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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level

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ABSTRACT

Article 14(2)(c) of the Protocol to the African Charter on the Rights of Women enjoins States Parties to take appropriate measures "to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus." This paper considers the implications of Article 14 for access to safe, legal abortion. It is submitted that Article 14 has the potential to impact positively on regional abortion law, policy, and practice in 3 main areas. First, it takes forward the global consensus on combating abortion as a major public health danger. Second, it provides African countries with not just an incentive, but also an imperative for reforming abortion laws in a transparent manner. Third, if implemented in the context of a treaty that centers on the equality and non-discrimination of women, Article 14 has the potential to contribute toward transforming access to abortion from a crime and punishment model to a reproductive health model.

1. Introduction

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol) was adopted on July 11, 2003, and came into force on November 25, 2005 [1]. Its primary objects can be summarized as consolidating as well as advancing women's rights at the African regional level with a focus on equality and non-discrimination. Like the Convention of the Elimination of All Forms of Discrimination against Women (CEDAW) [2], its point of departure is that women have been, and continue to be, disadvantaged and marginalized by gender discriminatory laws, policies, and practices. As a supplement to the African Charter on Human and Peoples' Rights (the African Charter) [3], the Protocol commits African states to protecting and promoting gender equality in the public as well as the private spheres. Abortion is among the areas that it addresses.

Article 14(2)(c) of the Protocol enjoins states to adopt appropriate measures "to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus." By squarely addressing abortion, Article 14 is momentous. It breaks new ground in international human rights law in that it constitutes the very first time that an explicit state obligation to permit abortion has appeared in a treaty. By imposing upon states a duty to permit abortion on the prescribed grounds, Article 14 necessarily inscribes into the substantive provisions of an international treaty a corresponding woman's right to abortion. If contrasted with treaties of the United Nations, as well as the treaties of the European and Inter-American regions that do not address abortion directly, the Protocol raises the visibility of women's abortion rights to the highest possible regional level.

By according abortion rights an enumerated regional human rights status, the Protocol has the potential to impact positively on access to abortion in 3 main areas. First, it takes forward the global consensus on combating abortion as a major public health danger. Second, it provides African countries with not just an incentive, but more significantly, a legal imperative for reforming abortion laws in a transparent manner. Third, if implemented in the context of a treaty whose underpinning philosophy centers on achieving the equality and non-discrimination of women, the Protocol has the potential to contribute toward transforming abortion law from a crime and punishment model, which has characterized African abortion laws in the colonial and much of the post-colonial eras, to a reproductive health model that complements the objects of CEDAW and the broader philosophy of the International Conference on Population and Development (ICPD) [4].

2. Global consensus in combating unsafe, unlawful abortion

According to the World Health Organization, 13% of global maternal mortality is attributable to unsafe abortion [5] (p.5). An overwhelming majority of unsafe abortions (almost 95%) take place in low-resource countries, but with Sub-Saharan Africa bearing a disproportionate

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burden of the consequent mortality and morbidity. An estimated 25% of unsafe abortions occur in Africa, but with an accentuated mortality risk. While the ratio of unsafe-abortion-related deaths in low-resource countries is estimated to be 330 per 100 000 abortions, that of Sub-Saharan Africa is 680 per 100 000 abortions [6]. This mortality risk translates into around 30 000 African women each year dying from unsafe abortion, and Africa assuming 50% or more of the global figure of unsafe-abortion-related deaths [5] (p.13). Although death is the most serious outcome of unsafe abortion, an even greater number of women suffer illness and disability [7].

There is ample evidence that demonstrates that although restrictive abortion laws are by no means the only explanation for the incidence of unsafe abortion, nonetheless, such laws constitute a potent obstacle to accessing safe abortion services. Restrictive abortion laws serve as major incentives or active catalysts for resort to unsafe, illegal abortion. The experiences of high- and low-resource countries show that when abortion law is liberalized and liberalization is complemented by provision of services that are accessible to women, are known to them and are ethically acceptable, the incentive for illegal, unsafe abortion is considerably removed [8]. The experiences of the United Kingdom with the Abortion Act of 1967 [9] and South Africa with the Choice on Termination of Pregnancy Act of 1996 [10], for example, attest to a high- and a low-resource country, respectively, achieving a salutary effect on maternal mortality and morbidity on account of liberal reforms of abortion law within an environment that seeks to render abortion services accessible to all women who need them. Africa's own regional plan for achieving the Millennium Development Goals (MDGs) has acknowledged the imperative of enacting enabling legal frameworks as one of the plans of action for reducing the regional incidence of unsafe abortion [11].

In Concluding Observations especially, United Nations Treaty Monitoring Bodies have, on myriad occasions, recommended the liberalization and decriminalization of abortion laws as part of discharging state obligations to protect the fundamental rights of women, including rights to life, health, equality, and non-discrimination. African abortion laws have been among the objects of such recommendations. For example, in 1998, against a backdrop of unsafe, illegal abortion as a major cause of maternal mortality in Zimbabwe, the CEDAW Committee recommended that the country "reappraise the law on abortion with a view to its liberalization and decriminalization" [12]. In 2004, the Human Rights Committee recommended that Gambian abortion law, which criminalized abortion even where the life of the pregnant woman is threatened or pregnancy is a result of rape, be "amended so as to introduce exceptions to the general prohibitions against abortion" [13].

By unequivocally imposing an obligation on African states to permit abortion, the Protocol implicitly advances the global consensus on reforming restrictive abortion laws as one of the tools for eradicating unsafe-abortion-related mortality and morbidity. At ICPD, global consensus was reached among 179 countries that unsafe abortion is a major public danger [4] (paras 8.25, 12.17). However, although ICPD was a major historic achievement in the global promotion and protection of women's reproductive health, it, nonetheless, adopted a compromise position on abortion. While ICPD committed governments to providing postabortion care services, and has, indeed, been instrumental in spurring African governments to establish such services [14], it concomitantly desisted from advocating, and much less, adopting a plan of action that includes liberalization of abortion law. Certainly, postabortion care ought to be an integral part of any abortion service. At the same time, it cannot replace the need for access to primary abortion services as they are more apt to stem the tide of unsafe abortion. Although ICPD implicated unsafe abortion in the persistence of unacceptable levels of maternal mortality and morbidity, as part of a political compromise to garner the support of countries that would have otherwise stood in the way of achieving global agreement, ICPD left abortion to be "determined at the national or local level according to the national legislative process" [4] (para 7.2).

Against a backdrop, therefore, of endemic regional levels of unsafe abortion, and reticence on the part of ICPD to clearly implicate restrictive abortion laws and recognize abortion as a woman's right, the Protocol takes forward the regional implementation of the consensus on implicating unsafe abortion as a major public danger. The MDGs to reduce the maternal mortality rate by 75% and achieve universal access to reproductive care by 2015 [15] cannot be remotely achieved in the African region unless all avoidable impediments, including unsafe abortion, are tackled with a singleness of purpose. The abortion provisions of the Protocol should be seen as an enabling human rights tool for achieving the MDGs.

3. State obligation to reform highly restrictive abortion laws

Article 14 is drafted in a peremptory style. The innovative contribution that the Protocol makes toward the development of the human rights of women is in imposing a mandatory rather than a discretionary duty on states to institute measures that allow women to access abortion in the circumstances that are indicated. As part of the states discharge of this duty, Article 14 envisages reform of abortion laws that are highly restrictive of abortion, or at least fall below the threshold that the Article prescribes. In this way, the Protocol seeks to ensure that reform of abortion is not in the sole gift of national authorities that are often hostage to constituencies that are implacably opposed to liberalizing abortion law and do not take the human rights of women seriously.

Historically, African abortion laws are largely bequests from European colonial legal regimes that were, in turn, replicas of laws in the metropolises that had their origins in sixteenth century ecclesiastical doctrines that equated abortion with mortal sin [16]. Colonial abortion laws were necessarily highly restrictive of abortion as they were conceived primarily to protect fetal life at the exclusion of the agency of the pregnant woman. For the greater part of the twentieth century, colonially inspired abortion laws in the African region adhered to this paradigm and criminalized abortion save where it was procured to save the life of the pregnant women. Although the post-colonial period has seen a welter of African countries moving from the colonial abortion law model to introduce reforms that are inspired by public health imperatives, social justice, or human rights [17], nonetheless, there are still many African countries that remain wedded to their colonial inheritance to the detriment of the life and health of women. Kenya, a former British colony, serves as a prime example in this regard.

Kenyan abortion law is contained in the convoluted provisions of section 240 of the Kenyan Penal Code. The section connects with abortion through the provision of a therapeutic defense. It says that: "A person is not criminally responsible for performing in good faith and with responsible care and skill a surgical operation upon any person for his benefit, or an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case." While section 240 has not been tested in Kenyan courts, it is generally understood by the Kenyan public as highly restrictive of abortion to the extent that it appears to countenance abortion only for the purpose of "the preservation of the mother's life" [18]. Although such an understanding flies in the face of a 1959 precedent [19], in which the East African Court of Appeal received into Kenyan common law the ruling in the Bourne case [20], and thus also recognized preservation of the pregnant woman's "health" and not just "life" as a ground for abortion, the more significant observation to make is that the Kenyan jurisdiction has done little to clarify the law on abortion by way of providing accurate and clear guidance to women seeking abortion and to healthcare providers.

The Protocol prescribes a broader range of grounds for abortion than section 240 of the Kenyan Penal Code. Jurisdictions such as Kenya whose abortion law ostensibly recognizes preserving the pregnant woman's life as the only permissible ground for abortion clearly fall

below the threshold prescribed by the Protocol to the extent that they exclude risk to the pregnant woman's health, sexual assault, incest, and risk to fetal life as alternative grounds. Upon ratifying the Protocol any such jurisdictions would need to liberalize their laws so as to comply with their international obligations. Furthermore, the Protocol should not only be understood as requiring the mere liberalization of the law. As will be elaborated in the next section, part of the reason why abortion law fails women is that abortion law is rarely rendered transparent.

4. State obligation to render abortion law transparent

Abortion laws that are not clear leave women uncertain about their rights. Equally, such laws deter health providers from providing lawful services for fear of prosecution. Lack of transparency in abortion laws denies women equality as well as equal protection under the law [21]. In respect of Kenya, for example, neither the Kenyan legislature nor the Kenyan Ministry of Health has taken steps to issue guidelines to clarify the meaning and application of section 240 of its Penal Code. In consequence, the Kenyan general public believes that the law is highly restrictive and only countenances abortion to save the life of the pregnant woman. To the extent that Kenyan abortion law is not transparent, it necessarily falls below the standard expected by Common law as well as by international human rights law.

From a Common law perspective, support for the proposition that laws such as section 240 of the Kenyan Penal Code fail the test of transparency comes from a case decided in 2004, the Court of Appeal of Northern Ireland [22]. In that case, it was held that failure by the Department of Health to issue guidelines to clarify Northern Ireland's abortion law and to investigate whether women seeking abortion were receiving the services to which they were entitled constituted a breach of a statutory duty to provide health services. The law in question is based on the Offences Against the Person Act of 1861. The Northern Irish case had arisen against a backdrop of uncertainty about the grounds for legal abortion among women seeking abortion as well as providers of abortion services.

The decision of the European Court of Human Rights in Tysiac v Poland [23] supports the proposition that the substantive abortion rights that are guaranteed by the Protocol impose obligations on the state to institute procedural safeguards, including rendering the law transparent, so as to facilitate the tangible realization of the guaranteed human rights. The European Court held that Polish authorities had failed to put in place effective and fair procedural and institutional mechanisms for determining whether a woman seeking abortion met the criteria prescribed by domestic abortion law. This failure constituted a breach of the procedural safeguards that are required by Article 8 of the European Convention on Human Rights, which guarantees the right to privacy. The European Court emphasized that where the law regulates abortion, it must concomitantly seek to ensure that the pregnant woman is provided with clarity so as to remove the "chilling effect" of law on the women as well as on providers of abortion services.

The moral is that rights that the Protocol guarantees are not illusory, and ought to be amenable to enjoyment in practice by women seeking abortion, in part, through the availability of domestic abortion law that articulates the rights of women clearly. The provision of implementing guidelines by ministries of health to guide health providers, and the conducting of human rights education to inform and educate women about their rights, are ways of supplementing abortion law and creating an enabling environment.

5. From crime and punishment to a reproductive health paradigm

Historically, abortion provisions have nearly always been contained in provisions of penal codes. The predominant paradigm has been to punish the procurement of abortion, subject to certain exceptions that the legislature deems acceptable. The paradigm has also been to regulate abortion, but without assuming any obligations to provide abortion services in respect of women meeting the prescribed grounds for abortion. In the result, even in jurisdictions that have enabling laws, the majority of women seeking abortion have been unable to access services. Zambian abortion law is but one illustration.

The Zambian Termination of Pregnancy Act of 1972 is a replica of the United Kingdom's Abortion Act of 1967. However, although the UK's Abortion Act of 1967 has been successful in stemming the tide of unsafe-abortion-related mortality and morbidity, its Zambian counterpart has had little or no impact. The major explanation for the abject failure of the Zambian Act to impact positively on abortion is that at best it has delivered only paper rights. Abortion rights under the Zambian Act have scarcely been responsive to access to abortion services, in contradistinction from their UK counterparts. Zambia does not command anywhere near enough doctors to meet the certification procedures required by the Zambian Act. A woman seeking abortion under Zambian law needs the approval of at least 3 doctors [24]. Furthermore, Zambia does not command enough facilities and healthcare providers that are ready and willing to provide abortion services in the public sector. Most Zambian women rely on the public sector for healthcare services and cannot afford the fees that are charged by the private sector. Zambian women have been forced to rely on unsafe, illegal abortion as the more realist alternative. In the result, Zambia paradoxically has an incidence of unsafe-abortion-related mortality and morbidity that is comparable to countries that have highly restrictive abortion laws [25].

It is submitted that part of the implications of positing abortion as a human right, as does the Protocol, is that a country such as Zambia whose abortion law only delivers paper rights, would be in breach of its treaty obligations if it ratifies the Protocol. It would not be sufficient for a ratifying state to stop at merely enacting a law that permits abortions in circumstances that at a minimum meet the grounds prescribed by the Protocol. Over and above permitting abortion, the state also has an obligation to provide requisite services for every woman who meets the prescribed grounds. The right to abortion under the Protocol must be understood not only in terms of the obligation to "respect" and "protect" the right, but equally significant, in terms of the state obligation to "fulfill" the right [26]. These arguments are supported by the broader provisions of the Protocol, especially Article 14(2)(a), which provides that "the state has a duty to take appropriate measures to provide adequate, affordable, and accessible health services, including information, education and communication programmes to women especially those in rural areas" and Article 26(2), which enjoins states to "adopt all necessary measures and in particular budgetary resources for the full and effective implementation" of the rights guaranteed by the Protocol. The reference to rural women in Article 14(2)(a) is particularly revealing of the substantive equality premises of the Protocol generally. When contrasted with their urban counterparts, rural-based women often miss out on the benefit of legal reforms on account of relatively poorer economic and educational opportunities and greater deficiencies in provisions of health services and transportation [27].

It follows, therefore, that states must discharge their abortion obligation on premises that are very different from merely decriminalizing abortion. The Protocol implicitly envisages a paradigm in which the respect, protection, and fulfillment of reproductive health is the overarching goal, and the accessibility of abortion services is the ultimate benchmark for measuring compliance with state abortion obligations. In this respect, African states need not start afresh in conceiving accessibility but can, instead, benefit not only from jurisprudence around the meaning and application of accessibility that has been developed by the Committee on Economic, Social and Cultural Rights in General Comment 12 [28], and by the CEDAW Committee in General Recommendation 24 [29], but also from the jurisprudence of the African Commission of Human and Peoples' Rights. In two communications that have come before it, the African Commission has effectively applied the substantive equality premises underpinning General Comment 12 and General Recommendation 24

in its interpretation and application of the right to health guaranteed by Article 16 of the African Charter [30].

In touting the Protocol as conducive to the development of a reproductive health model for African abortion laws, it is also fair to point out that the Protocol does not come without limitations. Although the overall tenor of the Protocol is supportive of a reproductive health model, the precise drafting of the grounds for abortion under the Protocol can be criticized for appearing to resuscitate a crime and punishment model. It is particularly significant that the Protocol does not recognize the woman's mere request or socio-economic circumstances as grounds for abortion. This is unfortunate, as evidence shows that socio-economic reasons account for why the majority of women have recourse to abortion [31]. The general tenor of the grounds for abortion under the Protocol can, therefore, be interpreted as denying women's agency, and instead presuming that women should be mothers first and that abortion is the exception to the rule. Also, grounds such as rape and incest in Article 14 add little to empowering women, unless the woman's account is to be believed, and not second-guessed by a forensic and judicial process at the domestic level that turns women seeking abortion into defendants first before they can prove entitlement to abortion.

But notwithstanding the limitations in the manner in which grounds for abortion are couched under the Protocol, it must be conceded that the Protocol is a product of political compromise that was designed to engender the support of member states that would have otherwise stood in the way of adopting the Protocol [32]. The Protocol sought to inscribe for the first time in the history of modern human rights, a fundamental right to abortion in a binding treaty. Against this backdrop, the grounds for abortion under the Protocol need not be seen as forsaking the notion of a meaningful right to abortion. Unlike the ICPD compromise on abortion, the Protocol did not throw out the baby with the bath water. The fact that mere risk to the health of the woman suffices as a ground for abortion is enabling, but providing health is interpreted holistically to include psychosocial wellbeing [33]. Global support for a holistic definition of health can be derived from the Constitution of the World Health Organization [34]. The definition of reproductive health that was adopted by ICPD provides even more apt support to the view that the decision whether to become pregnant or remain pregnant is fundamental to the physical and mental health of the woman [4] (para 7.2), and that, perforce, compelling motherhood is detrimental to a woman's health.

6. Conclusion

The efficacy of the Protocol, like any other international treaty, ultimately depends on political willingness at the domestic level to fulfill the obligations that it imposes. Even the fact of ratification does not per se translate treaty obligations into realizable tangibles at the domestic level if political will is lacking. It is therefore incumbent upon civil society, especially, to galvanize popular support for the objects of the protocol at the local level. Notwithstanding the importance of a rights discourse, in the end, for the majority of African women seeking abortion, what will matter is not so much knowledge about the fine details of how abortion rights have been formulated, but knowledge about whether abortion services are accessible in a substantive sense at the local level.

The availability of resources is crucial to the availability of abortion services. Part of what resource-strapped regions such as Sub-Saharan Africa can do is devise innovative ways of ensuring that they comply with their international obligations under the Protocol. One way of meeting the obligations would be to dispense with the assumption that only doctors can perform abortion, but without compromising the safety of women seeking abortion. Abortion laws that assume the easy availability of doctors would be a recipe for failure in low-resource settings where doctors are highly scarce for a number of reasons. The experience of some countries, including South Africa [35], shows that African countries would be better placed to meet abortion needs if the design of abortion laws moves beyond a singular preoccupation with the grounds for abortion so as to also focus on aspects that address facilitating access in a low-resource setting context. Dispensing with excessive, burdensome certification procedures that make doctors the sole gatekeepers of access to abortion, and recognizing the competences of mid-level providers to perform early abortions, are innovative ways of assuring equitable access.

References

[1] AHG/Res. 240 (XXXI).
[2] G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, adopted 18 Dec. 1979, entered into force 3 Sept. 1981.
[3] OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), adopted 27 June 1981, entered into force 21 Oct. 1986.
[4] United Nations, Population and Development, Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5–13 Sept. 1994, Doc. ST/ESA/SER.A/149.
[5] World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Geneva: WHO; 2005.
[6] Singh S. The incidence of unsafe abortion. In: Warriner IK, Shah IH, editors. Preventing Unsafe Abortion and its Consequences. New York: Guttmacher Institute; 2006. p. 35–50. at 45.
[7] Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua F, et al. Unsafe abortion: the preventable pandemic. Lancet 2006;368(9550):1908–19 at 1910-1912.
[8] Guttmacher Institute. Abortion Worldwide: A Decade of Uneven Progress. New York: Guttmacher Institute; 2009.
[9] Morgan D, Lee RG. Human Fertilisation & Embryology Act of 1990. London: Routledge; 1991. p. 37.
[10] Jewkes R, Rees H, Dickson K, Levin J. The impact of age on the epidemiology of incomplete abortion in South Africa after legislative change. BJOG 2005;112(3): 355–9.
[11] Zampas C, Gher JM. Abortion as a human right – international and regional standards. Hum Rights Law Rev 2008;8:249–94.
[12] Committee on CEDAW CEDAW/C/ZWE/1, 1998, para 159.
[13] Human Rights Committee, CCPR/CO/75/GMB, 2004, para 17.
[14] Brookman-Amissah E, Moyo JB. Abortion law reform in Sub-Saharan Africa: No turning back. Reprod Health Matters 2004;12(24 Suppl):227–34 at 229.
[15] General Assembly, United Nations Millennium Declaration 18 September 2000, U.N. Doc. A/RES/552, Goal 5: Improve Maternal Health.
[16] Cook RJ, Dickens BM. Human rights dynamics of abortion law reform. Hum Rights Q 2003;25:1–59 at 9.
[17] Ngwena C. Access to legal abortion: development in Africa from a reproductive and sexual health perspective. S Afr Public Law 2004;19:328–50.
[18] Guttmacher Institute. Unsafe Abortion in Kenya 2008, 1.
[19] Mehar Singh Bansel v. R (1959) EALR 813.
[20] R v. Bourne 1 Kings Bench 687 (Central Criminal Court, London) 1938.
[21] Cook RJ, Howard S. Accommodating women's differences under the Women's Anti-discrimination Convention. Emory Law J 2007;56:1039–91 at 1069.
[22] Family Planning Association of Northern Ireland v Minister of Health, Social Services and Public Safety [2005] Northern Ireland Law Report 188 (Civ).
[23] Tysiac v. Poland, Application No. 5410/03, 45 EHRR 42 (2007).
[24] Section 3(1) of the Zambian Termination of Pregnancy Act of 1972.
[25] Sims P. Abortion as a public health problem in Zambia. J Public Health Med 1996;8:232–3.
[26] Scheinin M. Characteristics of human rights norms. In: Krause C, Scheinin M, editors. International Protection of Human Rights: A Textbook, Turku/Abo: Abo Akademi University, Institute for Human Rights; 2009. p. 19–37. at 27-29.
[27] Pruitt L. Gender, geography and rural justice. Berkeley J Gend Justice 2008;23:338.
[28] Committee on ESCR, General Comment 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000).
[29] CEDAW Committee, General Recommendation 24 (Women and Health) U.N. Doc. A/59/38 (2004).
[30] Social and Economic Rights Action Centre (SERAC) and Another v. Nigeria (2001) AHRLR 60 (ACHPR 2001) paras 44–48; Purohit and Others v. The Gambia (2003) AHRLR 96 (ACHPR 2003), paras 80–85.
[31] Bankole A, Singh S, Haas T. Characteristics of women who obtained induced abortion worldwide. Int Fam Plann Perspect 1999;25:68–77.
[32] Banda F. Blazing the trail: the African protocol on women's rights comes into force. J Afr Law 2006;50:72–84 at 82.
[33] Cook RJ, Ortega-Ortiz A, Romans S, Ross LE. Legal abortion for mental health indications. Int J Gynecol Obstet 2006;95(2):185–90 at 187.
[34] Preamble to the Constitution of the World Health Organization 1948.
[35] Ngwena CG. The history and transformation of abortion law in South Africa. Acta Acad 1998;30:32–68 at 47-48.