The Rights Based Approach (RBA) in the Basic Health & HIV Program of the ICCO Alliance

A Position paper written for Program Officers,
and a working document, to be reviewed in December 2014

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Contents

1. Introduction

The ICCO Alliance is a faith-based organization with the mission *to work towards a sustainable global society where poverty, inequality and injustice are eradicated, where men, women and children can live in dignity and wellbeing*[1]. The Alliance bases its work on the three core values: justice, compassion and stewardship. As a faith-based Alliance, we believe that every human being is created in God's image and that we are, therefore, all equal in our inherent human dignity, irrespective of race, sex, religion, ethnicity, caste, class, political affiliation, social position and capacities. The ICCO Alliance pursues the realization of its mission by addressing the underlying structural causes of poverty, inequality and injustice, like structural inequality, social exclusion, discrimination and exploitation.
The ICCO Alliance considers the Rights Based Approach (RBA) as a useful and effective approach that embodies our core values. This approach departs from the fundamental human rights of people and is considered well-placed to address those root causes. Notions on which a RBA is based are human dignity (cf. compassion), equal and just power relations (cf. justice) and shared responsibility (cf. stewardship).

> *"A Rights-Based Approach to development promotes justice, equality and freedom and tackles the power issues that lie at the root of poverty and exploitation."*
>
> *From: Promoting Rights Based Approaches, J. Theis, 2004, pg 2*

The IA sees a RBA as *complementary to other approaches*, like for example a values-oriented approach, a needs-based approach and a capabilities approach. The RBA adds essential elements to e.g. the needs-based approach: in the RBA beneficiaries are not seen as receivers only but are seen as active contributors and participants; civil society has a role to play but other actors, notably the state, as well. Short term interventions focusing on direct needs should be complemented by longer term interventions focusing on the change of structural causes.

The IA supports the notion that there is *not one RBA* that fits all situations or agencies: rights-based strategies depend on an organisation's mandate and philosophy (emergencies, development, human rights, activism, cooperation), the issues the organisation is working on (protection, basic services, civil society strengthening) and the country context (type of government, strength of civil society and independence of human rights institutions, media and the judiciary)[2].
However, we can distinguish a number of *common elements* within the different RBAs:

- Attention to needs and rights of vulnerable groups
- Empowerment (enabling people to take and act on their own decisions)
- Freedom of discrimination
- Active participation
- Accountability
- Progressive realisation.

[1] ICCO Alliance, Grant Application, Phase 1, MFS II. Pg 5
[2] "Promoting Rights-Based Approaches.", Joachim Theis, Save the Children, 2004

2. A Rights Based Approach (RBA) to promote health

The core of a RBA to promote health is that it re-frames basic health needs as health rights. By doing so, becoming healthy and remaining healthy , is not merely seen as a medical, technical or economic problem, but as a question of social justice, which includes shared responsibility, and concrete government obligations.[3]
Looking at health from a rights-based perspective, civil society is better able to contribute to, and hold relevant stakeholders accountable for, the delivery of equally accessible quality basic health care and other health related services[4],[5].

2.1 The Right to Health

The Right to Health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". The preamble further states that "*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*" It is a right recognized by all States as every State has ratified at least one international human rights treaty in which the Right to Health is mentioned.

These definitions are rather abstract, how are they being translated in practice?

[3] Taken and adapted from http://www.ifhhro.org/health-a-human-rights/a-rights-based-approach-to-health From: The Right to Health, A Resource Manual for NGOs by Judith Asher.

[4] "Political will for better health, a bottom up approach", De Ceukelaire, Wim ao. Tropical Medicine and International Health, Volume 00 No 00, 2011 Blackwell Publishing Ltd.

[5] *A RBA is relevant to much NGO work*

The right to health is relevant to the everyday lives of ordinary people and is therefore relevant to NGOs working in health as their work is to promote and protect the health of individuals and local communities. However, this is a responsibility they can and should not bear alone; governments have a responsibility in this as well. All states have ratified human rights treaties and therefore have agreed to assume responsibility for guaranteeing that people can enjoy the benefits of the right to health. NGOs can hold governments accountable.

- *A RBA can provide NGOs with a powerful tool*

As said above, states have ratified human rights treaties, NGOs can hold them to their obligations.

- *A RBA will enhance strategies to promote and protect the health of individuals and groups already used by NGOs*

In many respects, there is an overlap between strategies and goals employed in public health and in 'right to health' advocacy and monitoring. Although they both use different terminologies, the two perspectives share many common concerns including providing populations with the preventive and treatment services that are essential to health promotion and protection, like clean water, sanitation, adequate nutrition and primary health care. A human rights framework can enhance public health policies by helping to shape more comprehensive, effective and equitable responses to diverse public health problems. It can also help strengthen NGO advocacy by enabling the evaluation of existing public health policies and programs in light of concrete government obligations.
Taken and adapted from http://www.ifhhro.org/health-a-human-rights/a-rights-based-approach-to-health From: The Right to Health, A Resource Manual for NGOs by Judith Asher.

2.2 Aspects of the Right to Health[6]

1. The right to health is an inclusive right. It is about *access to* health information, care and treatment but also about access to a wide range of factors that support a healthy life, the so called "underlying determinants of health". They include:

- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;
- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality.

2. The right to health contains freedoms. These *freedoms* include the right to bodily integrity, the right to be free from non-consensual medical treatment and to be free from torture and other cruel, inhuman or degrading treatment or punishment.

3. The right to health contains entitlements. These *entitlements* include:

- Access to a system of health protection providing measures equally available and accessible for everyone;
- Access to interventions that prevent, treat and/or control diseases;
- Access to essential medicines;
- Access to maternal, child and reproductive health and health related services;
- Equal and timely access to basic health services;
- Access to health-related education and information;
- Participation of the population in health-related decision making at community, district and national levels.

4. Health services, goods and facilities must be provided to all without discrimination[7]. Non-discrimination is a key principle in human rights.

5. All services, goods and facilities must be available, accessible, acceptable and of good quality. In our view there are four essential standards for evaluating the obligations related to the right to health; these are:**.**

- Functioning public health and health-care facilities, goods and services must be *available* in sufficient quantity within a State.
- They must be *accessible* physically (in safe reach for all sections of the population) as well as financially and on the basis of non-discrimination. *Accessibility* also implies the right to seek, receive and impart health-related information in an accessible format, but does not impair the right to have personal health data treated confidentially.
- The facilities, goods and services should also respect medical ethics, be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally *acceptable*.
- Finally, they must be scientifically and medically appropriate and of *good quality.* This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water.

[6] Many of these and other important characteristics of the right to health are clarified in general comment N° 14 (2000) on the right to health, adopted by the Committee on Economic, Social and Cultural Rights. The Covenant was adopted by the United Nations General Assembly in its resolution 2200A (XXI) of 16 December 1966. It entered into force in 1976 and by 1 December 2007 had been ratified by 157 States.

[7] That is to say, discrimination on grounds that are not relevant for the health care provision; of course health care provisions will be delivered only to those needing them on the basis of professional indication

2.3 A RBA to promote Health: actual state of affairs, roles and responsibilities

When we look at the general health status of the population worldwide, we can conclude that not everybody has profited equally from the improvements in health status achieved over the last decade (see also annex 1). To the contrary, social exclusion, discrimination in access, exclusion from decision-making processes and bodies, exploitation and unequal distribution have all contributed to a growing inequality in health status.

Following a RBA means that we are all: as citizens, civil society organisations, the business and public sector, governments and international organisations, responsible for realising the right to health. However, our responsibilities differ. There are certain actors, the so called *duty bearers,* who have a particular duty to respect, protect and fulfil the right to health of the so called *right holders*, e.g. all citizens within society and particularly those whose right to health is most compromised. These right-holders in turn have a personal responsibility to maintain their own health and the health of those dependent on them, e.g. their children. To be able to do so, however, right holders are dependent on how duty-bearers fulfil their particular duties, as duty bearers have signed and ratified human rights treaties etc., right holders can hold them accountable.
In addition, a responsible exercise of human rights requires that all individuals respect the rights of others.

2.3.1 Duty bearers

States

It is the state that is ultimately responsible for the fulfilment of the right to health. States have signed and ratified human rights treaties and have therefore the obligation to respect, protect and fulfil the right to health.

> *Respect*: This means simply not to interfere with the enjoyment of the right to health.
> *Protect*: This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health.
> *Fulfill*: This means taking positive steps to realize the right to health.

This means that the state has a responsibility to implement these obligations in legislation, policies and concrete actions regarding public health and health care. Relating this to health: to make basic health care available and accessible and services acceptable, appropriate and of a minimum standard of quality.

International Community

International agreements such as the Convention on the Rights of the Disabled, the UNGASS Declaration of Commitment and the Convention of the Rights of the Child have clearly indicated that the fulfilment and protection of rights is a responsibility of the global community. As a result, not only governments of low and middle income countries can be hold accountable; high income countries have an obligation as well.

Non-state actors

Non-state actors like NGOs, the business sector and individual members within a society can all be identified as duty bearers: they all have an obligation to contribute to optimal healthy nations. For example, NGOs and the business sector have an obligation to maintain the health of their staff. Those that have the power to influence factors that fuel exclusion or exploitation have an obligation

to address these exclusion mechanisms. And all individuals have the obligation to live a life as healthy as possible. However, not all may have the capacity to fulfil this duty.

2.3.2 Right holders

Right holders refers to all individuals (girls, boys, woman and man), groups of people and (civil society) organizations within a society that have certain rights, based on signed treaties, legislation and policies, where they can hold duty bearers accountable for.

3. A Rights-Based Approach within the Basic health & HIV program of the ICCO Alliance

3.1 The RBA within the ICCO Alliance

The Rights Based Approach within the IA in general features the following common elements/ strategies:

- Focus on those marginalised and/or excluded and therefore on addressing structural and root causes of marginalisation/exclusion
- Focus on equality and non-discrimination
- Focus on empowerment
- Focus on participation
- Focus on accountability of governments, health care providers and other stakeholders, upwards and downwards
- Focus on community and the inter-relatedness of human-beings.

These strategies will be used to work towards positively changing some key aspects related to the right to health.

3.2 A RBA to promote Basic Health

We will work towards:

a. Health policies and implementation that support and contribute to equal available, accessible, acceptable and quality health education, information, prevention, care and treatment, with special attention for women, young people, people living with a disability and people living with HIV, particularly in relation to their sexual and reproductive health;
b. Health policies and implementation that support and promote a healthy living and working environment and a healthy life style;
c. Health policies and implementation that are being informed by evidence;
d. Health policies and implementation being connected to other relevant underlying determinants of health;
e. Ethics, particularly in relation to non-discrimination, safe guarding bodily integrity and confidentiality and informed consent.

3.3 A RBA to promote Sexual and Reproductive Health and Rights, including HIV

In its Basic Health & HIV program the ICCO Alliance has specific attention for the promotion of Sexual and Reproductive Health and Rights (SRHR). Before we explain how our RBA is translated to promote SRHR, first some definitions. There is a range of different understandings of SRHR. Some of these understandings focus more on health; others draw attention to the significance of rights in women's and men's sexual and reproductive choices[8].
The IA takes the UNFPA declaration on Reproductive Rights as a referral for its own Rights Based work (see box below).[9]

Reproductive Rights

- Attaining the goals of sustainable, equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the right to:
- Reproductive health as a component of overall health, throughout the life cycle, for both men and women;
- Reproductive decision-making, including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children and the right to have access to the information and means needed to exercise voluntary choice;
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.

The IA takes the sexual rights as formulated by the WHO as a referral for its own Rights Based work (see box below)[10].

Sexual rights

Sexual rights embrace human rights that are already recognised in national laws and international human rights documents. They include the right of all individuals, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive, and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide whether or not to be sexually active;
- Remain free of coercion into sex, a sexual relation or marriage
- Be spared of unwanted third party interference in decision making with respect to having children
- Pursue a satisfying, safe and pleasurable sexual life.

8 http://www.eldis.org/go/topics/resource-guides/health/key-issues/sexual-and-reproductive-health-and-rights/what-does-it-mean
9 http://www.unfpa.org/rights/rights.htm
10 WHO draft working definition, 2002: http://www.who.int

Applied to our practice of developmental work, our RBA towards the promotion of SRH leads to some specific focus areas:

Related to SRH in general:

- Acknowledgement and promotion of respect for the sexuality of youth, their right to appropriate and correct information, youth-friendly services and protective means (evidence based interventions, inclusive prevention messages), public health considerations may exceed moral considerations but only justified;
- Making pregnancies as safe as possible for all women, including women living with HIV or a disability: no woman's life should be put at risk or endangered by reason of pregnancy. This point refers in particular to avoidable deaths, especially to the risk factors for high-risk pregnancies which are "too early, too late, too close or too many".
- No infants' life should be put at risk or endangered by reason of her/his gender;
- Prevention of (unsafe) abortions;
- Elimination of harmful, traditional, practices;
- Men and women, boys and girls, independent of their sexual identity, can live in security, free from threat of harassment and violence;
- Power relations between men/women, adults/youth do respect individual rights.

Related to HIV:

- Challenging issues that hamper an effective HIV response, eg stigma & discrimination, criminalisation of HIV transmission;
- Quality pre-and post -counselling related to HIV-testing, voluntarily and confidential;
- Quality pre- and post-counselling related to HIV-testing for pregnant women; informed consent of women before testing;
- Access to PPTCT (access to interventions/medication related to Prevention of Parent to Child Transmission);
- In relation to male circumcision: attention for universal precautions and comprehensive prevention;
- No obligatory testing before marriage;
- Promotion of access to male & female condoms.

Related to Disability:

- Special emphasis on equal access of people living with a disability to education, information, prevention, care and treatment related to their sexual and reproductive health, including family planning, STIs and HIV.

3.4 A RBA as reflected in the results of our Basic Health & HIV program

When looking at the objectives of our Basic Health & HIV program, 2011-2015, the results and connected indicators, we can see that all crucial elements of a RBA are included (see also page 3) .

We depart from *the needs and rights of marginalised groups* as perceived by these people themselves and work towards their *empowerment* so that they can *participate* in decision and policy making processes related to the promotion of health and equal access to health service, *challenge discrimination* and hold duty bearers *accountable* for their performances, including health service providers. And this all adjusted to the local situation and cultural and religious context.

Some examples as taken from our Monitoring Protocol:

1. Well-established *accountability* mechanisms in which civil society effectively calls the health system to account for the delivery of *equally* accessible basic health care
Increased health seeking behaviour and use
Number of partners with documented *inclusion* strategies/strategies to improve equal access
Increased participation target group
Number of partners with structures in place that facilitate *participation* of target groups in decision making process related to the development and implementation of health (related) services
Number of projects that can show concrete evidence of the *influence* of, representation of, the target group in relevant decision making processes related to the development and implementation of the basic health and health related services
Increased accountability of government
Number of program coalitions having lobby plans, budgets focusing on *increased accountability* of government.
Number of countries where government has become *more transparent on implementation and budgeting for pro-poor health policies* ; Second indicator (impact): number of countries where *equal access* to basic health care for the poor *has increased*
2. Capacitated change agents through which civil society promotes effective prevention of SRH problems, HIV transmission and disabilities
Increased capacity of interest groups in advocacy
Number of countries in which program coalitions/partners support capacity building of interest groups (can vary between advocate skills to organizational capacities) to *become more effective advocates* for their constituency
Inclusive health policies & programs
Number of countries where program coalitions in collaboration with interest groups have developed a shared lobby strategy and plan related to *inclusive health programs* and policies based on equal rights of people living with HIV and/or with a disability
Number of countries where health or health related policies have been changed in favour of *equal rights of vulnerable people* to basic health/health-related services (inclusion: access & available).
3. Well-established HRH policies, strategies & activities that sustain the quality, accessibility and sustainability of the health system through civil society participation
Improved government policies on HR
Number of countries where (partners in) program coalitions have formalized their collaboration with the government around HRH
Number of countries where an *increased part of staff costs are covered* by the government

4. Dilemma's

Working with a RBA within a Faith Based Alliance with Faith Based members, constituencies and partners, is not without dilemmas and subsequent tensions: human rights, the foundation of a RBA, are not always being perceived as matching religious norms and values.

- If we state that our RBA towards the promotion of SRH leads to the "Acknowledgement and (the) promotion of respect for the sexuality of youth, their right to appropriate and correct information, youth-friendly services and protective means …"and that "public health considerations may exceed moral considerations"., we realise that this is not for all our members, constituencies and partners evident, for all kinds of reasons.
- Or that "Men and women, boys and girls, independent of their sexual identity, can life in security, free from threat of harassment and violence", will not be evident for all either.
- Another tension often mentioned is the right of the individual versus the interest, the sustainability, of the collective.

It is important to be aware of these tensions; to bring these out in the open and to be able to discuss them in a respectful and safe manner; to explore the underlying concepts and convictions; to connect them to reality in which we work and live and; to work towards effective approaches acceptable for all parties.

An additional and important strategy not mentioned yet, is the strategy of dialogue. As a Faith Based Alliance we consider it important to enter into such a dialogue ourselves, with members, constituencies, marginalised groups and partners. And we consider it important to facilitate such a dialogue between partners and their constituencies and/or those excluded from their constituencies.

Some people do fear that a RBA would require from them taking up an activist approach. This fear is not being supported by evidence. However, an activist approach might complement the efforts of those who have chosen for a more 'bridging' approach.

5. In conclusion

A RBA to promote health involves a different perspective: health is not merely seen as a medical, technical or economic problem, but as a question of social justice. Looking at health from such a perspective automatically brings in notions like having a shared responsibility and a focus on the obligations of governments and other duty bearers. For the *realisation* of the right to health a strong civil society is crucial: to hold governments, and others, accountable as well as to allow its participants to bear their own responsibilities[11].

When looking at the practicalities of a RBA towards health and what is happening already within the overall Basic Health & HIV program of the ICCO Alliance, we see that the work of the IA is gradually shifting from a strong focus on service delivery to a stronger focus on capacity development related to empowerment and participation of beneficiaries, including upward accountability, and on capacity development related to effective lobby & advocacy, including downward accountability.

[11] "Political will for better health, a bottom up approach", De Ceukelaire, Wim ao. Tropical Medicine and International Health, Volume 00 No 00, 2011 Blackwell Publishing Ltd.

6 Annexes

Annex 6.1. Background: growing inequalities in Health & HIV

As stated in the first paragraph of the IA program on Basic Health & HIV, based on findings from the WHO[12], when we look at the general health status of the population worldwide important improvements have been achieved over the last decade. However, when looking more closely at these results it becomes clear that not everybody has profited equally, to the contrary: inequalities in health status have grown.

Some figures from the WHO report, *World Health Statistics 2011*

	Life expectancy at birth (men & women), 2009	Under 5 mortality (m&w) [13], 2009	Maternal mortality ratio[14], 2008	Birth attended by skilled health personnel (%), 2000-2010
Afghanistan	48	199	1400	14
Bolivia	68	51	180	71
Ethiopia	54	104	470	6
Kenya	60	84	530	44
Netherlands	81	5	9	100

Inequalities are not only found between countries, but also between regions within countries.

Also taken from the WHO report, *World Health Statistics 2011*

	Under 5 mortality (m&w) [15]	Birth attended by skilled health personnel (%), 2000-2010
Afghanistan rural	Not available	na
Urban	na	na
Bolivia rural	(2008) 99	(2008) 51
Urban	55	88
Ethiopia rural	(2005) 135	(2005) 3
Urban	98	45
Kenya rural	(2008-2009) 86	(2008-2009) 37
Urban	75	75
Netherlands rural	Na	na
urban	na	na

Particularly rural areas in low income countries are underserved which is very much connected with the weakness of their health systems, including the fact that these are often seriously under-resourced (e.g. finances, staff).
In addition, there are groups of people whose access to health care services is jeopardized due to judgments of society, including health staff, related to their physical, or mental state of being, their socio-economic position (women) or other cultural, including religious, factors. Examples of these groups of people are those living with a disability, with HIV, pregnant teenagers, sexually active youth (15-24 yr), sexual minorities and commercial sex workers (CSWs). Besides poor and unequal distribution of health services, lack of capacity and persisting exclusion mechanisms, financial costs are another big obstacle hampering equal access (this in turn relates to poverty and socio-economic position).

It should be noted here, that in many low income countries national health policies are pro-poor and their budget spending is, generally speaking, geared towards the poor as well[16]. However, only a small proportion of the poor really profit from these policies and budget priorities. Underlying reasons: policies do not respond to local needs and/or are not well implemented due to issues like weak governance, ineffective/inefficient management, weak accountability mechanisms and corruption.

[12] http://www.who.int/whr/2008/en/index.html
[13] Probability of dying by age 5 per 1000 live births
[14] Per 100.000 live births
[15] Probability of dying by age 5 per 1000 live births
[16] CSDH (2008). *Closing the gap in a generation: health equity trhough action on the social determinants of health*. Final report of the CSDH, Geneva, WHO

Annex 6.2. Indicators and benchmarks for monitoring the Right to Health[17]

There are many possible ways to monitor the right to health by using indicators and statistical data, but monitoring must always be carried out systematically.

Monitoring involves a three-step process:
- Identifying which types of data are relevant and how to obtain them;
- Collecting the data; and
- Analysing the data.

Although the use of indicators, benchmarks and statistical data must remain the principal means of monitoring progressive implementation of the right to health, NGOs have great flexibility in what they monitor and how they choose to do so. While they may feel intimidated at the prospect of measuring implementation with quantitative data, they should bear in mind that their main strength lies in the fact that they have access to important information about what is going on *at the community level*. Such information is essential for monitoring how a government is actually fulfilling its obligations.

Indicators

Indicators are *signals* that make it possible to determine the extent to which a particular obligation or standard has been, or is being, attained. They are tools that can be used to indicate the *present* situation. They can show trends; serve as signs; reveal symptoms; and mark progress towards targets. They are substitutes for capturing elements of the right to health that are otherwise difficult to measure directly.
Ex.: An example of an indicator of child mortality is under-5 child mortality rates (expressed as the number of deaths per 1,000 live births and of children below age 5 years); or the infant mortality rate (also expressed as the number of deaths per 1,000 live births).

Benchmarks

Benchmarks are self-set *goals or targets* to be reached at some *future* date. National and international benchmarks set the framework for measuring progress in implementing the right to health and are used normally for assessing the effectiveness of policies.
Ex.: Reduce infant and under-5 child mortality rates by two-thirds by 2015.

Both benchmarks and comparative indicators can be used to monitor equity, namely the elimination of discrimination, which is an immediate state obligation. States must formulate explicit, quantifiable and time-limited objectives for the purpose of meeting their obligations and must identify appropriate indicators and benchmarks with which they intend to measure progressive realization. The combined application of indicators and benchmarks enables results to be measured against targets.

How to select and use indicators and benchmarks

The choice of indicators and benchmarks, together with the ways in which they will be used, depends on a number of factors, including:
- Particular aspect of the right to health that is being monitored;
- Aims of the NGO concerned;
- Resources and expertise that are available to assist in the exercise;
- Whether national-level indicators and benchmarks have been established; and
- Availability of accurate and reliable data.

Wherever feasible, NGOs should work with national indicators and benchmarks.

[17] From: The Right to Health, A Resource Manual for NGOs by Judith Asher

Annex 6.3. Abortion

When it comes to the issue of abortion, there are some differences in the point of views between ICCO and Prisma:

- We both support the importance to prevent, unsafe, abortions. ICCO will actively support partners delivering, or lobbying for the delivery of, safe abortions; Prisma will not do so unless abortion is needed on medical grounds. Prisma will support partners to take properly care of complications due to incomplete or illegal abortions.
- We both support the importance of pre- and post-counselling in the case of abortion.
- We both challenge the use of abortion as a mean for family planning.
- We both support the importance of the accessibility, availability, affordability and quality of contraceptives for those sexually active. Prisma would rather see young people, and people not being married, abstaining from sex, for ICCO this is not an issue. We both support enabling these groups to make informed decisions about, and act upon, maintaining their own sexual and reproductive health.
- The main difference is related to our emphasis: ICCO puts the emphasis on the right of the woman, Prisma on the right of the unborn child.

The following text has been taken from the Prisma's position paper on SRHR[18]

"The unborn child
In modern Western discourses often the rights of women are stressed but the right to life and care of the foetus is neglected. The Universal Declaration of Human Rights only takes into account life that has already been born. Abortion is never an action of little moral consequence. Thus prenatal life must certainly not thoughtlessly be destroyed and if at all possible, not at all.

Some guiding principles in this area are:
- The human embryo deserves to be protected. It is a new biological organism, an entity with its own unique genetic characteristics, and has all potential to fully develop as a human being. Every unborn child is therefore to be welcomed.
- From a Christian ethical point of view abortion should only be performed for the most serious reasons, an example being to save the life of the pregnant mother (the vital medical indication). The availability of safe abortions under such circumstances and in specific institutions can in itself be desirable.
- In the reality of people's lives, decisions about life are made in the context of a fallen world, full of sin, violence and suffering. In that world human beings confront tragic dilemmas that more frequently than desirable lead to an abortion. Christians need to be present in that world demonstrating love and care.
- Not infrequently, women are pressed to an abortion that they would not want if there were support for them and their child, once born. The church should offer gracious support to those who personally face the decision concerning an abortion.
- Christians are commissioned to become a loving, caring community of faith that assists those in crisis when alternatives like adoption are considered.
- We should make a distinction between acts and people; whereby we should not approve of wrong acts (and sometimes it is difficult to determine that) but should also not reject people; we should be open to share their burden and sorrow. Writing people off is totally inappropriate for Christians.
- Since so many pregnancies are unintended and unwanted, it is of utmost importance to address the circumstances that lead to (mostly unsafe) abortions.

[18] Pro-Creation ; Prisma vision paper on Sexual and Reproductive Health and Rights, November 2009. http://www.prismaweb.org/media/50595/prisma%20vision%20paper%20srhr,%20november%202009.pdf

Important strategies for the prevention of abortion are:

- Reducing reliance on abortion. In countries where abortion is legal and easily accessible and where contraceptives have generally been unavailable, women have come to rely heavily on abortion to regulate their fertility. In these countries, women and couples need more contraceptive choices.
- Providing full information is essential. Abortion services are only a small part of the picture; alternatives to abortion and information about the growth and development of the foetus are equally important. Alternatives of abortion should be thoroughly reviewed with the partner organisations: what are possible options for the unborn child in instances of unwanted pregnancies?
- Supporting women with unwanted or unplanned pregnancies. This can be done by raising awareness about an unwanted pregnancy and its impact on women. Secondly it is important to guarantee a conscious decision-making process since the decision to abort a pregnancy is irreversible. Further research on alternatives to abortion is needed and these possible alternatives should be discussed (e.g. support from the extended family, possibilities for foster care). This needs multi-disciplinary investigation (e.g. encompassing oral and written information), involving different groups of professionals like doctors, social workers and psychologists.
- Improving the ability of health care providers to manage and treat incomplete abortion complications. At the same time, there may be a need to strengthen post abortion counselling and contraceptive information.
- Reducing unsafe abortions. This includes providing adequate quality care when abortion is needed on medical grounds."

Annex 6.4. Useful resources, links etc.

Rights-based development for a faith-based perspective. Aprodev agencies, June 2008
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