage for girls at 18, but it has been recorded that about 50% of women enter their first union before their eighteenth birthday and almost 30% have their first child by age 18. See Alan Guttmacher Institute. 1998. *Into a New World: Young Women's Sexual and Reproductive Lives*. New York. AGI: 18.

due to pregnancy. However, some other medical risks aggravated by pregnancy are socially conditioned. Prominent among these is HIV/AIDS, to which women are often exposed because of their powerlessness to resist sexual intercourse with infected men or to require men to wear condoms, or their lack of access to such protection because of financial, legal, health system or other barriers. Pregnancy naturally reduces women's immunity to infection, and their vulnerability is considerably increased when HIV/AIDS has already compromised their immune systems. In some religions and cultures, female genital cutting, often described judgmentally as mutilation, also contributes to unsafe motherhood in causing medical complications antenatally, and in early labour and childbirth, including prolonged labour and, for instance, post partum hemorrhage, and death.[10]

Health system failures often add significantly to the burden of unsafe motherhood. It has been explained that in the course of pregnancy, labour and delivery, women '... in every country and every population develop complications, but women in developing countries are much less likely to get prompt adequate treatment, and are therefore more likely to die.'[11]

The scarcity of physicians, trained nurses or midwives and often of skilled birth attendants, in urban as well as rural settings, accounts for much of the incidence of maternal mortality and morbidity.[12] Social factors and customs may also be involved, however. Where prenatal and maternity care are available, for instance, women may not be allowed to travel to them alone. Further, husbands' consent or consent of unmarried adolescents' parents may be required before women can receive care, for instance because male healthcare providers are present, or pregnant women lack independent means to ensure that service fees will be paid. Cost itself is often a barrier to access to available care among impoverished families that seek it.

[10] Department of Women's Health, Family and Community Health, World Health Organization. 2000. *A Systematic Review of the Health Complications of Female Genital Mutilation, including Sequelae in Childbirth*. Geneva. World Health Organization (WHO/FCH/WMH/00.2): 48.

[11] D. Maine et al. 1997. *The Design and Evaluation of Maternal Mortality Programs*. New York. Center for Population and Family Health, School of Public Health, Columbia University: 4.

[12] W.J. Graham, J.S. Bell and C.H.W. Bullogh. 2001. Can Skilled Attendance at Delivery Reduce Maternal Mortality in Developing Countries? In *Safe Motherhood Strategies: A Review of the Evidence*. V. DeBrouwere and W. VanLerberghe, eds. Antwerp. ITG Press: 97–130.

PUBLIC HEALTH BIOETHICS AND UNSAFE MOTHERHOOD

The United Nations' International Conference on Population and Development, held in Cairo in 1994, and World Conference on Women, held in Beijing in 1995, both recognized that reproductive health failures embodied in unsafe motherhood raise concerns that transcend clinical medicine, and must be addressed in addition as public health concerns. The public health implications of developing country urbanization have come to be recognized in recent years,[13] but the public health dimensions of unsafe motherhood, and public health potential for its reduction, have escaped general attention, except for recognition that the consequences of unskilled abortion, both where abortion is legally permissible and where it is not, should be addressed less as a moral than as a public health concern.[14]

It has been conventional to observe that unsafe motherhood is strongly associated with pregnancies that come too early, too late, too often and too closely spaced in women's reproductive lives. This observation has no prognostic value in the clinical care of any individual adolescent or woman, but remains an epidemiological or public health truism. Safe motherhood depends on women's avoidance of untimely and otherwise inappropriate pregnancy, for instance by means of women's education and power to decide whether, when, with whom and in what ways to be sexually active. It also requires access to natural and assisted means of fertility control, and, for example, women's unimpaired access to medical and related care during pregnancy, labour and childbirth and the immediate and longer post-partum period. These goals are most effectively advanced through public health strategies, which may be implemented through public health law. Public health law has recently been defined as:

> [T]he study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g. to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally

[13] See World Health Organization, Centre for Health Development, Kobe, Japan. 1996. *Urbanization: A Global Health Challenge*. Geneva. WHO (WHO/WCK/SYM/96.1).

[14] See the Programme of Action of the International Conference on Population and Development, Cairo, Egypt 5-13 September 1994, para 8.25, in Report of the International Conference on Population and Development, U.N. Doc. A/CONF.171/13/Rev.1, U.N. Sales No. 95. XIII. 18 (1995).

> protected interests of individuals for the protection or promotion of community health.[15]

In formulating this definition, Gostin, justly celebrated for his pioneering work to advance civil liberties in the UK, Europe and the US, is conscious that his acknowledgment of 'the power of the state to constrain the autonomy ... of individuals,' though limited, itself runs counter to a key ethical value in the US and beyond.[16] A prominent bioethicist, however, noting that '[a]utonomy has become a dominant bioethical value in the Western world,'[17] has pointed to instances in which individual autonomy has traditionally been subordinated to community values. An instance is social action to prevent a competent person's suicide, on the justifications that 'a person's death diminishes others as well and that therefore society is permitted to intervene.'[18] This reflects the historical observation of the English poet and cleric John Donne (1572–1631) that '[a]ny man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the [graveyard] bell tolls; it tolls for thee.'[19]

The social sense of diminution has not been raised in many countries, however, by the incidence of maternal mortality. It is observable that:

> [T]hese hundreds of thousands of avoidable deaths each year are continuing evidence and condemnation of the unstated presumption on which many societies are organized, namely that lives of mothers are expendable and that women do not matter.[20]

Making mothers and all women's lives, and health, matter, goes beyond individualistic ethics and bioethics of autonomy, to implicate macroethical and community values. These are expressed in some bioethical literature, especially by feminist writers,[21] but

[15] L.O. Gostin. 2000. *Public Health Law: Power, Duty, Restraint*. Berkeley, CA. University of California Press; New York. The Milbank Memorial Fund: 4.

[16] Ibid. Preface: xxi.

[17] S.M. Glick. Unlimited Human Autonomy A Cultural Bias? *NEJM* 1997; 336: 954–956 at 954.

[18] Ibid. at 955.

[19] J. Donne. 1624. Devotions upon Emergent Occasions-Meditation no. 17.

[20] R.J. Cook. 2001. Advancing Safe Motherhood Through Human Rights. In *Giving Meaning to Economic, Social and Cultural Rights*. I. Merali and V. Oosterveld, eds. Philadelphia. University of Pennsylvania Press: 109–123 at 109.

[21] R. Tong. 1996. Feminist Approaches to Bioethics. In *Feminism and Bioethics: Beyond Reproduction*. S.M. Wolf, ed. New York. Oxford University Press: 67–94.

particularly in human rights principles, many of which are embodied in national and international laws.

The late Jonathan Mann identified contrasts and synergies, or complementarities, between medicine and public health,[22] the former focussing on individual, clinical care and cure, the latter on population health and prevention of health hazards, but both pursuing health as defined by the World Health Organization, namely as a state of physical, mental and social well-being.[23] Similarly he proposed, in a memorable keynote address opening the International Association of Bioethics' Third World Congress of Bioethics in San Francisco in 1996, that the equivalent of the role of bioethics in medicine is the role of human rights in public health. The Summer 2001 edition of the *Cambridge Quarterly of Healthcare Ethics*, dedicated to his memory, is appropriately entitled *Keeping Human Rights on the Bioethics Agenda*.

The initial paper of this edition, an appreciation of Jonathan Mann,[24] addresses the significance of human rights in opening the public health agenda to ethical perceptions, observing that '[t]he conceptualization of the health and human rights movement resonates with ideas that the bioethics movement b[r]ought to medicine. Indeed, a conceptual parallel between this movement and bioethics is to be found in how each views the field and goals of medicine.'[25] This insight shows links between human rights and bioethics, particularly as bioethics progress beyond their contemporary US and more general Western preoccupation with individual autonomy. It constitutes a creative response to Mann's critique of the narrowness of bioethics emerging from medical or clinical experience. Writing in the US in 1997, Mann noted that:

> [T]he contribution of medicine to health, while undeniably important (and vital in certain situations) is actually quite limited. For example, it is estimated that only about one-sixth of the years of life expectancy gained in this country during this century can be attributed to the beneficial impact of medicine, medical care, and medical research. And it has been

[22] J.M. Mann. Medicine and Public Health, Ethics and Human Rights. *Hastings Center Report* 1997; 27(3): 6–13.

[23] Constitution of the World Health Organization, Preamble, para. 2.

[24] J.C. d'Oronzio. The Integration of Health and Human Rights: An Appreciation of Jonathan M. Mann. *Cambridge Q. Health Care Ethics* 2001; 10: 231–240.

[25] Ibid. at 231.

> estimated that only about 10 % of preventable premature deaths are associated with a lack of medical care.[26]

Accepting that 'none of these data ... suggest that medical care is irrelevant; rather they suggest its limits,'[27] Mann looked beyond those limits for explanations of health differences among populations, and found explanatory materials at the public and community health levels. He concluded that the conventional understanding linking socioeconomic status to health status is inadequate, and noted that:

> Other measures, such as the extent of socioeconomic inequality within a community, the nature, level and temporal pattern of unemployment, societal connectedness and the extent of involvement in social networks, marital status, early childhood experiences, and exposure to dignity-denying situations have all been suggested as powerful potential components of a 'black box' of societal factors whose dominant role in determining levels of preventable disease, disability, and premature death is beyond dispute.[28]

It is a tragic irony that Jonathan Mann's own premature death in September 1998, while flying from New York to Geneva to attend a meeting at the World Health Organization, robbed him and us of his further exploration of how public health strategies inspired by human rights values can promote population health. A legacy, however, is his focus on how social inequality, economic powerlessness, societal exclusion and denials of human dignity condition preventable disease, disability and premature death. These factors relate directly and indirectly to women's high rates of maternal mortality and morbidity.

RELIGIOUS MORALITY AND UNSAFE MOTHERHOOD

The laws and social customs that have often conditioned unsafe motherhood and condemned generations of women to suffer pregnancy-related death and disability may have their roots in religiously-guided perceptions of morality. The demographically-driven Biblical imperative to the people of the Bible to 'be fruitful and multiply,' for instance, has cast a long moral shadow over artificial contraception. Contraceptive means frequently remain critical to women's self-defence against life- and health-

[26] J.M. Mann, *op. cit.* note 22, at p. 7.
[27] Ibid.
[28] Ibid. at p. 8.

endangering pregnancies, but until 1969, for example, the Canadian Criminal Code punished distribution of means and knowledge of contraception as a 'crime against morality.' The Roman Catholic Church maintains its prohibition of contraceptive means such as condoms, opposing distribution even in the face of the international HIV/AIDS pandemic.

This inflexible historical prohibition in fact was transformitive three decades ago in the emergence of modern, secular bioethics from traditional ethics rooted in often intransigent moral philosophy. Catholic theologians and ethicists, whose advice on contraception the Catholic Church requested in the 1960s and then discarded, became the pioneers, when their hopes and expectations to modernize religious doctrine were frustrated. An historian of that time has recorded that:

> Fertility control was the major issue that spawned bioethics, more than any other single issue – certainly more than any high-technology-related issue in medicine. It was an issue that directly affected hundreds of millions of people; it dealt with quintessentially human suffering and fulfillment … The theologians, who were the first ethicists working in bioethics, cut their teeth on contraception/sterilization and abortion debates; and in a very real sense, much of the great energy that was turned toward bioethics around 1970/71 was energy that was diverted from the then-increasingly futile church debates on fertility control.[29]

The futility of proposing change in the moral doctrine of the Catholic Church remains, particularly since, in 1870, the Church adopted the concept of papal infallibility in pronouncements made *ex cathedra*, so that no new revelation can be accepted unless shown consistent with earlier teaching. There can be no reversal on the basis that earlier policies were erroneous.

Proponents of religiously-based morality are unpersuaded by evidence of the harmful consequences of their policies. The spread of HIV/AIDS attributable to the prohibition of condom distribution, and for instance of maternal mortality and morbidity due to Church pressure to maintain prohibitions against contraceptive methods, sterilization and abortion, are of no account to them. The deontological orientation of much religiously-based thinking rejects utilitarianism and consequen-

[29] W.T. Reich. The 'Wider View': André Helleger's Passionate, Integrating Intellect and the Creation of Bioethics. *Kennedy Institute of Ethics J* 1999; 9: 25–51 at 37.

tialism. Adherents to Church teaching feel no institutional or personal responsibility for preventable disease, disability or death that is a consequence of application of the doctrines of their faith, since such doctrines are considered to be founded on truths revealed to their divinely-appointed, infallible leader within schemes of supernatural mystery and mercy.

Many European powers of the colonial period based their laws on restrictive, ecclesiastically-derived religious morality, after as well as before the Protestant Reformation of the 16th century. It has been observed that:

> The canon law of the later Middle Ages was the first modern legal system of the West, and it prevailed in every country of Europe. The canon law governed … a great many aspects of the lives of the laity. The new hierarchy of church courts had exclusive jurisdiction over laymen in matters of family law, inheritance, and various types of spiritual crimes.[30]

In part protective and paternalistic, but also moralistic and punitive, these laws in time became predominant in certain affairs as 'the church … took legal jurisdiction over sins, and it influenced the secular law to conform to [its] moral principles.'[31] They applied to exclude women not only from religious ordination and authority in church life but also from political, professional, economic and scholarly life and, *inter alia*, from access to voluntary sterilization and abortion procedures.

In recent years, such European countries have largely liberalized their sterilization and abortion laws[32] in favour of accommodation of reproductive self-determination. However, the laws that they historically applied in the overseas territories they settled or conquered, by power of imperial legislative domination, have proven curiously tenacious in the post-colonial, independent countries that have re-emerged or arisen in these territories, including by successful rebellion against European

[30] H.J. Berman. 1974. *The Interaction of Law and Religion*. New York. Abingdon Press: 58.

[31] Ibid. at p. 61.

[32] See for instance the UK Abortion Act 1967, in France the 1975 Law 75–17 and 1979 Law 79–1204, in Portugal the 1984 Law 6 of 11 May, and in Spain the 1985 Organic Law 9 of 5 July; see generally R.J. Cook and B.M. Dickens. A Decade of International Change in Abortion Law: 1967–77. *Amer. J. Public Health* 1978; 68: 637–644; R.J. Cook and B.M. Dickens. International Developments in Abortion Laws: 1977–88. *Amer. J. Public Health* 1988; 78: 1305–1311; R.J. Cook, B.M. Dickens and L.E. Bliss. International Developments in Abortion Law from 1988 to 1998. *Amer. J. Public Health* 1999; 89: 579–586.

rule. Retention of these laws restrictive of women's rights in general and of their reproductive choice in particular is due in part to the remaining colonial legacy of influential European-derived religious institutions that support them. This is reflected to some extent in sometimes grossly differential rates of maternal mortality and morbidity that are not due to economic differences alone between the post-imperial European countries and those in the territories they once dominated. A recent global comparison between countries in regions with restrictive and accommodating abortion legislation has noted that 'The risk of death from unsafe abortion is about 1 in 150 procedures in Africa, and 1 in 150,000 in the USA and Europe.'[33]

A recent echo of religiously moralistic hostility to women's reproductive self-determination was heard at the two UN Conferences on Population and Development, and on Women, held respectively in Cairo in 1994 and Beijing in 1995. The Vatican employed the specious and increasingly contested statehood of the Holy See,[34] which privileges the Roman Catholic Church over other Christian denominations and different religions, to maximize its representatives' attendance, and to limit the development of legal recognition of women's human rights to fertility control. At the latter conference, the Church adopted the view that its enemies' enemies could be its friends, and sought to achieve solidarity with its historical religious adversaries, particularly the more reactionary Islamic countries, to resist 'feminist' initiatives in support of what both conferences defined as reproductive health.

REPRODUCTIVE HEALTH, ABORTION AND SAFE MOTHERHOOD

Building on the World Health Organization definition that 'health' is a state of physical, mental and social well-being, the Programme of Action developed at the Cairo conference proposed a definition of reproductive health that was endorsed at the International Conference on Women held the following year in Beijing. The definition reads:

[33] P.F. Thonneau. 2001. Maternal Mortality and Unsafe Abortion: A Heavy Burden for Developing Countries. In *Safe Motherhood Strategies: A Review of the Evidence*. V. DeBrouwere, W. VanLerberghe, eds. Antwerp. ITG Press: 151–173, at 151.

[34] See internet http://www.seechange.org.

> Reproductive 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 are 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.[35]

The establishment of a claim of access to methods for regulation of fertility had to be limited to methods 'which are not against the law,' since conferences that are UN initiatives cannot usually recommend illegal conduct. However, many countries maintain laws and practices that obstruct achievement of reproductive health as described in the earlier part of the definition, and the ethical status of such laws and practices is open to question on grounds of justice. Many women lack access to 'a satisfying and safe sex life,' reproductive freedom and methods of family planning, because of oppressive laws that make them dependent on the economic support of men, expose them to sexual and other violence, in their homes and outside and, for instance, leave them at risk of life- and health-endangering pregnancies.

Implicit in the above definition, because, for political reasons, it could not be stated explicitly, is the right to lawful abortion which, when available under skilled and timely medical management, is likely to be safely conducted. Religious authorities that oppose abortion in principle, such as in the Roman Catholic, Islamic and Hindu faiths, tend to allow termination of pregnancy in a clinical case when continuation of pregnancy poses an immediate threat to the survival of a particular woman. In the Catholic tradition, for instance, the doctrine of 'double effect'[36] allows the ending of an ectopic and other life-endangering pregnancy not to be characterized as abortion, in the same way that removing a man's cancerous testicles is not characterized as

[35] *Op. cit.* note 14, para 7.2.

[36] D.P. Sulmasy, E.D. Pellegrino. The Rule of Double Effect: Clearing-up the Double Talk. *Annals of Internal Medicine* 1999; 159: 545.

sterilization, notwithstanding that sterility is a secondary effect of the life-saving surgery. Laws often remain, however, that prohibit abortion where pregnancy poses an epidemiological, statistical or population-based risk to women in general but not to any one in particular. That is, even where women face a 1 in 7 or a 1 in 6 risk of maternal death in their reproductive life-span,[37] they have at least a 6 in 7 or a 5 in 6 likelihood to survive a particular pregnancy.

Unsafe or otherwise unwanted pregnancy that results in unsafe abortion, because abortion is not legally and therefore safely available, or is legally available but qualified practitioners decline to provide it,[38] raises macroethical, community-wide concerns. Governments endorsing the 1994 Cairo Programme of Action resolved: 'to strengthen their commitment to women's health to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services.'[39]

Similarly, the 1995 Beijing Conference developed a Platform for Action which recognized that: 'Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and the youngest who take the highest risk.'[40]

This is the case not only within countries but also among countries. That is, the highest rates of maternal mortality and morbidity due to unsafe abortion tend to be experienced in the world's poorest and younger independent countries,[41] many of which retain oppressive abortion laws inherited from colonization.

The injustice of these restrictive laws is not simply that they disrespect women as decision-makers in their own lives, but that their aim is to compel women to continue pregnancies, perhaps initiated by rape, incest or otherwise coerced sexual intercourse, to serve fetal interests or state interests in fetal life, while no other

[37] *Op. cit.* note 5.

[38] In India, abortion has been legally available through medical practitioners on liberal grounds since 1972, but subject to cumbersome conditions; of the estimated 6.7 million abortions in India each year, about 4 million are performed by non-physicians, primarily using drugs, indigenous methods and insertion of objects into the uterus. An estimated 15–20,000 abortion-related deaths occur each year. See A. Starrs, *op. cit.* note 1, p. 57.

[39] *Op. cit.* note 14, para 8.25.

[40] United Nations. 1995. Report of the Fourth World Conference on Women. New York. UN: para 97.

[41] *Op. cit.* notes 2 and 5.

persons are required to give the resources and services of their bodies to preserve the lives of others, including their own voluntarily conceived children. When children's lives are at risk due, for instance, to liver disease, leukemia or anemia, their parents and others are not compelled by law to provide liver segments for transplantation or even far less invasive bone-marrow or blood donations. The common legal requirement that parents provide their dependent children with the 'necessaries of life' is limited to financially affordable food, shelter, clothing and medical care, and has never been considered to cover even blood transfusion, which is usually a paradigm minimum-risk procedure considerably less risk-laden than continuation of routine pregnancy.

It has long been recognized that restrictive abortion laws are frequently legally avoided by women of means or influence, who receive safe, legal procedures by travelling abroad or obtaining medical explanations for local care that ends inconvenient or otherwise unwanted pregnancies,[42] but that such laws deny safe services to poor and powerless women, of all ages. Beyond resourceful avoidance, women of means may also simply evade restrictive laws. It has been observed that 'for example in Latin America, private physicians often perform safe abortions for relatively high medical fees, and the law is rarely enforced.'[43] The main effect of restrictive laws is not to reduce the numbers of abortions, but primarily to channel them into the least skilled, least safe hands, including those of desperate women who self-induce their abortion by primitive means. A leading obstetrician/gynecologist with wide-ranging international experience has observed that:

> Analysis of available data reveals that there is no direct correlation between the prevalence of induced abortion and how restrictive or liberal a country's abortion law may be ... Abortion rates seem to be more directly related to the number of unwanted pregnancies. The number of unwanted pregnancies will be greater where the desired fertility is low, and where effective methods of contraception (including emergency contraception)[44] and family-planning information

[42] A. Jenkins. 1961. *Law for the Rich: A Plea for the Reform of the Abortion Law*. London. Victor Gollancz.

[43] M.F. Fathalla. 1997. *From Obstetrics and Gynecology to Women's Health: The Road Ahead*. New York. Parthenon: 238.

[44] Post-coital contraception, within 72 hours of unprotected intercourse or of malfunction of pre-coital means.

> and education services are not available or easily accessible. In this situation, restricting access to abortion will only increase the number of illegal and unsafe abortions. The choice will not be between allowing or preventing abortion. The choice will be between decriminalizing abortion, or allowing it only to be performed as an illegal procedure.[45]

The burden of restrictive laws, which falls primarily on the poor and the powerless, can also have racial dimensions. The introductory language of South Africa's 1996 Choice on Termination of Pregnancy Act acknowledges that the country's former, restrictive law applied inequitably between women of European and African races, in stating that the new law is enacted: 'Recognizing the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism and the advancement of human rights and freedoms which underlie a democratic South Africa.'

The denial of human dignity implicit in legally compelled involuntary continuation of pregnancy, particularly but not only when it is life- and health-endangering, was recognized in 1995, when the Beijing Platform for Action analogized it to rape in its comprehensive condemnation of 'forced pregnancy.'[46] Indeed, the International Criminal Court at The Hague, considering the denial of abortion for pregnancy following rape as included within 'forced maternity,'[47] approaches it as a war crime committed not only by rapists but also by governments and states themselves.[48] The Rome Treaty of 1998, constituting the Court and its jurisdiction, defines rape, sexual slavery, enforced prostitution, forced pregnancy and other forms of sexual violence as both war crimes and crimes against humanity,[49] equal, for instance, to torture and the most egregious international crimes against humanitarian law.

[45] M.F. Fathalla, *op. cit.* note 43, p. 239.

[46] United Nations, *op. cit.* note 40, at paras 114, 132 and 135.

[47] See Finalized Draft Text of the Elements of Crimes, Preparatory Commission for the International Criminal Court, UN Doc. PCNICC/2000/INF/3/Add.2(2000).

[48] K.D. Askin. 1997. *War Crimes Against Women: Prosecution in International War Crimes Tribunals*. The Hague, Netherlands. Kluwer Law International.

[49] Rome Statute of the International Criminal Court. 1998. U.N. Doc. A/CONF. 183/9, Articles 7 and 8.

THE MULTIPLE INJUSTICES OF UNSAFE MOTHERHOOD

Restrictive abortion laws are perhaps the most obvious, but only one of many instances of how women, particularly in developing countries, are denied safe options in their reproductive lives. They are often compelled by such abortion laws to choose between continuing a life- or health-endangering pregnancy or resorting to illegal termination, conducted by an unskilled person, frequently in unsanitary conditions. Risks to life and health are not only medical. In several countries and regions of the world, women caught in adultery[50] or found pregnant before or outside marriage face injury or death at the hands of their family members.[51] Laws against so-called 'honour killings' are not uncommonly unenforced, or applied with sentences of such leniency as to constitute them of no deterrent effect.

Injustices are aggravated when women have little or no control over their sexual availability to men. Beyond instances of pregnancy following rape, for instance in military conflicts and civil turmoil, or when women are in police or comparable custody,[52] women denied education and economic opportunities, including rights of legal inheritance, may lack any feasible options in life to early marriage and repeated childbearing. When women cannot resist their husbands' demands and have no access to contraception, for instance because it is too costly, or because their husbands refuse them access to available means or refuse themselves to use condoms, their risks of unsafe motherhood mount. Availability of contraceptive drugs in their communities is often of little avail to young girls of whose vulnerability and perhaps dependency older men take sexual advantage, even while the men are affected by sexually transmitted diseases such as HIV/AIDS. In developed as well as developing countries, high percentages of adolescent girls have been shown to become

[50] The 1960 Penal Code of Jordan, article 340, No. 16 has been translated to provide 'He who discovers his wife or one of his female unlawfuls committing adultery with another, and he kills, wounds or injures one or both of them is exempt from any penalty'; see The Center for Reproductive Law and Policy. 2000. *Reproductive Rights 2000: Moving Forward*. New York. CRLP: 47.

[51] The Penal Code of Syria, article 548, has been translated to provide 'He who catches his wife or one of his ascendants, descendants or sister committing adultery or illegitimate sexual acts with another and he killed or injured one or both of them benefits from an exemption of penalty'; ibid.

[52] See e.g. Asia Watch, Women's Rights Project. 1992. *Double Jeopardy: Police Abuse of Women in Pakistan*. New York. Human Rights Watch.

pregnant due to intercourse imposed by older men they have no social or other practical means to resist.[53]

More contentious than contraception has been sterilization. Restrictive laws and religions have generally come to allow this to women on strictly established medical grounds, but it often remains denied as a reproductive choice. Husbands and family members may also deny women that choice, even when medically indicated, particularly when the son(s) required in their culture have not yet been born. Young women's health and survival can be compromised when, instantly on marriage, they are pressured to have successive pregnancies until sons are born. The attitude of husbands and of the families into which women marry, that women's primary role is as bearers of children, especially sons, presents one of the 'dignity-denying situations' that Jonathan Mann identified as a societal factor that conditions women's 'preventable disease, disability and death.'[54] His vision of finding solutions through human rights is enlightened, but some human rights initiatives illustrate the problem as much as they may offer a solution. For instance, the International Covenant on Economic, Social and Cultural Rights provides in Article 10(2) that: 'Special protection should be accorded to mothers during a reasonable period before and after childbirth.'[55]

This provides for legal effect to be given to Article 25(2) of the 1948 Universal Declaration of Human Rights, which states that 'Motherhood and childhood are entitled to special care and assistance.'[56]

Necessary though these provisions are, they link protection of women to their pregnant status and childbearing role. This reinforces the perception that protection of women's health is an instrumental means of serving children, rather than an inherent right for women to enjoy for themselves. Valuing women as

[53] It has been estimated for instance from Peru that only 72 cases of sexual abuse are reported of the 360 that occur each day and that 60% of pregnancies among 12 to 14 year old girls result from rape by family members or persons close to the victims; S. Tuesta. 2000. *The Search for Justice*. Lima. Movimiento Manuela Ramos: 5. The US Department of Justice reported that there were 330,088 rapes and sexual assaults in 1998 on victims aged 12 and above, the 12–19 age group suffering twice as many as victims aged over 25; F. McLellan. US Paediatricians Advised to Ask About Sexual Assault. *The Lancet* 2001; 357: 1951.

[54] *Op. cit.* note 22, p. 8.

[55] See I. Brownlie, ed. 1992. *Basic Documents on Human Rights* (3rd edition). Oxford. Clarendon Press: 117. See also J. Stanchieri, I. Merali and R.J. Cook. 2000. *The Application of Human Rights to Reproductive and Sexual Health*, http://www.acpd.ca/compilation.

[56] I. Brownlie, ibid., p. 26.

mothers risks their devaluation or invisibility in other aspects of their lives as girl children, adolescents, unmarried and non-pregnant women and widows. Unsafe motherhood is gaining attention, for instance in the Safe Motherhood initiative pioneered by the World Health Organization,[57] but it remains only an epitome of the socially-constructed multiple injustices that many women suffer throughout their lives.

CONCLUSION

The over half a million maternal deaths that occur each year, in all but about five thousand cases in developing countries,[58] are more a consequence than an isolated cause or expression of gender inequity and injustice to women. These deaths have become rare in countries and communities in which women's power of self-determination approaches equality with that of men, but remain pandemic where women's equal rights are not respected in their societies. Vulnerability to social, economic, religious and related repression denies women an effective voice in the decisions that affect their initiation and continuation of pregnancy, and their access to medical and other appropriate services before and during pregnancy, and at and following childbirth. An approach to relief through improved prenatal care, birth assistance and post-partum care is necessary but not sufficient to resolve the injustice of unsafe motherhood. Attention should be directed to such conditioning factors as women's inability to regulate their conception in particular and their reproductive and sexual lives in general. Unsafe motherhood condemns political, economic, religious, judicial and comparably influential social institutions not just for their disregard for motherhood, but for their disregard for and systemic discrimination against women.

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[57] See World Health Organization. 1995. *Mother-Baby Package: Implementing Safe Motherhood in Countries*. Geneva. WHO (WHO/FHE/MSM/94.11).
[58] *Op. cit.* note 1.