



IPPF Medical Bulletin

Contents

Access to safe abortion services to the fullest extent permitted by law

Marcel Vekemans, Manuelle Hurwitz1

Comments of IMAP on two reports associating hormonal contraception with cervical infections3

IPPF Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services – new edition3

Dreams and Desires: new publication on the sexual and reproductive health needs of HIV-positive women.....4

Access to safe abortion services to the fullest extent permitted by law

Marcel Vekemans, Manuelle Hurwitz

At the core of sexual and reproductive rights is a woman's fundamental right to decide whether and when to have children.¹ Ideally, all pregnancies should be planned and wanted. However, unwanted and unplanned pregnancies are facts of life. Among the reasons for their occurrence are non-use of contraception (sometimes because of pressure from partner or family), contraceptive failure, and lack of access to family planning. As a result, induced abortion – i.e., voluntary termination of pregnancy – is a common procedure throughout the world. Here we review the current situation of abortion internationally and discuss the underprovision of safe abortion in relation to what is permitted under the law.

Current situation

Worldwide, the World Health Organization (WHO) estimates that each year about 46 million pregnancies end in induced abortion.² Of these, 20 million are unsafe, in that they are performed by persons with insufficient training, or are conducted in unsanitary environments, or are self-induced by dangerous methods.³ Almost all unsafe abortions take place in the developing world. They result in 80 000 maternal deaths each year (13% of all pregnancy-related deaths) and cause disability in hundreds of thousands.⁴ WHO further estimates that between 10% and 50% of women who undergo unsafe abortion experience complications, the most common being incomplete abortion, tears in the cervix, perforation of the uterus, fever, infection, septic shock, and severe haemorrhage. The treatment of these conditions is costly in hospital admissions, staff time, and blood transfusions, and they represent a major burden to primary healthcare systems and to the facilities to which referrals are made.

All these consequences can be prevented through access to contraceptives and availability of safe abortion services.⁵

International commitments

Documents formulated at several international meetings – e.g., the 1994 International Conference on Population and Development (ICPD) in Cairo, the 1995 Fourth World

Conference on Women in Beijing – reflect a global consensus on women's right to sexual and reproductive health. It was at the ICPD that unsafe abortion was identified as a major public health concern and governments agreed to work for its elimination. The Programme of Action included better access to modern contraceptive methods, availability of high-quality post-abortion care, and access to abortion services to the full extent permitted by local laws.

These international documents not only provide a stimulus to action in countries where many women lack access to safe and legal abortion; in addition they offer support for further reforms in countries that have already decriminalised abortion.

Yet today, in many countries access to legal abortion is difficult or impossible. The reasons include cost, unavailability or inaccessibility of services, lack of trained providers, administrative barriers, and lack of information. Also, several governments are actively working to restrict sexual and reproductive rights – in particular, a woman's right to choose and obtain a safe abortion. For example, in 2003, the United States Administration reinstated the Mexico City Policy (also known as the Global Gag Rule). This policy, originally applied in 1984-92, prevents foreign non-governmental organisations from receiving USAID funding if they are directly or indirectly involved in abortion-related activities, such as providing abortion services, counselling clients on their pregnancy options, referring clients for abortion services, or lobbying governments to legalise abortions, even when these activities are carried out with their own funds. An aim of the policy is to reduce the incidence of abortion by limiting women's access to such services. However, in the years when the Global Gag was first applied there is no evidence that it reduced the incidence of abortion. The opposite effect is more likely, since by reducing access to contraception it leads to more unwanted and high-risk pregnancies, and more unsafe abortions with their toll of maternal illness, injury, and even death. In Ethiopia, for example, a country where one in nine women die from pregnancy-related causes, the Global Gag Rule has since 2003 denied donated supplies to the largest family planning organisations, with a consequent shortage of contraceptives; in Kenya it has decreased women's access to primary healthcare services; in Romania it has prevented integration of family planning with abortion services; and in Zambia it has led to a scaling-down of the family planning services.⁶

Providing safe and affordable abortion services to the fullest extent permitted by law

It was mainly in the last half-century that countries began to liberalise their abortion laws. Nearly all now permit abortion when the woman's life is threatened and when the pregnancy has resulted from rape or incest, and about 61% of the world's population live in countries where abortion is permitted for broader indications.⁷ Non-restrictive abortion laws and wide access to contraceptives are associated with low rates of abortion and abortion-related

death. For instance, when abortion was legalised in Guyana in 1995, admissions to a capital city hospital for septic and incomplete abortion declined by 41% within six months.³ Unfortunately, even in countries where the law allows abortion with few restrictions, safe abortion services are often not available, accessible, or affordable. Some of the reasons are as follows.

Lack of awareness and inaccessibility of services

In many countries there is wide ignorance – not only in the general population but also among policy-makers and health professionals – of what the law permits. Commonly, women do not know the specific indications for which services provide abortions. Such ignorance is especially prevalent in developing-country populations such as poor or rural women, adolescents, and refugees. The systematic rape of women has been well documented as a weapon of war, and most countries permit abortion in these circumstances; yet few people know this. In refugee camps women are commonly unable to gain access to abortion or post-abortion care despite their right to these services. NGOs and other agencies providing humanitarian assistance in such camps tend to neglect this issue.⁸

Legal interpretation

Local interpretation of abortion laws can also affect the provision of services, as illustrated by experience from Spain and Portugal. The law in both these countries allows abortion to save a woman's life, to preserve her physical or mental health, in cases of rape, or when there is fetal abnormality. In practice, safe legal abortion is easily available in Spain but difficult to obtain in Portugal: Portuguese hospitals and doctors often refuse to help women in these circumstances. In private clinics safe abortion is available in both countries, though at a high price and with important geographical disparities. The difference in access between the two countries originates from different interpretations of 'preserving mental health' and the attitude of the prosecuting authorities, which is much harsher in Portugal. At least 5000 women attend Portuguese hospitals every year with complications of unsafe abortions.⁹

Lack of quality services

The issue of the quality of care and of access to existing care also threatens the correct implementation of abortion laws. The principle that every woman has a right to the highest attainable standard of healthcare is internationally recognised. Since 15% of pregnancies end in spontaneous abortion, all governments regard post-abortion care as an integral part of primary healthcare; yet, for millions of women worldwide, safe and comprehensive post-abortion care remains severely restricted by the deficiencies of health systems and lack of access. In countries where abortion is illegal, health providers do not routinely receive training in abortion-related counselling and procedures; moreover, fear of criminal prosecution may affect their willingness to treat women with complications arising from unsafe abortion. Similarly, women who have undergone an illegal abortion are likely to delay seeking care for fear of prosecution, thus putting their lives at greater risk.

Administrative and procedural barriers

Even in countries where abortion is legal, administrative and procedural barriers can obstruct access to safe abortion services. Such barriers include long waiting periods, consent requirements, restrictions on abortion advertising, and limitations on where abortions may be performed and by whom. In India, where a liberal abortion law has been in place since 1974, the ratio of unsafe to safe abortions remains at 7:1. This can be attributed partly to a lack of information among women but also to the fact that the law requires surgical termination of pregnancy to be performed at certified service locations or specialised facilities, or by practitioners with postgraduate training or qualifications in gynaecology and obstetrics. The process of certifying clinics is long, and bureaucratic delays greatly limit availability.¹⁰

Conclusion

The provision of safe, sensitive, and affordable abortion services to the fullest extent permitted by the local law should be part of a comprehensive package of sexual and reproductive health services. Special attention should be given to the most vulnerable, including adolescent and young women, unmarried women, refugees, women in war zones, widows, and those who are undernourished, diseased or anaemic. Where organisations do not provide clinical services, effective referral systems should be established with partner organisations.

In addition to advocating for liberalisation of abortion laws or decriminalisation, a necessary step to help women access safe legal abortion is to disseminate information on the circumstances in which abortion is already legal and to ensure that services are provided accordingly. Even when abortion is legally permitted, enormous challenges remain. If the practice of unsafe abortion is to be combated worldwide, vital steps are needed to remove administrative barriers, to train service providers, to introduce new safe technologies such as medical abortion, and to help women assert their rights.

Professor Marcel Vekemans MD is IPPF's Senior Medical Advisor and Theme Leader on Abortion. Manuelle Hurwitz is Programme Coordinator with IPPF's Innovation Fund and its focal person on abortion.

References

- 1 IPPF. IPPF Charter on Sexual and Reproductive Rights. London: IPPF, 1996
- 2 World Health Organization. Address unsafe abortion (http://www.who.int/archives/whday/en/pages1998/whd98_10.html). Accessed November 2004
- 3 Alan Guttmacher Institute. Sharing Responsibility: women, society and abortion. New York: AGI, 1999
- 4 World Health Organization. Unsafe Abortion: global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data. Geneva: WHO, 1998
- 5 World Health Organization. Health Benefits of Family Planning. Geneva: WHO, 1994
- 6 Global Gag Rule Impact Project. Access denied – US restrictions on international family planning. [www.globalgagrule.org]. Accessed November 2004
- 7 Ahman E, Shah I. Unsafe abortion: worldwide estimates for 2000. *Reprod Health Matters* 2002; **10**(19): 13-17
- 8 Program for Alternative Technology in Health (PATH). Annotated bibliography: Impact of displacement and conflict on women's health (<http://www.rho.org/html/ref-b-01.html#impactofdisplacement>). Accessed November 2004
- 9 Women on Waves Press. Young woman on trial for illegal abortion in Portugal [www.womenonwaves.nl]. Accessed November 2004
- 10 World Health Organization. Safe Abortion: technical and policy guidance for health systems. Geneva: WHO, 2004:92-3

Comments of IMAP on two reports associating hormonal contraception with cervical infections

At its October 2004 meeting, the International Medical Advisory Panel (IMAP) discussed two recent prospective cohort studies of contraception in relation to cervical infections. The first was a report from Morrison et al¹ on 819 women attending two reproductive health centres in Baltimore, USA. The risk of acquiring a chlamydial or gonococcal infection was threefold higher in those using depot-medroxyprogesterone (DMPA) than in those using non-hormonal methods; there was no significant excess risk with oral contraceptives. The other study was by Baeten and co-workers,² conducted in 948 Kenyan sex workers. These researchers found that both DMPA use and oral contraception were associated with a significantly increased risk of chlamydial infection.

Associations between hormonal contraception and cervical infections have previously been reported in observational studies. While these latest results must be taken seriously, they should be interpreted with caution because it is not possible to state whether the association observed between chlamydial infection and DMPA or with combined oral contraceptives is causal, or whether other

factors in the study designs or in the study populations may have contributed to the increased risk.

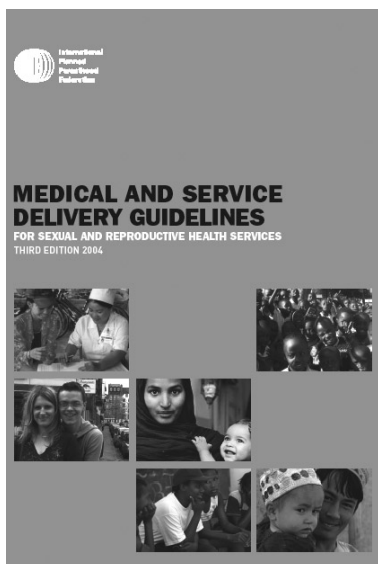
IMAP reviewed the current guidance on the use of DMPA and combined oral contraceptives in women at risk of sexually transmitted infection (STI), which is based on the World Health Organization's Medical Eligibility Criteria. The Panel's conclusion was that the new results do not call for change in the provision of DMPA. However, IMAP stresses that hormonal contraceptives do not protect against acquisition of STIs, and reinforces the message that all women at risk of STI infection should be counselled on the importance of correct and consistent use of condoms (male or female) and of reducing the number of sexual partners. In all circumstances, counselling about the choice of contraceptive method should take account of the linked issues of contraceptive efficacy, the risks of an unwanted pregnancy, the risk of STIs/HIV, and the feasibility of correct and consistent use of condoms.

References

- 1 Morrison CS, Bright P, Wong EL, et al. Hormonal contraceptive use, cervical ectopy, and the acquisition of cervical infections. *Sex Transm Dis* 2004; 31: 561-7
- 2 Baeten JM, Nyange PM, Richardson BA, et al. Hormonal contraception and risk of sexually transmitted disease acquisition: results from a prospective study. *Am J Obstet Gynecol* 2004; 185: 380-5

News

IPPF Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services – new edition



The IPPF *Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services* is intended to improve the knowledge, skills, and confidence of service providers in the delivery of high-quality sexual and reproductive health services. Based on a client-rights approach, the *Guidelines* offers up-to-date evidence-based guidance on a range of sexual and reproductive

issues, including family planning.

In the seven years since the last edition, the *Guidelines* have been extensively updated and made consistent with the World Health Organization's (WHO) 2004 *Medical Eligibility Criteria for Contraceptive Use* and *Selected Practice Recommendations for Contraceptive Use*. Like previous editions, the *Guidelines* were written with the support and technical expertise of IPPF's International Medical Advisory Panel (IMAP). The 3rd edition includes four new chapters, on the normal menstrual cycle, reproductive health screening for well women, safe abortion, and HIV infection and AIDS. The *Guidelines* are written to be easily adapted to the needs and resources of different settings.

Intended users

The intended users of the *Guidelines* are programme planners and managers, clinical services providers, and trainers and supervisors of clinical and community-based services. The content is appropriate for doctors, nurses, midwives, and other health professionals. The recommendations are also relevant to community-based services and can be used for developing materials for these workers/volunteers – best done at the local level. The *Guidelines* can be used as a:

- *Guide for the delivery of services* – The handbook offers clear guidance to managers and service providers for the planning and performance of tasks which are related to their duties
- *Reference document for assessing quality of care* – The focus is on providing high-quality sexual and reproductive health services; quality of services can be assessed by comparing actual performance with the recommendations and instructions contained in the guidelines

- *Training instrument* – Each chapter can serve as the basis for the development of training curricula
- *Tool for supervision* – The *Guidelines* can serve as a reference to supervisors in identifying situations which require corrective actions and in identifying training needs. The supervisors can use the *Guidelines* for bringing to the attention of service delivery personnel essential elements of quality of care and proper procedures.

Guideline overview

Chapter 1 of the *Guidelines* reviews IPPF's framework of clients' rights and providers' needs. It underlines the importance that both the rights of clients and the needs of service providers must be met in the delivery of quality sexual and reproductive health services. Chapter 2 discusses counselling in sexual and reproductive health services. Chapters 3-4 discuss the normal menstrual cycle and reproductive health screening for well women. Chapters 5-10 provide guidance on methods of contraception, which include:

- *Hormonal contraception*: Combined oral contraceptives, progestogen-only pills; progestogen-only injectable contraceptives; combined injectable contraceptives; subdermal implants; vaginal ring; patch.
- *Intrauterine devices (IUD)*: Copper releasing IUD and the progestogen-only IUD
- *Barrier methods*: Male and female condoms and the diaphragm
- *Female and male sterilisation*
- *Fertility-awareness based methods*
- *Emergency contraception*: Emergency contraceptive pills and the copper releasing IUD.

Each of these chapters includes:

- A definition of the method
- Who the method is indicated for
- Medical eligibility for contraceptive use (information on who can use the method)
- Counselling and information (information on providing the method, explaining how to use it, and how to deal with potential side-effects)
- Follow-up care (information on what to ask and do during later visits).

Chapter 11 discusses the basics of clinical and laboratory pregnancy diagnosis. Chapter 12 provides information on safe abortion procedures, including medical and surgical methods. Chapter 13 reviews reproductive tract infections, and sexually transmitted infections, and provides information on the treatment of both. Chapter 14 discusses HIV/AIDS within the context of sexual and reproductive health services. The chapter provides information on prevention, counselling and testing, treatment, and reproductive decision making for the HIV-positive person. The final chapter discusses infection prevention control mechanisms. It describes the key features of antisepsis, processing equipment and instruments, storage of equipment, care during procedures, waste disposal and prophylactic antibiotics.

The *Guidelines* are currently available in English. In 2005, the resource will be translated in Arabic, French, and Spanish. The complete document will soon be available in electronic format at www.ippf.org or can be ordered in hard copy by contacting medtech@ippf.org

The *Guidelines* are available free of charge to individuals and organisations in developing countries. Elsewhere, the *Guidelines* cost US\$25 (UK£14).

Dreams and Desires: new publication on the sexual and reproductive health needs of HIV-positive women

For the first time in the 20-year history of the AIDS epidemic, more women than men are infected with HIV. Globally, women now account for more than 50% of those infected. The possibility for HIV-positive women to live long, productive, sexually fulfilling lives and to give birth to healthy babies has increased with the expansion of access to anti-retroviral treatment (ARV) and care. These developments go hand in hand with a growing demand for sexual and reproductive health services for women living with HIV.

In response, IPPF and the International Community of Women living with HIV/AIDS (ICW) – an international network of HIV-positive women – decided to explore the specific sexual and reproductive health issues facing HIV-positive women. The publication consists of 13 stories by women from around the world and highlights what it means to be a sexually active HIV-positive woman. Told from women's own perspective, the collection provides an insight into the dreams and desires

of HIV-positive women in relation to their sexual and reproductive health.

These stories will inform the design of appropriate and integrated sexual and reproductive health services. For example, positive women need increased access to prevention services and accurate information. Addressing any misinformation is an essential step to curb the epidemic. They also need support in addressing many of the psycho-social issues related to ARV side effects and complications, as well as the freedom to make choices about whether and/or when to have children. Abundantly clear is the vital role of condoms as a protective method from re-infection and unwanted pregnancies for positive women. It is imperative that access to condoms, including the female condom, becomes standard practice to meet the sexual health needs of positive women.

This joint publication is a small step towards realising the dreams of many HIV-positive women for access to appropriate sexual and reproductive health services. Electronic copies of the publication are available on-line at www.ippf.org or can be ordered from info@ippf.org.