

4320 Health and Population
Supraregional Project :
Promotion of Reproductive Health

(UN)SAFE ABORTION

A REVIEW & DISCUSSION PAPER

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November 2004



Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

commissioned by:



Federal Ministry
for Economic Cooperation
and Development

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Impressum:

Auftraggeber: Sektorvorhaben ‚Förderung der reproduktiven Gesundheit‘
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November 2004

ABBREVIATIONS

D&C	Dilatation & curettage
DHS (RHS)	Demographic (Reproductive) and Health Survey
EC	Emergency contraception
GGR	Global gag rule
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
ICEC	International Consortium for Emergency Contraception
ICMA	International Consortium on Medical Abortion
ICPD	International Conference on Population and Development (Cairo 1994)
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MA	Medical abortion
MDGs	Millennium Development Goals
MVA	Manual vacuum aspiration
NGO	Non Government Organisation
PAC	Post abortion care
STD/STI	Sexually transmitted disease/infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner for Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNIAP	United Nations Inter Agency Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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Summary

Globally, about one in four pregnancies is being terminated. This reflects the high incidence of unplanned and unwanted pregnancies. They do for various reasons occur in any society and in all societal strata as no contraceptive offers 100% protection and because sexuality and procreation do not always happen in a planned and completely controlled context. A high number of pregnancies occurs under conditions of coercion and violence. Terminations of pregnancies are performed under life-threatening conditions and no matter how threatening sentences may be.

Unsafe abortion is an important contributing factor to maternal morbidity and mortality. This has not been translated adequately into health policy discourse, legal change and health care services. At various important occasions (ICPD, Cairo 1994, *United Nations Millennium Summit* 2000) governments and relevant intergovernmental and non-governmental organisations have therefore been urged to deal with the health impact of unsafe abortion as a major public health concern.

This paper highlights the current situation regarding unsafe abortion as a public health concern, and the range of abortion laws worldwide including recent developments. It reviews the current status of the debate and challenges ahead, including the role technical cooperation can play.

Precise data about the extent of the problem are by its nature difficult to obtain.

- 46 million pregnancies are estimated to end in induced abortion each year, nearly 20 million of them unsafe;
- About 13 per cent of pregnancy-related deaths have been attributed to complications of unsafe abortion, and probably number about 67,000 deaths annually;
- 95 % of all abortions take place in developing countries;
- In developing countries, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions;
- Complications resulting from unsafe abortion contribute to serious consequences for women's health; 10 – 50 % of all women require medical treatment as a result of complications.

Studies suggest that treating abortion complications consumes a disproportionate amount of hospital resources. Thus, improved access to *safe abortion* and effective *post abortion care* does not only save lives and reduce morbidity, but has the potential of reducing costs for health facilities. It has often been wrongly assumed that a large proportion of unsafe abortions are performed by unqualified personnel. In fact, most clandestine abortions are performed by health professionals who have no specific training making them potentially unsafe.

The reasons for unwanted pregnancy to happen are diverse including insufficient access to modern methods of contraception, failure and imperfect use of contraceptives, and sexual coercion and rape. The reasons for termination of pregnancies may include changing circumstances resulting in a wanted pregnancy to become unwanted, economic reasons, social reasons such as unstable or changing relationships, rejection of fatherhood; among adolescents fear of negative parental reactions to a pregnancy or of expulsion from school; social stigmatisation in case of pregnancy out of wedlock, among others.

There is no typical profile of women with an unwanted pregnancy. There are, however, women who are particularly at risk of an *unsafe abortion*: Young and/or unmarried women, women in crises, conflict and refugee situations, women exposed to sexual violence, and poor women.

Global reviews of abortion policies and comparisons of legal frameworks worldwide came to the striking conclusion that there are hardly any two abortion legislations in the world that are completely identical. Grounds on which abortion is permitted can be differentiated into the following categories: (1) prohibited altogether or to save the woman's life, (2) to preserve her physical health, (3) to preserve mental health (large room for interpretation!), (4) on economic or social grounds (5) without restriction as to reason.

Practice often differs considerably from written law, at times into a more restrictive direction, at times in a more liberal way. Permission of pregnancy termination by law is not the most decisive but an important factor determining women's access to safe abortion. Where abortion is legal maternal morbidity and mortality are almost as a rule lower.

Currently, more than 61% of the world's people live in countries where induced abortion is permitted either for a wide range of reasons or without restriction as to reason. In contrast, 26% of all people reside in countries where abortion is generally prohibited.

However: A range of legal restrictions and conditions limit access to *safe abortion* even in countries with liberal legislations. These include gestational age restrictions, third-party authorisation, narrow specification of medical facilities and personnel allowed to perform the abortion, mandatory counsel-

ling and waiting periods and fees. If several of these conditions apply, a woman's actual access to safe abortion may be very restricted even in a context where she is entitled by law to terminate an unwanted pregnancy on her own request.

Various studies confirm that, paradoxically, abortion rates in regions with restrictive laws are not lower than in regions where legal barriers to pregnancy terminations are low. Laws that seek to restrict the use of abortion often produce the opposite effect by driving it underground, making it more dangerous. Conversely, treating abortion openly has the potential of bringing quality and regulatory standards.

Trends and recent developments

There is a global trend of bringing out the issue of unsafe abortion more openly and a range of positive steps has been taken towards liberalisation of abortion laws. Where laws have not been liberalised in some form there have been attempts to interpret them more permissively.

In East and Central Europe there has been the reduction of abortion rates over the past decade. This is explained with improved accessibility to modern contraception.

In sub-Saharan Africa unsafe abortion has since the ICPD been brought out of the shadows and into the realm of policy and health planning discussions at the regional and national levels and there have been signs of progress related to abortion care, such as the broader distribution of the *manual vacuum aspiration* technology and expanded Post Abortion Care programmes (PAC).

As laws in Latin and Central America continue to remain among the strictest, access to safe abortion services also continues to remain limited. Some progress has however, been reported in terms of advocacy and public debate and expanded availability of PAC services.

Many Asian countries do have liberal abortion laws. This does not automatically imply easy access to good quality services. The most striking change has happened in Nepal where one of the harshest legislations of the world was transformed into one of the most liberal.

The USA continue to range well above Western European rates (23/1000 against 11/1000).

A major setback to addressing the unnecessary suffering of millions of women has been the "global gag rule" by the US government.

Strategies and options

Applicability and appropriateness of strategies for improving access to *safe abortion* or to quality post abortion care have to be examined in each individual context. In general, any intervention should avoid focussing on abortion in isolation but rather follow a systemic approach, be it in a context of maternal/women's health (e.g. Nepal) and/or a human rights based approach as was the case in South Africa. The following elements are important:

Promoting an enabling policy environment: The most important single determinant of abortion's impact on women's health appears to be its legal status. Whether active advocacy for decriminalising and legalising of abortion is appropriate and which body and key personnel should be involved is being controversially discussed. Technical cooperation should as much as possible initiate and promote dialogue about causes for and consequences of illegal and *unsafe abortion* with institutions in partner countries and assist in developing options. Often, there is lack of awareness about existing laws among health workers hence a need to inform them respectively including about ways of interpreting the law in favour of the woman in need.

Raising awareness in the public: Legalisation does not necessarily change entrenched social attitudes toward abortion, or persuade husbands and family members to accept a woman's decision to abort. The case of Nepal has shown that advocacy work of individuals and organisations that included extensive use of the press, building advocacy and public education strategies on public health issues, such as maternal deaths and the burden on public hospitals, was instrumental in preparing the ground for the legislation change. In South Africa too, mobilisation of public opinion and advocacy to parliament preceded the policy change. Public awareness campaigns for initiating as well as accompanying change may therefore constitute a challenge for technical cooperation, possibly in collaboration with national and international NGOs who can permit themselves a clearer advocacy for marginalised groups or politically "hot" topics without alienating the average client.

Collection of data and dissemination of information: In any case, the development of an appropriate strategy requires a thorough situation analysis. Most studies are hospital-based and quantitative. There is a need for more community-based and in-depth/qualitative research in order to understand the dimensions and dynamics of *unsafe abortion* in diverse environments. Data regarding the incidence of *unsafe abortion* (e.g. complications treated in health facilities) should, if possible, be made part of routine health information collection in order to sensitise local health personnel and health

planners for the problem as well as to build a data basis for respective interventions. The case of Nepal illustrates vividly the important role research can play in the change process.

Improving access to modern methods of contraception: Access to and quality of contraceptive methods and services should continue to be improved. A modern contraceptive mix does include post coital contraception, also termed *emergency contraception*, which in many countries is not much offered by public health services. This constitutes a challenge for technical cooperation. The availability of EC is of paramount importance in refugee and crises situations where coercion and violence towards women and girls, and as a result unwanted pregnancies, are common.

Promoting the use of manual vacuum aspiration: WHO recommends the use of the traditional technique of *Dilatation and Curettage (D&C)*, which for many years has been used in the management of incomplete abortion in resource poor settings only where vacuum aspiration or medical methods of abortion are not available. *Manual vacuum aspiration (MVA)* is an appropriate and cost effective method of incomplete abortion and safe abortion where it is legal for up to 12 completed weeks since the woman's last menstrual period.

Post Abortion Care (PAC) and counselling links prompt and safe emergency care to prevention of another unwanted pregnancy. Introduction of PAC into routine health services has, independent from the legal context, been strongly advocated and promoted in order to reduce abortion-related morbidity and mortality and prevent further unwanted pregnancies.

Medical abortion: In the last decade, attempts to develop alternative abortion methods have largely focused on medical methods, which are based on pharmacological drugs. While in some European countries it is increasingly the method of choice, medical abortion (MA) has not yet been much used in low resource settings. Programme managers should be aware of the upcoming changes and of what would be required to introduce medical methods of abortion into health services in terms of service delivery norms and practices, training of providers and staff, counselling, as well as managerial and practical aspects of clinical facilities.

Training of health personnel: There is a need for orientation and training in new approaches and strategies, in methods of treatment of abortion complications, in techniques of performing the procedure safely, as well as for measures for promoting attitudinal change. This raises also questions on the appropriate cadre for abortion care (physicians/specialists versus other cadres of providers, for example, midwives, clinical officers and medical assistants). Pilot programmes to train midwives in PAC showed that midwives could competently provide quality PAC services in decentralized settings. This requires the development of relevant curricula.

Collaboration with non government partners: Some renowned NGOs have in the past among other reproductive health services offered methods of *emergency contraception* and *post abortion counselling and care*, particularly in urban areas. This work has however been hampered tremendously by the *Global Gag Rule* that has affected NGOs in 56 countries. Finding ways and methods of filling the gaps left by the withdrawal of U.S. funds is of paramount importance. Collaboration with the private sector may be an option that has to be assessed through a careful analysis.

Appropriate and comprehensive sexuality education: This is essential in order to prevent as much as possible unwanted pregnancy and promote sustainable changes of girls' and women's submissive sexual behaviour on the one hand and of coercive behaviours of (young) men on the other hand. This is an important prerequisite for building responsible (sexual) relationships that respect the partner's rights of self-determination including conscious and informed choices regarding contraception and pregnancy. GTZ disposes over a vast experience in sexuality education and life skills development from numerous projects in many countries.

Organisations of technical cooperation should use the opportunity of the increasingly open climate and professional debate that has developed after the ICPD and other international conferences for seeking dialogue with partner countries and institutions, and translate it into planning and implementation of appropriate measures.

INTRODUCTION

“The political process, including the ideological preferences and values of the ruling elite, can be a far more important input into the formulation of abortion policy than data or knowledge about the actual context of abortion”¹.

This explains why despite all the existing knowledge about the serious and often deadly consequences of unsafe abortion and its prevention, *unsafe abortion* as an important contributing factor to maternal morbidity and mortality has not been translated adequately into health policy discourse, legal change and health care services. However, progress has been made in the last decade. This paper highlights the current situation regarding unsafe abortion as a public health concern, and the range of abortion laws worldwide including recent developments. It reviews the current status of the debate and challenges ahead, including the role technical cooperation can play.

From Cairo to the Millennium Development Goals - From a rights-based to a health-centred perspective

At the *International Conference on Population and Development (ICPD)* in Cairo 1994 representatives of 179 countries agreed that “reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health².” The Programme of Action had therefore urged “all Governments and relevant intergovernmental and non-governmental organizations 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”³. This understanding also constitutes the foundation for the present discussion paper. It is assumed that every termination of pregnancy constitutes the result of a failed attempt of avoiding, for various reasons, unwanted pregnancy. The issue of abortion must therefore be closely linked to improved quality and better access to modern methods of contraception. Nevertheless, unwanted pregnancy can never be fully avoided by improved access to and quality of contraception.

The United Nations General Assembly review and appraisal of the implementation of ICPD in 1999 (*ICPD + 5*) further agreed that, “in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health⁴”. It is against this background that WHO has developed a comprehensive manual that provides guidance to turn this agreement into reality⁵.

In October 2000, at the *United Nations Millennium Summit*, all countries present agreed on the global imperative to reduce poverty and inequities. The need to improve maternal health (goal 5) was identified as one of the key Millennium Development Goals (MDGs), with a target of reducing levels of maternal mortality by three-quarters between 1990 and 2015. “The causes of maternal deaths are multiple. Women die because complications during labour and delivery go unrecognised or are inadequately managed. They die from diseases such as

¹ Kulczycki, A. (1999), *The abortion debate in the world arena*, New York, quoted in: *Studies in Family Planning* (2000), 31 (1).

² United Nations International Conference on Population and Development (ICPD), Programme of Action, paragraph 7.3, Cairo, 1994.

³ ICPD, Programme of Action, op.cit., Paragraph 8.25.

⁴ ICPD, Programme of Action, op.cit., paragraph 63.iii

⁵ World Health Organization (WHO), *Safe abortion: technical and policy guidance for health systems*, Geneva, 2003.

malaria that are aggravated by pregnancy. They die because of complications arising early in pregnancy, sometimes even before they are aware of being pregnant, such as ectopic pregnancy. And they die because they seek to end unwanted pregnancies but lack access to appropriate services. Achieving the Millennium Development Goal of improved maternal health and reducing maternal mortality requires actions on all these fronts⁶. While health was perceived central to the achievement of the MDGs there has been some disappointment that there is no comprehensive sexual and reproductive health goal among the MDGs.

INDUCED, UNSAFE AND SAFE ABORTION - THE MAGNITUDE OF THE PROBLEM

In its recently published technical and policy guidelines⁷, WHO describes induced, unsafe and safe abortion, and the contexts they mostly occur in as follows:

Induced abortion

Of the 210 million pregnancies that occur each year, an estimated 46 million (22 per cent), end in induced abortion, i.e. are being terminated. Globally, the vast majority of women are likely to have at least one abortion by the time they are 45⁸. Where effective contraceptive methods are available and widely used the total abortion rate declines sharply⁹, but has nowhere declined to zero for several reasons....even with high rates of contraceptive use, unwanted pregnancies will occur which women may seek to end by induced abortion.

Unsafe abortion

An unsafe abortion is "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both"¹⁰. About 20 million, or nearly half, of the induced abortions annually are estimated to be unsafe. Ninety-five per cent of these occur in developing countries¹¹. Globally, there is an estimated ratio of one unsafe abortion for every seven live births, but in some regions the ratio is much higher. For instance, in Latin America and the Caribbean, there is more than one unsafe abortion for every three live births¹². About 13 per cent of pregnancy-related deaths have been attributed to complications of unsafe abortion; when applied to the most recent estimate of maternal deaths worldwide, this percentage corresponds to about 67,000 deaths annually. In addition, unsafe abortion is associated with considerable morbidity.

Safe abortion

Almost all the deaths and complications from unsafe abortion are preventable. Procedures and techniques for early induced abortion are simple and safe. When performed by trained health care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures. In countries where women have access to safe services, their likelihood of dying as a result of an abortion performed with modern methods is no more than one per 100,000 procedures. In developing countries, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions.

⁶ WHO, 2003, op.cit.

⁷ WHO, 2003, op.cit

⁸ Alan Guttmacher Institute, Sharing responsibility: women, society & abortion worldwide, The Alan Guttmacher Institute, New York and Washington DC, 1999.

⁹ Bongaarts, J. and Westoff, C.F., The potential role of contraception in reducing abortion, Studies in Family Planning 31, 2000.

¹⁰ WHO, The prevention and management of unsafe abortion, Report of a Technical Working Group, Geneva, 1992.

¹¹ WHO, Unsafe abortion: global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data, Geneva, 1998.

¹² Ibid.

Precise data are obviously difficult to obtain. Demographers use various assumptions to extrapolate abortion rates and ratios from different sources of data¹³. One of the most comprehensive studies that has also informed figures provided by WHO has been that of Henshaw et al.¹⁴. According to this analysis, the average rate of abortion is at 35/1000 women from 15 – 44 years. Eastern European countries have the highest abortion rate (90/1000 women), Western Europe with 11/1000 on average the lowest.

In countries where abortion is legal, Vietnam (83/1000) and Romania (78/1000) have the highest rate of abortion, Belgium and the Netherlands with 7/1000 the lowest. Tunisia too figures among the countries with good access to modern methods of contraception and low abortion rates (11/1000). The USA range well above Western European rates with 23/1000. Explanations for these differences are of a complex nature and include widespread access to contraception in Europe, including emergency contraception¹⁵ and, first and foremost, early and appropriate sexuality education which, in contrast, is not offered on a large scale in the US. As a matter of fact, it comes increasingly in the form of “abstinence only” programmes. The prevalence of teenage pregnancies in the U.S. is highest among the poor and black population¹⁶.

Abortion rates in Latin America¹⁷, where abortion laws are among the strictest globally, are high. Despite the fact that Brazilian law permits abortion only in cases of rape and when the life of the woman is threatened, an estimated 1.4 million abortions - 31 percent of total pregnancies - are performed annually, and the majority of them clandestinely and under unsafe conditions; in addition, adolescent pregnancy rates are rising. In Bolivia, 27-35% of maternal deaths (390/100.000 life births) are attributed to unsafe abortion; in Brazil 24% (estimated maternal mortality ratio 262/100.000). In Central American countries - Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama – maternal mortality rates are high and risk from unsafe abortion is great. It is estimated that 14% of maternal deaths in Central America (maternal mortality on average slightly below or above 200/100.000) are the result of unsafe abortion. Reproductive choices are severely restricted: El Salvadoran law, for example, does not permit abortion for any reason, not even to save the woman's life.

Various studies¹⁸ confirm that, paradoxically, abortion rates in regions with restrictive laws are not lower than in regions where legal barriers to pregnancy terminations are low. “Laws that seek to restrict the use of abortion often produce the opposite effect. “They do not make it safe or rare, but drive it underground, making it more dangerous. Conversely, treating abortion openly brings quality and regulatory standards”¹⁹. Whether abortions take place or not is much less determined by legal conditions rather than by social, cultural, personal and health systems-related factors.

In Asian countries, the rate of abortion has been directly influenced by national population policies. In China, after the one-child policy was introduced, the number of abortions increased sharply, as was the case in Vietnam where a two-child policy exists. In such contexts of small family norms, the preference for sons²⁰ influences decisions about abortion.

¹³ Comparison of data from different countries is also made difficult by the fact that some authors use abortion rates (number of abortions a woman would have in her lifetime if she experienced current age-specific abortion rates, while others use ratios (abortion/1000 livebirths). The former is prospective, the latter retrospective.

¹⁴ Henshaw, S.K., Singh, S., Haas, T. The incidence of abortion worldwide, *International Family Planning Perspectives*, (25) (1999), Supplement.

Sources: official and national statistics on legal abortions in 57 countries, population-based surveys in countries without official documentation; specific studies in countries, where abortion is legally restricted, expert assessments as well as world wide and regional estimates by WHO.

¹⁵ not defined as “abortion”, see below

¹⁶ See publications of Alan Guttmacher Institute (www.agi-usa.org)

¹⁷ Data in this paragraph informed by IPAS, www.ipas.org, based on national health information systems.

¹⁸ See Eser, 2000; Henshaw, 1999.

¹⁹ Otsea, Karen, Lives worth saving: Abortion care in sub-Saharan Africa since ICPD, A progress report, Ipas, Chapel Hill, NC, 2004.

²⁰ Berer, Marge, Making abortions safe, *Bulletin of the World Health Organization*, 2000, 78 (5).

METHODS OF ABORTION

WHO differentiates between²¹:

- Surgical methods of abortion, which imply the use of transcervical procedures for terminating pregnancy, including vacuum aspiration (MVA), dilatation & curettage (D&C), and dilatation and evacuation (D&E).
- Medical methods of abortion implying the use of pharmacological drugs to terminate pregnancy. Sometimes the term “non-surgical abortion” is also used.

An in-depth description of methods of abortion is beyond this paper’s scope. Readers interested in technical details of abortion care be referred to WHO (2003). An overview of the current discussion including preferred methods of abortion and strategies for improving access to *safe abortion* and to quality post abortion care is given below in the chapter *Strategies to pursue*.

WHAT MAKES ABORTION UNSAFE?

Most women who do want to terminate an unwanted pregnancy do not refrain from resorting to unsafe abortion despite considerable health risks. They attempt this either by themselves or with assistance of a third person with means and methods that may have serious effects on their health or even risk their lives. These attempts may include pricking the amniotic sac with sticks and sharp instruments to remove the amniotic fluid and instil another fluid such as a salty solution, soap, etc. into the uterus; the introduction of solutions into the vagina; the intake of substances that have a toxic effect on the embryo or stimulate contractions. (e.g. bleach, pesticides, plant extracts or drugs such as quinine); use of external force such as shocks, hitting the abdomen, massaging of the uterus, etc.

It has often been wrongly assumed that a large proportion of unsafe abortions are performed by unqualified personnel. In fact, most clandestine abortions are performed by health professionals who have no specific training²² making them potentially unsafe.

Legal abortions can be unsafe – if they are conducted under unsafe conditions – just like safe abortions can be offered in an illegal context. Some authors though, consider an abortion being conducted in an illegal context as being by definition unsafe.

Where for various reasons even in a legal context women’s access to safe abortion services is limited, there is a tendency of resorting to unsafe abortion. On the other hand those women who are financially better off can access safer abortion services even in illegal circumstances. It is therefore important to understand that law reform is a necessary, though not sufficient condition for making abortion safe. “Women remain vulnerable where safe abortion is not legally sanctioned because quality of care cannot be assured, abuses cannot be challenged and both women and providers remain at high risk of prosecution, blackmail, and social and professional stigma....In the long run, abortion needs to be decriminalised in order for it to be safe”²³.

COMMON COMPLICATIONS

Depending on the circumstances in which an unsafe abortion is performed including the gestational age, 10 – 50 % of all women require medical treatment as a result of complications. The most common complications include incomplete removal of the foetus, cervical or vaginal lacerations, haemorrhage, bowel or uterine perforation, sepsis, and secondary reproductive tract infections, which sometimes result in long-term consequences including chronic

²¹ WHO (2003), p.22.

²² A study conducted by the Tanzania Midwives Association among women who have been treated for abortion complications in four district hospitals in Dar es Salaam, found that in more than 70% of these cases health workers had performed the intervention, GTZ, 1997.

²³ Berer, Marge, Bulletin of the World Health Organization, 78(5),2000,

pelvic inflammatory disease and secondary infertility. Infertility can also result from a hysterectomy (removal of the uterus) performed to manage the complications of unsafe abortion²⁴. If not treated in time, these complications may lead to the woman's impairment or death.

WHY DO WOMEN RESORT TO ABORTION?

The majority of women opting for an induced abortion are married or live in a stable union and have several children²⁵. Young unmarried women form another important group. Unwanted pregnancy may occur for various reasons:

- Millions of women and men either do not have *access to appropriate contraceptive methods*. UNFPA estimated 350 million couples worldwide to have insufficient access to modern methods of contraception²⁶.
- No contraceptive method is 100 per cent *effective*. Even if all contraceptive users were to use methods perfectly all the time, there would still be nearly six million accidental pregnancies annually. Thus, even with high rates of contraceptive use, unwanted pregnancies will occur which women may seek to end by induced abortion.
- Many people do not have adequate information and support to use contraceptives effectively or do not always manage to *use them perfectly*. WHO differentiates between "perfect" and "typical" use.
- *Sexual coercion and rape*: Women's right of sexual self-determination is restricted in many societies – a highly controversial issue debated at the ICPD. Unwanted pregnancy caused through rape is a particular concern in conflict and refugee situations.
- *Cultural reasons*: In societies where a woman's value is much defined over her fertility, an ambiguous attitude towards pregnancy and contraception – often among young married women and even adolescents – is found. Moreover, women are often in a position, where they can hardly resist sexual expectations of men, including their partners, and sexual harassment from men whom they are all too often dependent on.

Pregnancies can also change from being wanted to becoming unwanted through *changing circumstances* such as unstable or changing relationships or rejection of fatherhood. In the case of adolescents, fear of negative parental reactions to a pregnancy or of expulsion from school may lead to the decision of pregnancy termination. *Social and economic reasons*, fear of job loss and of social stigmatisation in case of pregnancy out of wedlock, and finally achievement of planned family size are decisive factors.

WHO IS AT PARTICULAR RISK OF UNWANTED PREGNANCY AND UNSAFE ABORTION?

Every woman in reproductive age carries the risk of an unwanted pregnancy. There is no typical profile of women with an unwanted pregnancy regarding age, parity, socio-economic background, educational status, type of current union, even not the state of knowledge on contraception²⁷.

There are, however, women who are particularly at risk of an *unsafe abortion*:

Young and/or unmarried women

UNFPA reports²⁸ that 10-14% of young unmarried women around the world have unwanted pregnancies and at least 2-4.4 million abortions occur among adolescent women in developing countries each year. Their access to modern contraception is often limited, the kind of

²⁴ Based on WHO, 2003, op.cit.

²⁵ WHO, Abortion: A tabulation of available information, 3rd edition, Geneva, 1997.

²⁶ Sadik, N., The state of the world population, UNFPA, New York, 1997.

²⁷ WHO, Emergency contraception, A guide for service delivery, Geneva, 1998.

²⁸ UNFPA. 2003. State of world population 2003, Making 1 billion count: investing in adolescents' health and rights, New York, 2004.

services available does not respond to their needs and expectations appropriately and with good quality. Young people's sexuality is typically characterised by limited capacity of negotiation with their sexual partners, changing and instable relationships and conflicting, ambiguous feelings. They have fewer contacts and financial means for accessing *safe abortion* services and tend to delay the procedure and resort to unskilled providers, both of which increase the risks. Studies in Tanzania confirmed that although married women have the highest abortion rates, schoolgirls have much higher rates of complications²⁹. Among women admitted to hospital for treatment of unsafe abortion complications, those aged under 20 years account for 38-68% of cases in many developing countries³⁰. A comprehensive review on *Adolescents, unwanted pregnancy and abortion* was recently published by Ipas³¹.

Women in crises, conflict and refugee situations

They are particularly exposed to sexual coercion and instable relationships. Instances of systematic mass rapes as has been happening in the war in former Yugoslavia and recently in Sudan are of particular concern, but only the tip of the iceberg. Women's access to contraceptive information and services as well as to safe abortion and good quality health care in case of abortion complications in such situations is highly limited³².

Women exposed to sexual violence

Worldwide, up to one-third of women report their first sexual experience as being forced. Estimates of the number of pregnancies resulting from coerced sex vary. An US study that followed over 4,000 women for three years found a 5% rape-related pregnancy rate among women aged 12-45 years; pregnancies reported as a result of sexual assault by rape victims in Mexico and Ethiopia affected 15-18% and 17% of women, respectively³³.

Poor women

They lack resources required for accessing safe abortion services. This may apply to abortion both in a legal as well as in an illegal context. Where abortion is criminalised – for example in most of Latin America – women have to face particularly high costs for an abortion.

ABORTION LAWS WORLDWIDE – AN OVERVIEW

An extensive review and comparison of legal frameworks worldwide came to the striking conclusion that there are hardly any two abortion legislations in the world that are completely identical³⁴. This variation is determined by differing motives of regulation and protection interests – which are at times conflicting:

- protection of the unborn life
- avoidance of pregnancy termination
- health and/or the woman's right of self determination
- the father's/partner's interest

²⁹ Mpangile G.S., Leshabari M.T. and Kihwele DJ. Induced abortion in Dar es Salaam, Tanzania: the plight of adolescents. In: Mundigo AI and Indriso C. (eds). *Abortion in the developing world*. New Delhi, Vistaar Publications for the World Health Organization, pp. 387-403, 1999.

Anderson, D., *Abortion, Women's Health and Fertility*, IUSSP Policy and Research Paper No.15, 1998.

³⁰ Olukoya, A.A, Kaya A., Ferguson, BJ & AbouZahr C.. *Unsafe abortion in adolescents*. International Journal of Gynecology & Obstetrics, 75: 137-147, 2001.

Treffers P., *Issues in adolescent health and development*. Adolescent pregnancy. WHO/FCH/CAH/02.08 & WHO/RHR/02.14. Geneva, 2002.

³¹ de Bruyn, M., Packer, S., *Adolescents, unwanted pregnancy and abortion*. Policies, counseling and clinical care. Chapel Hill, NC, Ipas. 2004.

³² United Nations High Commissioner for Refugees *Reproductive health in refugee situations*. An inter-agency field manual, 1999.

³³ Jewkes, R., Garcia-Moreno, C. & Sen, P., 2003, op.cit., Chapter 6, Sexual violence. In Krug EG et al., eds. *World Report on Violence and Health*. World Health Organization. Geneva, 2004.

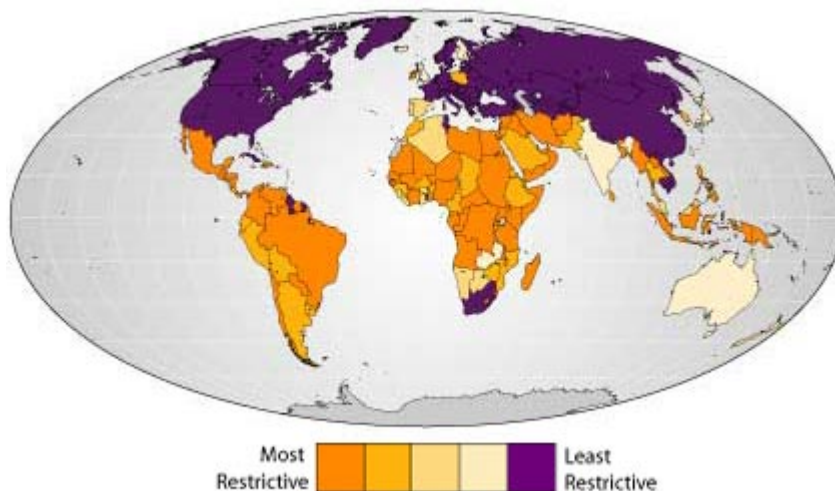
³⁴ Eser, A. & Koch, H.G. (Max Planck Institut für deutsches und internationales Strafrecht), *Schwangerschaftsabbruch im internationalen Vergleich, Befunde – Einsichten – Vorschläge*, Freiburg, 2000.

- adaptation to societal change
- aims related to population policy
- abolishment of discriminatory laws
- procedural simplifications

A detailed review of legislations around the globe would exceed the scope of this paper. In a compilation of world abortion policies by UNDP, annotations for country-specific implementation make up 90 additional articles³⁵. It is these additional, often limiting commentaries, which determine to a large extent the degree of accessibility to *safe abortion*, as well as *how* legislation is interpreted³⁶ and how strictly the law is enforced. Practice often differs considerably from written law, at times into a more restrictive direction, at times in a more liberal way. Permission of pregnancy termination by law is not the most decisive but an important factor determining women's access to safe abortion. Where restrictive laws prohibit or limit access to abortion, qualified and trained personnel is hardly prepared to perform respective interventions and public health services which are commonly the only service available for poor women do hardly offer such services. Costs of induced abortion in private facilities – offering this service despite legal restrictions – are usually high and unaffordable for poor women. Where abortion is legal maternal morbidity and mortality are almost as a rule lower. In Romania, for instance, the highest maternal mortality rate in Europe, which according to UNFPA was largely attributable to *unsafe abortions*³⁷, dropped dramatically after abortion was legalised³⁸.

Currently, more than 61% of the world's people live in countries where induced abortion is permitted either for a wide range of reasons or without restriction as to reason. In contrast, 26% of all people reside in countries where abortion is generally prohibited.

Figure 1: The World's Abortion Laws



Source: Center for Reproductive Rights³⁹

Global reviews of abortion policies differentiate grounds on which abortion is permitted into the following categories⁴⁰: (1) prohibited altogether or to save the woman's life, (2) to pre-

³⁵ World Abortion Policies 1999, United Nations, 1999.

³⁶ The interpretation of the clause „to preserve the woman's mental health“ ranges from accepting the psychological distress of a woman with an unwanted pregnancy to serious psychological disorders and mental illness.

³⁷ Safe Motherhood Newsletter (1998), Issue 26.

³⁸ From 170/100.000 life births in 1989 to 41/100.000 in 1996.

³⁹ http://www.crlp.org/pub_fac_abortion_laws.html

⁴⁰ Based on the following sources: United Nations, World Abortion Policies 1999;

Rahman, A., Katzive, L., Henshaw, S.K., A global review of laws on induced abortion, 1985 – 1997, International Family Planning Perspectives 24 (2), 1998; and:

The world's abortion laws, Center for Reproductive Rights, New York: http://www.crlp.org/pub_fac_abortion_laws.html, 2004.

serve her physical health, (3) to preserve mental health (large room for interpretation!), (4) on economic or social grounds, (5) without restriction as to reason⁴¹.

(1) Prohibited altogether or permitted only to save the woman's life

The most restrictive laws are those that either permit abortion only to save a woman's life or prohibit the procedure entirely. Many countries in this category (appearing in bold on the table in annex 2) explicitly permit abortion when a pregnancy threatens a woman's life. In other countries, laws that make no explicit exception are often interpreted to permit abortion under life-threatening circumstances on the grounds of "necessity". Such an exception may also be recognised in national norms of medical ethics.

(2) Physical health grounds

This category includes laws that authorise abortion to protect the pregnant woman's life and physical health. These laws sometimes require that the threatened injury to health be either serious or permanent. While laws in this second category do not explicitly permit abortion to protect mental health, many are phrased broadly enough – referring simply to "health" or "therapeutic" indications – to be interpreted to allow abortion on mental health grounds. In Cuba, on the other hand, the woman's "health" was understood to comply with the comprehensive definition of WHO as the complete physical, mental and social well-being.

(3) Mental health grounds

Laws in this category expressly permit abortion to protect the woman's mental health, as well as her life and physical health. The interpretation of "mental health" varies around the world. It can encompass, for example, psychological distress suffered by a woman who is raped or severe strain caused by social or economic circumstances.

(4) Socio-economic or social grounds

Laws in this category allow abortion on socio-economic grounds, permit consideration of such factors as a woman's economic resources, her age, her marital status, and the number of her children. Such laws are generally interpreted liberally.

(5) Without restriction as to reason

Finally, the least restrictive abortion laws are those that allow abortion without restriction as to reason. Most countries with such laws, however, impose a limit on the period during which women can readily access the procedure.

A number of countries explicitly recognize three other grounds for abortion: when pregnancy results from rape; when pregnancy results from incest; and when there is a high probability of foetal impairment. Countries that recognise these grounds may fall within any of the categories described above. In addition, countries in any category may restrict access to abortion by requiring a woman to obtain parental or spousal authorisation.

Countries where exclusively the first category is considered do have the strictest legislation. This applies to most Latin American, African and Arab countries as well as Bangladesh, Indonesia, the Philippines, the PDR of Lao and Ireland. In these countries induced abortion is defined as a criminal offence, which may be prosecuted accordingly. In some South American countries (e.g. Chile) health personnel is obliged to report women treated for abortion complications. Some countries' legislation leaves some not precisely defined leeway for the performer of the procedure "that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon...an unborn child for the preservation of the mother's life if the performance of the operation is reasonable, having

⁴¹ This categorisation includes medical and social grounds. Legal and eugenic grounds (rape/incest; foetal impairment) may build additional categories (UN) or figure under category 3 or 4.

regard to the patient's state at the time, and to all circumstances in the case⁴². Other countries (e.g. Congo, Mali, Zimbabwe) recognize the „defence of necessity“ for a range of criminal acts including abortion.

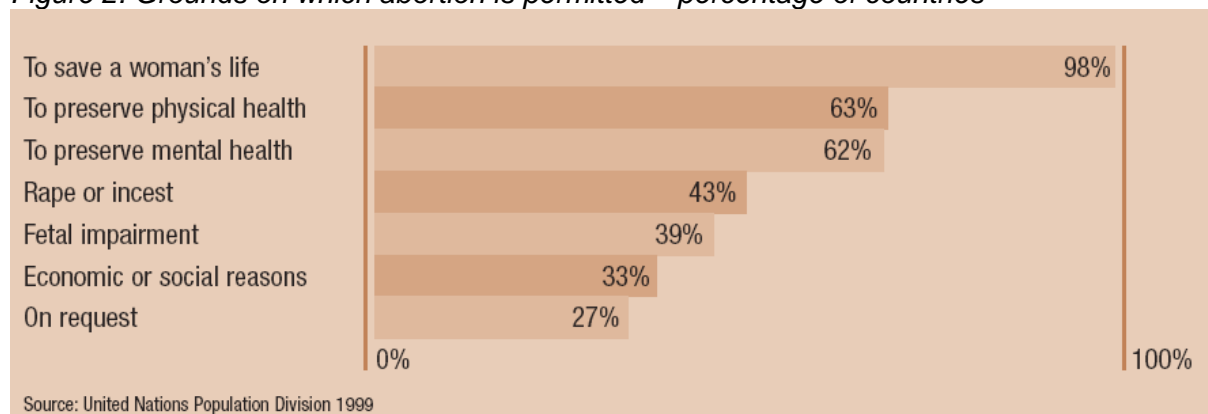
Among the countries where grounds (1) and (2) above are recognised are Argentina, Bolivia, Ecuador, Kuwait, Morocco, Saudi Arabia, Pakistan, Korea, Thailand and Poland. Reasons (1) to (4) are considered in some Caribbean countries, Algeria, Israel, Jordan, Iraq, Australia Malaysia, India, Japan, Portugal, Spain, Switzerland, Finland and Great Britain. The least restrictive abortion laws (category (5)) that permit abortion without restriction as to reason are found, among others, in Canada, Cuba, USA, some Central Asian and Russian Federation countries, Turkey, China, Cambodia, Vietnam, as well as in most European countries. In Africa this applies only to South Africa, Cape Verde, and Tunisia. Ghana, Burkina Faso, Zambia, Namibia and Botswana do have more permissive legislations than other African countries whose additional clauses, however, inhibit women-friendly implementation.

A remarkable change has taken place in Nepal, whose abortion law was among the most restrictive and is now among the most liberal in the world (see annex 1).

In a number of nations with federal systems (Australia, Canada, USA, Switzerland, Nigeria) federal states may regulate abortion differently, limited however, by a minimum national standard (USA, Switzerland, Canada), unlike Mexico and Australia where each federal state is free to formulate its own abortion law.

A complete overview on abortion laws worldwide is given in table 1 (annex); it also provides a visual impression on how polarised the world is in terms of abortion legislation: Categories at the extreme end (strictest vs. most liberal) include the highest number of countries.

Figure 2: Grounds on which abortion is permitted – percentage of countries⁴³



However: As a matter of fact, a range of legal restrictions and conditions limit access to *safe abortion* even in countries with liberal legislations:

- Gestational age restrictions;
- Third-party authorisation: commonly husband; in some countries in given circumstances replaceable by the regional chief medical officer (e.g. Morocco); Parental authorisation for minors is required in Norway, Italy and Denmark replaceable by a hospital committee;
- Approval of the grounds on which abortion is sought from other doctors or health professionals not involved in performing the abortion (e.g. Zambia, Benin, Lebanon);
- Medical facilities and personnel: in most countries types of medical facilities in which abortions may be performed and categories of health workers permitted to perform the procedure are specified (e.g. Great Britain, South Africa, India, Botswana, and Cameroon). In Zambia only a few referral facilities are authorised to perform abortions;

⁴² Tanzania penal code, quoted in Rahman, A. et al.

⁴³ WHO guidelines 2003, information based on an analysis by United Nations Population Division 1999, i.e. not completely up-to-date.

- Mandatory counselling (Germany, USA, Belgium) and mandatory waiting periods (e.g. abortion not to be performed before three days after counselling, Germany);
- Fees: while in some countries costs for pregnancy termination are borne by public health services or health insurances, in others only under certain circumstances women are entitled to free services (e.g. in case of pregnancy as a result of rape or incest; for minors)

If several of these conditions apply, a woman's actual access to safe abortion may be very restricted even in a context where she is entitled by law to terminate an unwanted pregnancy on her own request. So will a poor woman from a rural region in Zambia or Namibia, for example, most likely not have the means, the possibility and the courage of seeking approval from two to three specialists and have the procedure performed in an authorised facility in one of the major cities. In 1991 for each abortion performed as per legal conditions five women were treated for complications of *unsafe abortion*⁴⁴. Additional specifications to the otherwise liberal abortion law in India are similarly restrictive. On the other hand, in Bangladesh law does not allow abortion; *menstrual regulation*, however, is permitted and accessible.

TRENDS AND RECENT DEVELOPMENTS

A comprehensive review of laws in 1998 revealed that 61% of the world's population lived in countries where induced abortion was permitted for a range of reasons or without restrictions, and 25% in nations where abortion was generally prohibited. Six years later, this still applies by and large.

There is, however, a continuing global trend of bringing out the issue of unsafe abortion more openly and a range of positive steps has been taken towards liberalisation of abortion laws. Where laws have not been liberalised in some form there have been attempts to change highly restrictive laws or interpret them more permissively. In Mozambique, although abortion has not been legalised as such, safe terminations have been made available at the Maputo tertiary hospital⁴⁵. In Sri Lanka, abortion is banned except when a pregnancy is a mortal danger to the mother. Yet practitioners and clinics abound that give quick pregnancy tests and perform vacuum aspirations. Police ignore these activities unless a woman dies.

Where, as a matter of serious concern, choices continue to remain limited and laws very strict, is in Latin and Central America. El Salvadoran law, for example, does not permit abortion for any reason, not even to save the woman's life. Considering that these are countries where gender-based violence is reportedly high, this is even more alarming.

In some countries where the law does not or only with major restrictions allow induced abortion, *emergency contraception* is offered – mostly, however by Non-Government organisations or by the private sector. This post-coital contraceptive method ("the morning-after-pill") does, by definition, not constitute an „abortion“.

A major setback to addressing the unnecessary suffering of millions of women has, however been the "global gag rule" by the US government (see below).

Eastern Europe and Central Asia

A conspicuous development over the past two decades has been the reduction of abortion rates in East and Central Europe over the past decade. This is explained with improved accessibility to modern contraception.

An analysis of *Reproductive Health Surveys* (RHS) and *Demographic and Health Surveys* (DHS) conducted in 11 countries of Eastern Europe, the Caucasus and Central Asia from

⁴⁴ Bradley, J. et al., Improving abortion care in Zambia, *Studies in Family Planning* 22, (6), 1991.

⁴⁵ Berer, M., op.cit.

1993 to 2001⁴⁶ looked at levels and trends in contraceptive use, and women's knowledge and attitudes about contraception and abortion. For decades, the reliance on abortion as a means of preventing births had been a prominent aspect of reproductive health in the former Soviet Union, as modern contraceptives were often difficult to obtain, of poor quality, and not promoted by the medical community. In contrast, abortion has been legal, little restricted, and available at little or no cost. The improved availability of modern contraceptives through the Governments', donor agencies', and non-governmental organisations' efforts has helped increase their use, contributing to declines in abortion rates⁴⁷: they fell between 15 percent and 38 percent - a marked change in a relatively short period. Abortion rates range from 0.6 per woman in Uzbekistan to 3.7 per woman in Georgia, some of the highest rates in the world. Most of the decline occurred among women under age 30 and was associated with increased use of modern contraceptives.

Still, most women continue to view abortion as an acceptable means of birth control. Between 71 percent and 90 percent of unintended pregnancies end in abortion, indicating that women are strongly motivated to avoid an unplanned birth.

Asia

Many Asian countries do have liberal abortion laws. This does not automatically imply easy access to good quality services as the example of India illustrates.

The most striking change has happened in Nepal where until recently, one of the harshest legislations of the world had led to a situation where an estimated 20% of women in Nepali jails were convicted on charges of abortion or infanticide. After a long process of actions of diverse stakeholders, reform of the abortion law in Nepal was achieved in 2002. The new law is one of the most liberal, representing a tremendous step from a situation of complete prohibition to abortion on demand up to 12 weeks gestation; up to 18 weeks in cases of rape or incest; and at any time on health grounds. In order to give an opportunity to learn from the case of Nepal, a more detailed description of the process leading to this tremendous change, which has also been supported by GTZ, is given in annex 1.

Africa

A review of developments in sub-Saharan Africa since the ICPD concludes that the topic of unsafe abortion has been brought out of the shadows and into the realm of policy and health planning discussions at the regional and national levels and that there have been many signs of progress in Africa related to abortion care⁴⁸:

"Across the continent, important developments have occurred at the national level, ranging from new or expanded Post Abortion Care programmes (PAC) to significant debates in several countries about revising the legal restrictions against abortion. Some countries have seen services expand by authorizing and enabling more providers to offer care. This decade has also witnessed a broader spectrum of organizations collaborating for change in this area. Landmark legislation was passed in South Africa in 1996 legalizing abortion for all South African women in the first trimester. Momentum continued with first-ever regional meetings on unsafe abortion held for the Francophone African countries and another for countries across sub-Saharan Africa. And, prompted by the ICPD mandate, the World Health Organization (WHO) published important policy and technical guidance for safe abortion care at all levels of the healthcare system".

At the same time, advocacy through media and community awareness campaigns have sought to increase public awareness and mobilisation around the issue. As a result, there is

⁴⁶ Reproductive Health Trends in Eastern Europe and Eurasia, Population Reference Bureau, 2003.

⁴⁷ The total abortion rate is the number of abortions a woman would have in her lifetime if she experienced current age-specific abortion rates.

⁴⁸ Otsea, Karen, 2004, op.cit.

now broader understanding and concern about addressing the problem of unsafe abortion across Africa.

These developments have however, not yet been widely translated into legal transformation and access to good quality care.

One significant measure of progress is the broader distribution of the *manual vacuum aspiration* (MVA) technology (see below). While in the past decade MVA was used in only a handful of countries, and mostly in pilot and small-scale hospital-based programmes, at present, according to the Ipas review⁴⁹, MVA instruments are available in over 20 countries in Africa, and there is increasing demand.

Also, there has been significant growth in *post abortion care* (PAC, see below) programming in Africa since 1994. In the past decade, efforts have been undertaken in many countries including Benin, Burkina Faso, Ethiopia, Ghana, Kenya, Malawi, Mali, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. Many have been undertaken in public-sector health systems, and most have focused on improving emergency care for abortion complications with linkages to contraceptive and other services. Examples of specific trends and related challenges in Africa over the past decade follow.

Provision of clinical and regulatory guidance

Several countries have put in place new health standards and guidelines that give more recognition to unsafe abortion and make provisions for stronger PAC programming. The above review provides examples from a number of countries, for example:

In Nigeria, where unsafe abortion contributes significantly to the large number of maternal deaths each year, the Federal Ministry of Health issued a new Reproductive Health Policy in 2001 that calls for reducing maternal mortality and morbidity by 40% through increased access to quality and affordable maternal and child health services including PAC.

In Kenya, where unsafe abortion has also been estimated to cause one-third of all maternal deaths, the Ministry of Health's *Reproductive Health and Family Planning Policy Guidelines and Standards for Service Providers* issued in 1997 states that all district-level hospitals should provide PAC services to ensure that women suffering from unsafe abortion have prompt access to care. In Ethiopia and Ghana too, progress has been reported.

Latin America

As laws in South and Central America continue to remain among the strictest, access to safe abortion services also continues to remain limited. Some progress has however, been reported in terms of advocacy and public debate. In Bolivia, this increased awareness of the serious impact of unsafe abortion on women's lives, in tandem with health sector reform efforts, has led to the expanded availability of post abortion care (PAC) services. In 1999, the Ministry of Health published a resolution integrating PAC with manual vacuum aspiration (MVA) into emergency obstetric services. As a result, Bolivia is the only country in the Latin American region that has included PAC as part of its national health plan, providing it free of charge to all women. The Bolivian Ministry of Health and Social Services currently is working to implement PAC with MVA for the treatment of incomplete abortion on a national scale⁵⁰. Some progress has also been reported in Brazil in terms of integration of post abortion care into emergency obstetric care services, though not at a national scale.

Products for emergency contraception ("the morning after pill") are marketed, but not all family planning programs in Latin America provide them. Nevertheless, other contraceptive methods that can be used for EC (combined oral contraceptives, levonorgestrel-only pills, and copper-releasing IUDs) are available free of cost or at low prices in many family planning

⁴⁹ Otsea, K. (2004)

⁵⁰ Ipas, Bolivia (www.ipas.org).

clinics. Pills are also sold over the counter in some countries. However, when used, EC is generally restricted to cases of rape⁵¹.

OTHER BARRIERS HAMPERING ACCESS TO SAFE ABORTION

Beyond the legal frame there are numerous other barriers, which may impede on access to the provision of safe abortion:

Health personnel's negative, disapproving attitude

Health personnel's option of refusing participation in the procedure of abortion for conscientious reasons in some countries or regions within countries leads to a situation where despite liberal laws abortions are hardly ever performed (USA, Austria, Germany/federal state of Bayern). In other countries with liberal legal frameworks it has been reported that the prevailing attitude of disapproval and stigmatisation of abortion-seeking women by health personnel prevents women from seeking the service in authorised facilities (India, Ghana, and South Africa). South Africa, however invests heavily in the training of nurse-midwives in the procedure including their psychosocial competences⁵².

Inadequate training of personnel

In India, for example, the number of trained practitioners and adequately equipped facilities in the public health system is able to accommodate only a small fraction of the demand for services. So sparse are abortion services and outreach in the state of Bihar, for example, that a significant proportion of women there told researchers they thought that abortion was still against the law - 25 years after its legalization in the 1972 Medical Termination of Pregnancy Act⁵³.

The Global Gag Rule – against all insight

In January 2001, the U.S. government reimposed restrictions on non-governmental organisations (NGOs) overseas receiving international family planning assistance. The restrictions, officially called the Mexico City Policy, are also known as the Global Gag Rule⁵⁴ (GGR) by those who oppose it. Under the policy, no U.S. family planning assistance can be provided to foreign NGOs that use funding from any other source to perform abortions in cases other than a threat to the life of the woman, rape, or incest; provide counselling and referral for abortion; or lobby to make abortion legal or more available in their country. Non-compliance will result in loss of funding from the U.S. Agency for International Development (USAID). According to the Center of Reproductive Rights, these NGOs form strong community ties, create innovative solutions, and build local capacity to respond not only to the demand for family planning but also to other critical health needs. They often work closely with public health systems in providing care to the poorest and most vulnerable groups. Yet, under the Global Gag Rule, funds are denied to foreign NGOs that choose to counsel their patients on a full range of reproductive health options.

“The Global Gag Rule therefore forces a cruel choice: in starkest terms, foreign NGOs can either choose to accept USAID funds for provision of essential health services -- but with restrictions which may jeopardize the health of many patients - or the NGOs can choose to reject the policy and lose vital U.S. support. For those who reject the gag rule, the price is not just monetary. They are unable to obtain donated USAID contraceptives and are forced

⁵¹ Diaz, Soledad, et al., Acceptability of emergency contraception in Brazil, Chile, and Mexico, *Cad. Saúde Pública*, Rio de Janeiro, 19(5), 2003.

⁵² Berer, Marge, op.cit.

⁵³ Anderson, D., Abortion, Women's Health and Fertility, IUSSP Policy and Research Paper No.15, 1998.

⁵⁴ To “gag” means “knebeln, mundtot machen” in German

to cut services and raise fees. In a number of countries, established referral networks of providers are collapsing as leading family planning NGOs downsize and struggle to cope with budget cuts and rapidly declining stocks of contraceptive supplies...In practice, the policy is likely to have the opposite effect: it will reduce access to contraception, leading to more unwanted and high-risk pregnancies, more unsafe abortions, and more maternal illness, injury, and even death"⁵⁵.

The gag rule has penalized hundreds of NGOs - and the women they serve - in nearly sixty countries around the world. According to IPPF⁵⁶, "the Gag Rule has, and will have, a devastating effect on all our members and those that we support... The US government is far and away the largest single source of funding for international reproductive health and rights programmes. President Bush's decision to reinstate the global gag rule spells a direct loss of services for millions of women around the world." "The cruel irony of this policy," says the new Director, Steve Sinding, "is that it produces more abortions - not fewer. And almost all of those abortions are unsafe and therefore very risky for the women who submit to them."

HIGH SUBSEQUENT COSTS OF UNSAFE ABORTION

Most studies agree that treating abortion complications in Sub-Saharan Africa consumes a disproportionate amount of hospital resources⁵⁷. Up to one-third of *unsafe abortions* result in complications requiring several days of hospital stay and respective treatment: operative surgery, blood transfusion, antibiotics, pain relief, and anaesthetics, among others. Studies confirm that in some countries 30 – 50% of admissions in gynaecological wards are due to abortion-related complications (e.g. Bangladesh). In two hospital-based studies in Kenya these amounted to 60% of admissions. Another study conducted at the university medical centre in Ibadan/Nigeria over a period of seven years concludes, that 77% of all gynaecological emergency admissions were due to abortion complications⁵⁸. This has considerable effects on the material, financial and personnel resources of health facilities. The high burden by emergency treatment of abortion complications combined with the shortage of qualified personnel, blood units and drugs can lead to life threatening delays in the treatment of all pregnancy-related emergencies including abortion complications. This was shown impressively by a study conducted at an Ethiopian hospital⁵⁹.

Improved access to *safe abortion* and effective *post abortion care* (see below) does not only save lives and reduce morbidity, but has the potential of reducing costs for health facilities. A comparison of costs at four Kenyan hospitals came to the result that outpatient treatment using manual vacuum aspiration (MVA) for *post abortion care* was 23%-66% less costly than by surgical curettage which had been standard treatment and usually requires admission. Similar effects were shown in Mexico⁶⁰. Meanwhile the surgical procedure is being increasingly replaced by MVA, which carries less risk.

The cost of premature death as a result of *unsafe abortion* can hardly be specified.

⁵⁵ Breaking the silence- - the global gag rule's impact on unsafe abortion, Center for Reproductive Health, New York, 2003.

⁵⁶ Homepage: www.ippf.org

⁵⁷ Benson, J. et al., Complications of unsafe abortion in sub-Saharan Africa: a review, Health Policy and Planning, 1996, 11 (2) quoted in Berer, op.cit.

⁵⁸ E.g. Solo, J. et al., Creating linkages between incomplete abortion treatment and family planning services in Kenya: what works best?, Population Council, Africa Operations Research and Technical Assistance Project, Nairobi, Kenya, 1998.

Konje, J.C. et al, Health and economic consequences of septic induced abortion, *International Journal of Gynaecology and Obstetrics* 37, (3) 1992.

⁵⁹ Ali, Y., Analysis of maternal deaths in Jima Hospital, south-western Ethiopia, *Ethiopian Medical Journal* 32 (2). 1994.

⁶⁰ Johnson, B.R. et al., Costs and resource utilization for the treatment of incomplete abortions in Kenya and Mexico, *Social Science and Medicine* 36 (11), 1993.

STRATEGIES AND OPTIONS

Despite the positive developments over the past years there is still urgent need for action to improve access to *safe abortion*. This is increasingly being addressed in the international discussion. How can this be translated into meaningful and acceptable action in projects and programmes of technical cooperation?

Options for improving access to *safe abortion* or to quality post abortion care in case of complications are highly, yet not exclusively determined by the country-specific, often complex legal situation. Strategies for change cannot simply be differentiated according to whether they are to be applied in countries with liberal or restrictive laws. Rather, their applicability and usefulness have to be examined in each individual context. In general, any intervention should avoid focusing on abortion in isolation but rather follow a systemic approach, be it in a context of maternal/women's health (e.g. Nepal) and/or a human rights based approach as was the case in South Africa.

Promoting an enabling policy environment

The most important single determinant of abortion's impact on women's health appears to be its legal status. Where abortion is legal, physicians can learn procedures in schools, and equipment and supplies can be manufactured and obtained openly. Providers do not need to conceal their activities; when they encounter complications they can refer their patients to emergency facilities promptly, along with the complete and accurate case histories that are needed for optimal management. Women can find abortion services more easily, since they can be freely advertised, and so are better able to obtain a procedure in the earlier, safer stages of pregnancy.

The development in Romania impressively illustrated the link between legality and safety. After a longstanding ban on abortion was lifted in 1990, abortion-related mortality fell by nearly two thirds, from 170 to 60 per 100,000 live births, despite a doubling of the abortion rate.

In South Africa, the election of a new government in 1994 formalised a growing emphasis on human rights and equality for all. In conjunction with the dismantling of apartheid, South Africa developed a number of initiatives that supported a rights-based approach to reproductive health care and personal autonomy and laid the foundation for the passage of a liberalised abortion law in 1996⁶¹. Mobilisation of public opinion and advocacy in parliament constituted important elements in the liberalisation process.

In contrast, in Nepal change was motivated by a public health rationale that no longer wanted to accept the high contribution of unsafe abortion to maternal mortality. Nevertheless, persistent lobbying over a long period of time played a decisive role in the change process.

Therefore, depending on the political and cultural context at hand, supporting local/national, international and other bilateral partners to support lobbying for liberalising abortion laws, is paramount.

In many countries, Women's Lawyers Organisations and women's rights activist groups have a profound expertise on these issues. Establishing contacts and where applicable, seeking collaboration with these organisations may be worth while.

Advising the partner country's institutions

Often, there is lack of awareness about existing laws among health workers hence a need to inform them respectively including about ways of interpreting the law in favour of the woman in need. It is therefore important to initiate and promote dialogue about causes for and con-

⁶¹ Otsea, Karen, Lives worth saving: Abortion care in sub-Saharan Africa since ICPD.A progress report. Chapel Hill, Ipas, 2004.

sequences of illegal and *unsafe abortion* with institutions in partner countries as well as to develop and suggest options for improving the given situation.

Whether active advocacy for decriminalising and legalising of abortion is appropriate and which body and key personnel should be involved is being controversially discussed; the debate pivots around cultural values and the given socio-political context. Some argue that the call for liberalisation may in some contexts result in more rigid reactions rather than a gradual loosening up of strict positions.

Other professionals argue that given a restrictive environment, it is advisable to explore the limits of the existing legal framework and improve on existing opportunities such as *menstrual regulation* and *post abortion care*. In any case, the development of an appropriate strategy requires a thorough situation analysis.

Collection of data and dissemination of information

A literature search on the issue of induced abortion yields a surprising number of studies on various aspects of the problem. Most of them are, however, hospital-based and quantitative: health service statistics, usually from referral level; for example, surveys on women with an experience of post abortion complications. By the nature of these studies they only touch the tip of the iceberg omitting abortion cases and deaths from abortion occurring in communities or at lower levels of the health care system. There is a need for more community-based and in-depth/qualitative research in order to understand the dimensions and dynamics of *unsafe abortion* in diverse environments.

From a methodological point of view abortion research is rather difficult as the phenomenon under study mainly occurs in clandestine ways. A recent article identified no fewer than eight methods that have been described to estimate the frequency of induced abortion: the "illegal abortion provider survey", the "complications statistics" approach, the "mortality statistics" approach, self-reporting techniques, prospective studies, the "residual" method, anonymous third party reports, and experts' estimates. The author describes the methodological requirements of each of these methods and discusses their biases. Empirical records for each method are reviewed with particular attention paid to the contexts in which the method has been employed successfully. Finally, the choice of an appropriate method of estimation is discussed depending on the context in which it is to be applied⁶².

Data regarding the incidence of *unsafe abortion* (e.g. complications treated in health facilities) should be part of routine health information collection and documentation – particularly in projects/programmes of technical cooperation in order to sensitise local health personnel and health planners for the problem as well as to build a data basis for respective interventions.

Existing information (local and national statistics, research, both of which are often only known to academics and/or international organisations) should be compiled and disseminated, and if need be adapted to the local situation. Discussion with health planners and decision makers should be sought. The case of Nepal illustrates vividly the important role research can play in the change process (see annex 1).

Improving access to modern methods of contraception

First and foremost, access to and quality of contraceptive methods and services should be ensured and continually be improved. In many cases women become pregnant because contraceptive means and services are not available, or financially, culturally, geographically not accessible, or because they are not effective. A number of studies show that contracep-

⁶² Rossier, C., Estimating induced abortion rates: a review, in *Studies in Family Planning*, 34(2), 2003.

tive prevalence of (particularly young) women with abortion complications had been low. Many had a previous experience of abortion⁶³.

A simulation using data from Armenia, Kazakhstan, the Kyrgyz Republic, and Uzbekistan showed that if women using traditional methods and those using no method but seeking to avoid a pregnancy were to use modern contraception, abortion rates would decline by between 55 percent and 64 percent, more than halving the number of abortions in those countries⁶⁴.

A modern contraceptive mix does include post coital contraception, also termed **emergency contraception**. In principle, it is available where hormonal contraceptives are available. This *emergency contraception* (EC), also called the “morning after pill”, does, by definition, not constitute a termination of pregnancy. According to the moment within the menstrual cycle when the pills are taken, EC inhibits or delays ovulation or tubal transport of the sperm. The most common method is the intake of hormones within a few hours up to 5 days after unprotected intercourse. Mechanical *post-coital contraception* is being performed by the insertion of an intrauterine device after unprotected intercourse.

In many countries, however, lack of government policy about the method leaves providers unclear about its legal status and insufficiently informed. Hence, the methods are not much offered by public health services. In some countries the private sector does fill this gap, though mostly without any counselling and technical advice. In Cairo, for example, an attempt of a simulated client buying respective drugs in 20 pharmacies was largely successful⁶⁵. This constitutes a challenge for technical cooperation.

Increased availability and accessibility of EC has the potential of preventing a great number of unwanted pregnancies. The Netherlands, for instance, where EC besides other methods of contraception, is widely available, is the country with the lowest abortion rate among all industrialised countries. Particularly for young unmarried women and adolescents EC may be an important option. There is no evidence that the availability of EC would encourage young people’s sexual activity. In contrast, the availability of EC in appropriate places for young people may constitute an incentive for getting in touch with health services, hence an opportunity for appropriate counselling on responsible sexual behaviour, including the prevention of unwanted pregnancy, STDs and HIV/AIDS.

The availability of EC is of paramount importance in refugee and crises situations where coercion and violence towards women and girls, and as a result unwanted pregnancies, are common.

Menstrual regulation

At local level, the term “menstrual regulation” is often mistakenly used by women as a synonym for emergency contraception when they try to purchase or obtain contraceptives for post-coital use⁶⁶.

WHO defines *menstrual regulation* as “early uterine evacuation without laboratory or ultrasound confirmation of pregnancy for women who report delayed menses”⁶⁷. This can be performed by *vacuum aspiration* or *dilatation and curettage*. As is argued in the following paragraphs, the former nowadays is the option of choice. In some countries with restrictive abortion laws this is being tolerated as a method of post coital contraception (e.g. Bangladesh).

⁶³ E.g. Benson, J. et al., Complications of unsafe abortion in sub-Saharan Africa: A review, Health Policy and Planning 11, (2), 1996.

⁶⁴ Population Reference Bureau, 2003.

⁶⁵ Personal communication

⁶⁶ Personal communication

⁶⁷ WHO (2003, p.23)

Promoting the use of manual vacuum aspiration

The traditional technique in the management of incomplete abortion in resource poor settings has for many years been *Dilatation and Curettage* (D&C, also known as 'sharp curettage') involving the mechanical dilation of the cervix and removal of the contents of the uterus through sharp curettage. It carries the risk of perforating the uterus while performing the evacuation. This is in particular a problem when infection is present and it is considerably more painful for women. This procedure requires specifically trained medical or paramedical personnel and is usually performed under anaesthesia. In most cases, women are admitted to hospital for this intervention.

Incomplete removal of the contents of the uterus leading to post-abortive complications is often the result of unsafe abortions.

Recently, *manual vacuum aspiration (MVA)* has been introduced as an appropriate and cost effective treatment of incomplete abortion and safe abortion where it is legal for up to 12 completed weeks since the woman's last menstrual period. It consists of an evacuation of the content of the uterus by a plastic pipe producing a vacuum. It does in most cases not require hospital admission, can be performed under local anaesthesia, and requires a much lower dose of analgesics. A comparison of costs at four Kenyan hospitals proved that the use of MVA on an outpatient basis had been 66% less costly than the standard dilation and curettage⁶⁸. An added advantage is that nurse-midwives can perform it on a larger scale after respective training. This has been introduced extensively in South Africa in order to improve access to safe abortion as widely as possible after the introduction of the *Choice on Termination of Pregnancy Act* in 1996.

WHO recommends the use of D&C only where vacuum aspiration or medical methods of abortion are not available. The use of MVA is also recommended for *post abortion care*. "Where D&C is currently practiced, all possible efforts should be made to replace it with vacuum aspiration, to improve the safety and quality of care of the abortion"⁶⁹. As far as possible, e.g. within the reach of reproductive health programmes, use of MVA as a safer and less costly method should therefore be promoted.

Treatment of abortion-related complications – Post abortion care and counselling

The ICPD programme of action includes recommendations for governments and others to provide the necessary care for women suffering complications of poorly performed abortions. High-quality, accessible emergency treatment for abortion complications is a key strategy for saving women's lives and reducing maternal mortality.

Post Abortion Care (PAC) is a strategy that links prompt and safe emergency care to prevention of another unwanted pregnancy. Introduction and improvement of PAC into routine health services has been strongly advocated and promoted in order to reduce abortion-related morbidity and mortality and prevent further unwanted pregnancies. This has been argued for independent from the legal context as a public health concern. In practice however, integration of contraceptive counselling appears to be the exception. A study in Zambia found out that 78% of women, who had been treated for complications of abortion, would have appreciated to receive information about methods of modern contraception; 44% would have opted for immediately initiating a method. Only 33% of women reported having been talked to about contraception and not a single client was offered to initiate a method immediately⁷⁰. Many abortions are repeat experiences illustrating that many opportunities for counselling and prevention of this risky experience are missed. It is therefore of utmost importance to invest more into the establishment of PAC and respective training of personnel.

⁶⁸ Johnson, B.R. et al., Costs and resource utilization for the treatment of incomplete abortions in Kenya and Mexico, *Social Science and Medicine* 36 (11), 1993.

⁶⁹ WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems*, Geneva, 2003.

⁷⁰ Benson, J. et al., Complications of unsafe abortion in sub-Saharan Africa: a review, *Health Policy and Planning* 11(2), 1996.

Post abortion counselling is an essential component of abortion care. It has to include contraceptive counselling and provision. WHO insists that, before women leave the health care facility, they should receive information and counselling on post abortion contraception including emergency contraception. Those women who choose a contraceptive method should be able to receive most methods from the abortion care delivery site, and in cases where the chosen method is not available, women should be referred to contraceptive services. Post abortion counselling should also include discussion of prevention of sexually transmitted infections (STI) including HIV and the importance of condom use regardless of the contraceptive method chosen by women. This information is particularly important for people who may be at a greater risk of getting such infections⁷¹. This had, for example been a major setback in Vietnam, where most women having had abortions, had not received any information about how to avoid another unwanted pregnancy in the future. In contrast, in Guyana, law stipulates counselling before and after abortion and suggests including the woman's partner to foster male responsibility⁷²

Medical abortion

In the last decade, attempts to develop alternative abortion methods have largely focused on medical methods, which are based on pharmacological drugs.

While in some European countries it is increasingly the method of choice (France about 30%, Sweden almost 50% of abortions), medical abortion (MA) has not yet been much used in low resource settings. According to WHO⁷³ it has proved acceptable in some low-resource settings (India, Vietnam, Tunisia). Currently, MA is being introduced in South Africa.

However, rapid development and ongoing research may lead to the wider introduction of MA methods in the near future which are suggested to provide good alternatives to unsafe procedures. Even when used outside medical settings MA has the potential of reducing risks, and thereby maternal morbidity and mortality. The most widely used regimens consist of an antiprogestogen, mifepristone (which binds to progesterone receptors, inhibiting the action of progesterone and hence interfering with the continuation of pregnancy), followed by a prostaglandine, misoprostol. The effects of medical methods of abortion are similar to those associated with spontaneous abortion and include cramping and prolonged menstrual-like bleeding. Side effects include nausea, vomiting and diarrhoea.

It is important to note that the drugs used for medical abortion are distinct from those used for emergency contraception in that they are used to terminate an existing pregnancy of up to seven weeks after implantation. They either block the hormones required to sustain an existing pregnancy or they stimulate uterine contractions to terminate the pregnancy. Confusion about EC and MA can lead to barriers to EC access.

A WHO-led multinational study in 11 countries compared the efficacy of oral and vaginal administration of misoprostol after a single oral dose of mifepristone for early abortion⁷⁴.

According to the International Consortium on Medical Abortion (ICMA)⁷⁵, use of medical abortion is growing in countries where abortion is legally restricted, as women are buying misoprostol over the counter to self-induce an abortion. The low cost, ease of administration and widespread availability of misoprostol make it appealing to women in developing countries whose only other recourse would be an expensive and possibly unsafe procedure.

In countries, such as India, where both mifepristone and misoprostol are available from pharmacies, the government is developing guidelines on provision of medical abortion to ensure its safe use.

⁷¹ WHO, 2003.

⁷² Berer, 2000.

⁷³ WHO, 2003.

⁷⁴ V.Hertzen, H. et al., WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. I: Efficacy., in *British Medical Journal of Obs.&Gyn.*, 110 (9), 2003.

⁷⁵ International Consortium of Medical Abortion (ICMA), unpublished paper

The ICMA views the following challenges:

- The need to clarify the policy, legal and service delivery context as even in countries where medical abortion is approved, it may not be offered as an option because of limited awareness among service providers, lack of clear guidelines, evidence-based protocols and training, or reluctance to recommend medical methods for use by women at home.
- The need for information and technical support in contexts where medical abortion is legal as well as those where it is not, to support the development of appropriate national policy frameworks and protocols, delivery mechanisms, health service back up in the event of incomplete or failed medical abortion, health worker training and public education strategies.
- The need to improve awareness, first and foremost among donor agencies and policymakers but also among women.

Programme managers should be aware of the upcoming changes and of what would be required to introduce medical methods of abortion into health services in terms of service delivery norms and practices, training of providers and staff, counselling, as well as managerial and practical aspects of clinical facilities

Training of health personnel

There is a need for orientation and training in new approaches and strategies, in methods of treatment of abortion complications, in techniques of performing the procedure safely, as well as for measures for promoting attitudinal change. In South Africa for instance, after the introduction of the *Termination of Pregnancy Act* in 1996 seminars on *value clarification* were conducted after it had turned out that an important factor preventing women wanting to terminate their pregnancy from having the procedure performed in public service facilities, was fear of being humiliated and verbally abused.

Training of health personnel in technical procedures such as performing MVA also has the potential of facilitating an open discussion on the subject of abortion that is so highly loaded with taboos, (unclarified) values and stigma.

There is a need for client-centred methods of *counselling* both in settings where the law allows induced abortion on various grounds as well as in those with restrictive legal situation: in the former for increasing women's (couple's) access to appropriate counselling on all options of dealing with an unwanted pregnancy including the possibility of safe abortion, in the latter in the context of *emergency contraception* and post *abortion care* with the aim of preventing repeated unwanted pregnancies.

The appropriate cadre for abortion care

Globally, training in abortion care - including PAC - and the authorisation to provide this care have focused primarily on physicians. In Africa, other types of health professionals are both more numerous and more decentralised than physicians. In many settings, health services offered outside of major urban centres are delivered by other cadres of providers, for example, midwives, clinical officers and medical assistants. The sheer numbers of these midlevel providers, as well as their proximity to communities and their experience in delivering primary-health services, suggest they are well placed and sometimes already well skilled to offer critical abortion services. Pilot programmes to train midwives in PAC were undertaken in Kenya, Ghana and Uganda in the mid-1990s. All showed that midwives could competently provide quality PAC services in decentralized settings⁷⁶. Subsequently, governments in

⁷⁶ Examples quoted in Otsea, 2004, op.cit.:

Billings, D. et al. Training midwives to improve postabortion care in Ghana. Major findings and recommendations from an Operations Research Project. Chapel Hill, NC, Ipas. 1999.

Kenya and Ghana as well as Nigeria have endorsed the training of midwives in this care, including initiatives involving private-sector midwives. Other countries have followed these experiences, or are in the process.

This requires the development of relevant curricula⁷⁷.

Raising awareness in the public

Legalisation does not necessarily change entrenched social attitudes toward abortion, or persuade husbands and family members to accept a woman's decision to abort. Women commonly report encountering abusive treatment from health workers who disapprove of their desire for an abortion. In Russia and former Soviet states, state health workers are apparently taking it upon themselves to administer punishment and reportedly often perform abortions without anaesthesia⁷⁸. In Nepal, it is reported, that many women were reported to the police for induced abortion by members of their family or their immediate social environment.

Lack of awareness in the general public can also lead to a situation where many women who are eligible for legal abortion nevertheless confront the same difficulties, as do women where abortion is illegal. In research conducted in the state of Bihar in India, a significant proportion of women told researchers they thought that abortion was still against the law - 25 years after its legalisation in the 1972 Medical Termination of Pregnancy Act. .

Collaboration with and support of Non Government Organisations (NGO)

Since the 1980s and particularly since the Cairo Conference (1994), NGOs have increasingly taken up the challenge to fill the gaps left by public services, in terms of specific target groups, specific concerns, and appropriate approaches.

The traditional, vertical health care structures have to some extent failed to address the distinct and changing sexual and reproductive health needs of various segments of the population. Government services, in the form of conventional maternal health, under fives', and family planning clinics, have predominantly served married women with children and, to some extent, their partners. Unmarried young women, men, and adolescents have not been formally excluded but, by virtue of the nature of services provided and IEC strategies chosen, their needs have not been addressed sufficiently. Services have simply been neither appropriate, nor culturally and socially accessible and acceptable to attract, for example, young people, men or very poor segments of the urban population. Innovative approaches were required. NGOs promised to be more flexible and experimental. They could permit themselves a clearer advocacy for marginalised groups or politically "hot" topics without the fear of alienating the "average" client. Some renowned NGOs have in the past among other reproductive health services offered methods of *emergency contraception* and *post abortion counselling and care*, particularly in urban areas.

This work has however been hampered tremendously by the *Global Gag Rule* (see above) that has affected NGOs in 56⁷⁹ countries. Finding ways and methods of filling the gaps left by the withdrawal of U.S. funds is of paramount importance.

Collaboration with the private sector may be an option that has to be assessed through a careful analysis.

Yumkella, F., and Githiori, F., PRIME's technical report 21: Expanding opportunities for postabortion care at the community level through private nurse-midwives in Kenya, Chapel Hill, NC, IntraH, 2000.

⁷⁷ For example: Ipas, Woman-centered postabortion care: Trainer's manual, see website:

http://www.ipas.org/english/publications/training_materials.asp

⁷⁸ Personal communication with women having undergone such treatment.

⁷⁹ USAID Missions with Programs Supported by Population/Reproductive Health Funding, 2003.

Appropriate and comprehensive sexuality education

An important though controversial issue at the ICPD in Cairo and following the conference were *sexual and reproductive rights*. Sustainable changes of girls' and women's submissive sexual behaviour on the one hand and of coercive behaviours of (young) men on the other hand are an important prerequisite for building responsible (sexual) relationships that respect the partner's rights of self-determination including conscious and informed choices regarding contraception and pregnancy. Measures promoting *empowerment* of girls and women („Girls can say no to sex“) and (young) men's change of role understanding towards a more partnership-oriented model are required. GTZ disposes over a vast experience in sexuality education and life skills development made in numerous projects in many countries. A number of publications and manuals have been produced over time⁸⁰. Intersectoral collaboration (health, education, informal sector) as well as collaboration with NGOs experienced in innovative methods for behaviour change is indispensable and has a lot of potential in this respect.

CONCLUSION

Globally, about one in four pregnancies is being terminated. This reflects the high incidence of unwanted pregnancies both in high resource as well as in low resource countries. The vast majority of them are the result of inadequate contraception. Therefore, the priority must be on increasing acceptance of and improving access to modern methods of contraception.

Nevertheless, unplanned and unwanted pregnancies do occur in any society for various reasons as no contraceptive offers 100% protection, and because sexuality and procreation do not always happen in a planned and completely controlled context. Moreover, a high number of pregnancies occur under conditions of coercion and violence. Therefore, abortions are performed in all societies and all societal strata, no matter how threatening sentences may be and even under life-threatening conditions.

Today, the procedure of induced abortion performed by trained personnel with modern methods and in hygienic conditions is associated with little risk for the woman. Despite this state of the art, the number of women dying, or suffering from possibly long term repercussions, as a result of the procedure being performed under unsafe conditions is very – and unacceptably – high. Preventing this avoidable death toll and the morbidity associated with unsafe abortion is a challenge to health services and decision makers at all levels.

Organisations of technical cooperation should use the opportunity of the increasingly open climate and professional debate that have developed after the ICPD and other international conferences (e.g. the WHO world health assembly 1999) for seeking dialogue with partner countries and institutions, and translate it into planning and implementation of appropriate measures. Intersectoral collaboration (health, political reforms including law) as well as collaboration with NGOs is paramount.

This should include an open debate on repercussions of the 'global gag rule' and considerations of counter-acting and collaboration with affected NGOs being.

⁸⁰ See website <http://www.gtz.de/srh/biblio/biblio1.html> and <http://www.gtz.de/youth/english/>

ANNEX 1: THE PROCESS OF CHANGE IN NEPAL – A MODEL?

Until recently, Nepal was one of the countries with very harsh legislation and one of only two countries in the world (the other being Chile) where the law was strictly enforced, and women sent to prison for abortion. It was estimated that 20% of women in Nepali jails were convicted on charges of abortion or infanticide. After a long process of actions of diverse stakeholders, reform of the abortion law in Nepal was achieved in 2002. The new law is one of the most liberal, representing a tremendous step from a situation of complete prohibition to abortion on demand up to 12 weeks gestation; up to 18 weeks in cases of rape or incest; and at any time on health grounds. The GTZ Reproductive Health Project has been one of the actors involved in the change process. The following chapter highlights the major features and phases of this process including the lessons learned⁸¹.

Background

By the end of the 1990s, the contribution of unsafe abortions to the high levels of maternal mortality⁸² and morbidity had been widely acknowledged. It was estimated that 54% of gynaecology and obstetric hospital admissions were due to abortion complications, and 20% of the maternal deaths in health facilities were the result of abortion complications. This does not include the many women dying at home, either because they are too far from a hospital, or afraid to go to a public institution because of the illegal status of abortion. Under the former legislation, abortion was only allowed with the signature of two physicians, testifying its necessity on grounds of saving the life of the woman. For women convicted of procuring an illegal abortion, the sentence could be three years or more, depending on circumstances, with a possible pardon after completion of 50% of the sentence. If the case was deemed to be "infanticide" the sentence could be up to 20 years, and as the law did not clearly distinguish between abortion and infanticide, many women received long sentences on the basis of an individual court decision.

Although the introduction of PAC services represented a major and presumably life-saving step forward, and helped women to access family planning services, it did not address the fundamental problem, which stemmed from the illegal status of abortion. Many women were still dying from unsafe abortions, or languishing in jail, often having been reported by their own relatives.

A key factor driving the reform process was the recognition that unsafe abortions were contributing significantly to the high maternal mortality ratio in Nepal, which the government committed to reducing during the late 1990s.

The process of change

Research

During the mid 1990s, the Centre for Research on Environment Health and Population Activities (CREHPA), a Non-Governmental Organisation specialising in research and advocacy, took on the abortion issue, carrying out a number of studies on the effects of its illegal status on women's rights and welfare. These studies complemented a WHO funded study on the types of abortion women undergo in Nepal, and the resulting deaths and costs of the post abortion treatment provided at three large Kathmandu hospitals. In 1996, CREHPA conducted a public opinion poll on abortion to ascertain the general feeling among the public about abortion and its legalisation. Further surveys were carried out among health personnel and village representatives. The results indicated that most sectors of Nepali society were in

⁸¹ Based on an unpublished report by Dr G. Shakya, Dr S. Kishore, J. Barak & C. Bird, project documentation (GTZ), and personal communication with Anne Erpelding, team leader, GTZ Reproductive Health Project

⁸² among the highest in South Asia, at 540 per 100,000 live births

favour of legalising abortion. Religion and culture did not constitute a barrier to change in the Nepali context.

This research was able to convince decision makers that legalising abortion and the provision of safe accessible services was the only effective way to address this issue. Thus the legal changes grew from a **public health rationale**, more than a human rights perspective, like for example in South Africa.

Advocacy

From around the mid 1990s, the advocacy work of individuals and organisations stimulated the interest of women's activist groups, and the issue gained momentum. CREHPA made extensive use of the press, building advocacy and public education strategies on public health concerns, such as maternal deaths and the burden on public hospitals caused by admissions for abortion complications. From 1999, other NGO partners became involved in designing an advocacy strategy. Two policy memoranda were submitted to parliament, explaining the case for legalisation of abortion, and in 2001 an advocacy paper was drawn up with the Department of Health Services' Family Health Division (FHD). The Forum for Women Law and Development (FWLD) also worked closely with the international NGO, Centre for Reproductive Health Law and Policy (CRLP), to draft legislation amending all gender discriminatory laws in the Country Code, including the prohibition of abortion.

In June 2002, a policy support paper submitted to FHD⁸³, based on a literature review of global lessons learned, highlighted three cross cutting principles for successful implementation of abortion law reforms:

1. Advocacy does not end with the passage of a liberal law
2. A progressive law that cannot be fully implemented is not an improvement
3. Strengthened family planning services must go hand in hand with the new abortion law if a significant reduction in maternal mortality is to be achieved.

Of particular importance was the growing support of the Ministry of Health and Department of Health Services, both of which played leading roles in the later stages of the process of changing the law.

Establishment of the Abortion Task Force

Membership of the Task Force was drawn from the Nepal Society for Obstetricians and Gynaecologists (NESOG), Nepal Safer Motherhood Project (NSMP), GTZ, CREHPA and Family Health Division, who chaired the group. GTZ, NSMP and Ipas provided financial and technical support.

The work of the task force included the review of international experiences (e.g. India, South Africa) in order to learn from their successes and limitations, as well as the development of key documents. These included, among others:

- *The Procedural Order* that defines clinical procedures and service provision facilities;
- *The Abortion Strategy that integrated* abortion services into the national reproductive health strategy.
- *The Implementation Plan*: A two-year implementation plan was drafted taking into account training, service delivery, advocacy, and monitoring and evaluation.
- *Reference and Training manuals*: Clinical protocols and training curricula were drafted, and based on these, reference and training manuals developed, covering all aspects of a quality comprehensive abortion care programme, including clinical procedures, counselling guidelines, equipment and facilities.

The new legislation

Abortion is now allowed up to 12 weeks for any woman, with her voluntary consent; up to 18 weeks if the pregnancy is the result of rape or incest; at any time during the pregnancy on the advice of a medical practitioner, if the life, or physical or mental health of the mother are

83 McCall, M (2002) Policy Support paper: A Review of Global Lessons Learned and Recommendations to His Majesty's Government of Nepal on the Implementation of Abortion Services.

at risk, or the foetus is deformed and incompatible with life. It is noteworthy that the consent of the husband or guardian is not required for women above 18 years, and for women less than 18 years of age, the interpretation of the term 'guardian' is loose, covering any adult member of the family or friend.

Implementation

During the interim period from passing the amendment of the country code of Nepal legalising abortion by parliament in March 2002, receiving Royal approval in September of the same year until passing the Procedural Order for implementation of the new legislation in December 2003, the focus of stakeholder activities moved from advocating for legal changes to development of strategies and plans for implementing services. Training of service providers has begun, and a model service and training site was established.

Having completed the policy development work, the Abortion Task Force was formally dissolved, and a new body was formed to implement the law, known as the Technical Committee for the Implementation of Comprehensive Abortion Services (TCIC). Their mandate relates to the following key areas:

- Training: To facilitate rapid implementation of services across the country, two key points were incorporated into the training strategy: the use of a cascade approach, and engagement of the private sector. It was decided that nurses be involved as service providers, so that services will be ultimately available at primary health care level; and the engagement of the private sector as partners to facilitate scaling up of services.
- Service delivery: The first service and training site was developed as a model centre at the Maternity Hospital in Kathmandu, with excellent facilities to cater for a high caseload. At smaller hospitals and health centres it is anticipated that training and services will be integrated into existing facilities.
- Behaviour change communication (BCC): A strategy is being drafted.
- Monitoring and evaluation: Mechanisms are being worked on.

Implementation of the revised abortion law will continue to be a challenge for various reasons:

- There are huge problems of accessibility (geographical, socio-cultural, and economical; an extremely low status of women);
- There is a severe political crisis, creating a very unstable situation that makes movement in the country very insecure;

Harmonising the new legislation to practice takes long: The fate of over 50 Nepali women is uncertain. Ten months after the Government of Nepal decriminalized abortion, women are continuing to serve prison sentences for abortion and related offences. They have been arbitrarily denied their freedom and other basic human rights⁸⁴.

Lessons learned

The following factors greatly enhanced progress:

- A strategic approach throughout. Being aware of who could be against the changes and for which reasons, and consciously inviting parties concerned including opponents to round table discussions greatly helped to take many on board. A two-day multisectoral planning workshop including key personnel involved in service provision, training, IEC as well as monitoring and evaluation was a great step forward.
- The identification of a key person in the Ministry of Health who:
 - was an authority in the area and held a politically influential stature

⁸⁴ Center for Reproductive Rights (CRLP), 2004.

- would take on the issue and promote change,
- was in a position to forge alliances, lobby and advocate for change
- was well conversant with policies and procedural orders
- can assess and make key decisions on what to formulate explicitly and what to leave out.

In the case of Nepal, this was the former health secretary who has a jurist background.

- Close collaboration of different stakeholders and partner organisations such as IPAS and others, taking note that no single organisation outside the government took the lead in the process. Different players contributed their potential in very different ways, from the advocacy of the NGOs, to the technical support of INGOs and donors, and information from international sources. It was critical that these individual efforts were well coordinated, through effective information sharing and recognition of different roles, so that they ultimately acted together to support the government in achieving the required changes.
- From the early stages of the process the government, through the Ministry of Health and Department of Health Services, has played a lead role in facilitating change and guiding policy development, and it was important that both the Abortion Task Force and TCIC were chaired by FHD.

ANNEX 2: ABORTION LAWS WORLDWIDE - AN OVERVIEW⁸⁵

Prohibited Altogether or Permitted Only to Save the Woman's Life ⁸⁶	To Preserve Physical Health (also to save the woman's life)	To Preserve Mental Health (also to save the woman's life and physical health)	Socio-economic Grounds (also to save the woman's life, physical health and mental health)	Without Restriction as to Reason
Afghanistan Andorra Angola Antigua & Barbuda Bangladesh Bhutan–U Brazil –R Brunei Darussalam Central African Rep. Chile–x Colombia Congo (Brazzaville) Côte d'Ivoire Dem. Rep. of Congo Dominica Dominican Republic Egypt El Salvador–x Gabon Guatemala Guinea-Bissau Haiti Honduras Indonesia Iran Iraq Ireland Kenya Kiribati Laos Lebanon Lesotho Libya –PA	Argentina–R1 Bahamas Benin–R/I/F Bolivia–R/I Burkina Faso–R/I/F Burundi Cameroon–R Chad–R/I/F Comoros Costa Rica Djibouti Ecuador– R1 Eritrea Ethiopia Grenada Guinea–R/I/F Jordan Kuwait–SA/PA/F Liechtenstein Maldives–SA Morocco–SA Mozambique Pakistan Peru Poland–PA/R/I/F Qatar–F Rep. of Korea –SA/R/I/F Rwanda Saudi Arabia–SA/PA Saint Lucia Thailand–R Uruguay–R Vanuatu Zimbabwe–R/I/F	Algeria Botswana–R/I/F Gambia Ghana–R/I/F Hong Kong–R/I/F Israel–R/I/F Jamaica–PA Liberia–R/I/F Malaysia Namibia–R/I/F Nauru New Zealand–I/F Northern Ireland Portugal–PA/R/F Saint Kitts & Nevis Samoa Seychelles–R/I/F Sierra Leone Spain–R/F Trinidad & Tobago	Australia–◇ Barbados–PA/R/I/F Belize–F Cyprus–R/F Fiji Finland–R/F Great Britain–F Iceland–R/I/F India–PA/R/F Luxembourg–PA/R/F Japan–SA Saint Vincent & Grenadines–R/I/F Taiwan–SA/PA/I/F Zambia–F	Albania Armenia Austria* Azerbaijan Bahrain Belarus Belgium* Bosnia- Herzegovina–PA Bulgaria Cambodia* Canada° Cape Verde China°–S Croatia–PA Cuba–PA Czech Rep.–PA Dem. People's Rep. of Korea° Denmark–PA Estonia France* Fmr. Yugoslav Rep. Macedonia– PA Georgia Germany* Greece–PA Guyana† Hungary Italy–ÁPA Kazakhstan Kyrgyzstan Latvia

⁸⁵ Center for Reproductive Rights, New York; based on information provided by the Alan Guttmacher Institute (AGI), http://www.crlp.org/pub_fac_abortion_laws.html, 2004.

⁸⁶ Countries printed in bold make an explicit exception to save a woman's life.

Madagascar Malawi –SA Mali -R/I Malta Marshall Islands–U Mauritania Mauritius Mexico ◊- R Micronesia–U Monaco Myanmar Nicaragua –SA/PA Niger Nigeria Oman Palau-U Panama –PA/R/F Papua New Guinea Paraguay Philippines San Marino Sao Tome & Principe Senegal Soloman Islands Somalia Sri Lanka Sudan –R Suriname Swaziland Syria –SA/PA Tanzania Togo Tonga Tuvalu Uganda United Arab Emirates –SA/PA Venezuela West Ban & Gaza Strip Yemen				Lithuania Moldova Mongolia Nepal–S Netherlands ^Y Norway–PA Romania* Russian Fed. Serbia & Montenegro–PA Singapore*** Slovak Rep.–PA Slovenia–PA South Africa Sweden** Switzerland Tajikistan Tunisia Turkey–‡SA/PA Turkmenistan Ukraine United States– ^V ◊PA Uzbekistan Vietnam°
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"Countries" listed on the table include independent states and, where populations exceed one million, semi-autonomous regions, territories and jurisdictions of special status. The table therefore includes Hong Kong, Northern Ireland, Puerto Rico, Taiwan, and the West Bank and Gaza Strip.

Gestational Limits Key

Note: All Countries have a gestational limit of 12 weeks unless otherwise denoted. Gestational limits are calculated from the first day of the last menstrual period, which is generally considered to occur two weeks before conception. Statutory gestational limits calculated from the date of conception have thus been extended by two weeks.

ΔGestational limit of 90 days

†Gestational limit of 8 weeks

‡Gestational limit of 10 weeks

*Gestational limit of 14 weeks

**Gestational limit of 18 weeks

***Gestational limit of 24 weeks

∨ = Law does not limit pre-viability abortions

° = Law does not indicate gestational limit

Key for Additional Grounds, Restrictions and Other Indications:

R-Abortion permitted in cases of rape

R₁-Abortion permitted in the case of rape of a woman with a mental disability

I-Abortion permitted in cases of incest

F-Abortion permitted in cases of foetal impairment

SA-Spousal authorization required

PA-Parental authorization/notification required

◇= Federal system in which abortion law is determined at state level; classification reflects legal status of abortion for largest number of people

x-Recent legislation eliminated all exceptions to prohibition on abortion; availability of defence of necessity highly unlikely

S-Sex selective abortion prohibited

U-Law unclear

ANNEX 3: KEY REFERENCES

(Specific references are referred to as footnotes in the paper)

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Annex 4: Important organisations and networks

Name	Address
Alan Guttmacher Institute	120 Wall Street 21st Floor New York, N.Y. 10005 Tel: 212-248-1111 Fax: 212-248-1951 www.agi-usa.org
International Center for Research on Women (ICRW)	International Center for Research on Women 1717 Massachusetts Avenue, NW Suite 302 Washington, DC 20036 Phone: (202) 797-0007 Fax: (202) 797-0020 Email: info@icrw.org www.icrw.org
International Planned Parenthood Federation (IPPF)	International Planned Parenthood Federation (IPPF) Regent's College Inner Circle, Regent's Park London NW1 4NS United Kingdom Telephone: +44 (0)20 7487 7900 Fax: +44 (0)20 7487 7950 www.ippf.org
Ipas	300 Market Street, Suite 200 Chapel Hill, NC 27516, USA Tel: 1-919-967-7052 Fax: 1-919-929-0258 e-mail: ipas@ipas.org http://www.ipas.org
Global Health Council	1701 K Street Suite 600 Washington, DC 20006 (202) 833-5900 20 Palmer Court White River Junction, VT 05001 (802) 649-1340 www.globalhealth.org
International Consortium for Emergency Contraception	c/o Meridian Development Foundation 1250 24 th Street NW Suite 350 Washington DC 20037 info@cecinfo.org www.cecinfo.org
International Consortium for Medical Abortion (ICMA)	c/o Marge Berer, RHMjournal@compuserve.com
Mary Stopes International	153-157 Cleveland Street London W1T 6QW, UK Tel : +44 (0) 20 7574 7400 Fax: +44 (0) 20 7574 7417 Email: info@mariestopes.org.uk www.marystopes.org
Pathfinder International	Nine Galen Street Suite 217 Watertown, MA 02472, USA phone: 617.924.7200 fax: 617.924.3833 information@pathfind.org www.pathfinder.org

The Center for Reproductive Rights	120 Wall St. New York, NY 10005 (917) 637-3600 (917) 637-3666 (fax) info@reprorights.org www.crlp.org
World Health Organization (WHO)	20 Avenue Appia 1211 Geneva 27 Switzerland Fax: +41-22-791-4171 Email: rhrpublications@who.int http://www.who.int/reproductive-health/