

Death and Denial: Unsafe Abortion and Poverty



Foreword by Gareth Thomas MP

Parliamentary Under-Secretary of State for International Development

Millions of women have no access to reproductive health services; many more have little or no control in choosing whether to become pregnant. As a result, every year, some 19 million women have no other choice than to have an unsafe abortion. Many of these women will die as a result; many more are permanently injured. Nearly all the women who die or are injured are poor and live in poor countries.

Preventing these deaths and injuries will not be achieved without stopping unsafe abortions which cause around 13 per cent of all maternal deaths. Virtually all the deaths of women from unsafe abortion are in fact preventable. A woman facing an unwanted pregnancy should not have to risk death through having an unsafe abortion.

Access to legal and safe abortion care - as well as to care to treat incomplete abortion or complications from unsafe abortion - would help save the lives of thousands of women every year. It would also provide a vital opportunity to ensure women can subsequently access family planning and contraception to help avoid repeat abortions.

Punitive legal measures and restricting access to safe abortion do not reduce the incidence of abortion; they just make it more dangerous. The result is that more women suffer. Not surprisingly, it is the poorest women - women least able to pay for any minimal level of care - who end up paying the highest price. I welcome this report as an important contribution to dealing with a subject where rational debate and considered action are much needed.

Gareth Thomas
January 2006

“No woman should anywhere have to face death or disability for the want of a safe abortion. Is there anybody who would disagree with the right of a woman not to die in pregnancy? Anybody? No.”

The Rt Hon Hilary Benn, MP,
Secretary of State for International Development, Countdown 2015,
The Global Roundtable,
London, 2004.

“A straightforward public health problem with a known solution has been allowed to become the killing fields of women in developing countries, particularly Africa.”

Fred Sai, Special Adviser to the President of Ghana, speaking on unsafe abortion, Countdown 2015, The Global Roundtable, London, 2004.

Introduction

This year alone, an estimated 19 million women and girls, faced with unintended and unwanted pregnancies, will face the deadly consequences of unsafe abortion. Nearly 70,000 of these women and girls will die, and hundreds-of-thousands of others will be left with debilitating, and frequently lifelong injuries, as a result. Over 96 per cent of these women will come from the world's poorest nations.

For reasons ranging from human rights to religion, abortion generates more political and social disagreement than almost any other subject. It remains a singularly emotive and complicated issue in many countries, at times seemingly without any room for balanced discussion.

This report offers an overview of the current situation regarding unsafe abortion around the world. In doing so it seeks to open a much needed and timely debate among governments, parliamentarians, public health, development and medical experts, as well as service providers and global advocates for legal and safe abortion such as IPPF.

Unsafe abortion is one of the largest contributors to global maternal mortality: a very preventable human tragedy that highlights the failure of national governments and the international community to address a public health issue that perpetuates one of the greatest social injustices separating rich and poor nations.

Unsafe abortion is a cause and consequence of poverty; it is also intimately linked to gender

inequality within societies. It is the inability of women, especially young women and girls, to fulfil their basic sexual and reproductive rights, and to have control over their own bodies, which forces upon them a stark choice - face social exclusion or risk their lives and health through unsafe abortion.

During last September's United Nation's World Summit, world leaders reaffirmed their commitment to the Millennium Development Goals, including the goal of reducing maternal mortality and improving maternal health. The Summit also reasserted a previous global commitment to achieve universal access to reproductive health. The review process noted that little progress had been made towards achieving either since the Millennium Development Goals were first adopted five years ago. It further highlighted the fact that unsafe abortion is a major contributor to these stubbornly high levels, particularly in developing countries.

Extensive independent research shows that restricting access to abortion does not make it go away; it only makes it clandestine and unsafe. Health authorities and political leaders in more and more countries are prepared to re-examine abortion policy when they understand how unsafe abortion contributes to maternal mortality and ill health. Moreover, renewed interest in the issue of preventing unintended pregnancies has brought renewed focus on the role family planning and reproductive health services play in preventing unwanted pregnancies.

Lack of access to modern contraception as a factor driving unwanted pregnancies to unsafe abortions cannot be ignored.

There is a pressing need for an open and informed discussion to address the fundamental injustice of the causes and consequences of unsafe abortion. There are few governments with the courage to take a leadership position on abortion rights and there are equally few international organisations with such courage. The Government of the United Kingdom and IPPF are two of the few that have both the courage and the resolve to act in a struggle so crucial to women's well-being.

Through the work of the Department for International Development, the United Kingdom has promoted an approach to addressing abortion based on sound public health evidence. In doing so, the UK has established an international reputation for both leadership and wisdom. IPPF is determined to play a constructive role as partner with the Department for International Development in this undertaking. With upwards of 15 per cent of maternal mortality directly attributable to illegal and unsafe abortion – perhaps as much as 50 per cent in some countries in Africa and South East Asia – tackling head-on the reduction and even the elimination of this preventable cause of maternal death is of paramount importance.

Steven W. Sinding
Director-General,
International Planned Parenthood
Federation



IPPF/Chloe Hall
The Ethiopian Member Association strives to reduce the number of unwanted pregnancies by establishing community based distribution schemes for contraceptive services in rural areas

Unsafe abortion, maternal mortality and the Millennium Development Goals

The World Health Organization defines abortions as unsafe when they are performed by “*persons lacking the necessary skills or in an environment lacking the minimal medical standards or both*”. The impact of unsafe abortion casts a spotlight on the gaping social and public health inequalities between developed and developing nations, as well as within those nations where abortion is illegal or severely restricted. There is one simple truth: unsafe abortion disproportionately affects the poorest women in those countries where it occurs.

“Latin Americans are beginning to look at abortion as an issue of maternal mortality, not just maternal morality.”

New York Times, 06 Jan 2006

Unsafe abortion: a cause and consequence of poverty

Poverty has multiple dimensions which include a lack of economic resources, an absence of human rights, poor health and the deprivation of choices. At the United Nations Millennium Summit, in October 2000, 191 countries agreed on the imperative of reducing poverty and inequity worldwide. Improving maternal health and reducing by three-quarters the number of maternal deaths were identified as one of the Millennium Development Goals key to addressing inequality.

Almost all maternal mortality occurs in developing countries, representing one of the widest, and most unjust, health gaps between developed and developing nations. Of the 500,000 annual maternal deaths,

complications from unsafe abortion account for approximately 70,000, or 13 per cent, of all deaths.

Achieving the Millennium Development Goals, especially the goal of improved maternal health and reduced maternal mortality, will require action across a broad front. The causes of maternal mortality and morbidity are numerous and complex, but in countries where women can be responsible for up to 100 per cent of household income and for raising a family, death and morbidity from unsafe abortion exacts a heavy economic and societal toll.

Equal access to education for girls is another key aim of the Millennium Development Goals. The failure to fulfil her educational

potential has an unequivocal impact on a woman’s ability to play a full economic, social and political role within her community, and is directly linked to poverty. For young women and girls, unintended and unwanted pregnancy frequently forces them to decide between risking their lives and health to have an unsafe abortion or leaving school to continue with the pregnancy.

“A poor woman in many parts of Africa is over 200 times more likely to die as a result of pregnancy and childbirth than a woman in the UK.”

Department of International Development, UK.

Unsafe abortion: the cost of gender inequality

Many women, married or unmarried, simply have no control over their own sexual lives. They cannot access, or are not permitted to access, safe family planning services and as a consequence have little choice over when or if they become pregnant. The prevailing cultural and religious norms of many societies leave women, especially young women and girls, facing death or injury from unsafe abortion, or social exclusion and abandonment.

Many girls and women are prevented from enjoying basic sexual and reproductive rights due to their unequal status in society.

They lack control over their own bodies, just as they lack decision making power, mobility and control of resources within the household. This social, political and economic inequity prevents many women from accessing safe services or from demanding the services they desire.

Young women, adolescents and girls are particularly vulnerable to sexual coercion, abuse and exploitation. Almost 50 per cent of sexual assaults worldwide are against adolescent girls of 15 years of age or below. They are powerless in relationships where older men control their lives. This not only puts them at greater risk of unwanted

pregnancy and unsafe abortion, but it is also a significant factor fuelling HIV infection rates amongst young women in many countries.

Gender inequality, cultural norms, religious practices and poverty are all factors limiting opportunities for women and girls to make choices about their own sexual and reproductive lives. This leaves girls and women without the choice to say 'no' to sex, especially if they are poor or living in marginalized communities. This has dire consequences for many women, especially the very poorest women.

Millions of women suffer injury or illness from unsafe abortion

While the death of a mother, daughter or sister from unsafe abortion has a devastating impact on a family, equally devastating are the debilitating injuries and illness or lifelong disability hundreds-of-thousands of women suffer as a consequence of unsafe abortion.

Accessed early, medical care can address the complications in many cases, but large numbers of women have no reliable access to primary health care facilities. Not all women are able to get hospital treatment for medical complications following unsafe abortion; however, the data from 10 countries indicate the sheer scale of the problem and its subsequent impact on health care systems.

In countries where abortion is permitted only on narrow grounds, thousands of women are hospitalized each year with serious complications from unsafe procedures.

Country	Abortion-related hospitalizations	Hospitalizations per 1,000 women 15–44
Africa		
Egypt, 1996	216,000	15.3
Nigeria, 1996	142,200	6.1
Asia		
Bangladesh, 1995	71,800	2.8
Philippines, 1994	80,100	5.1
Latin America		
Brazil, 1991	288,700	8.1
Chile, 1990	31,900	10.0
Colombia, 1989	57,700	7.2
Dominican Republic, 1990	16,500	9.8
Mexico, 1990	106,500	5.4
Peru, 1989	54,200	10.9

Alan Guttmacher Institute, Sharing Responsibility; Women, Society and Abortion Worldwide

Health impact caused by unsafe abortion

A WHO study from Nigeria in 2000 showed that 75 per cent of women suffered injury or illness. The study of 144 women who underwent unsafe abortion in Ilorin, Nigeria, reported typical complications:

- Sepsis 27%**
- Anaemia (haemorrhage) 13%**
- Death 9%**
- Cervical tear 5%**
- Injury to gut 4%**
- Chemical vaginitis 4%**
- Sepsis with anaemia 3%**

- Pelvic abscess 3%**
- Uterine perforation with peritonitis 3%**
- Laceration of vaginal wall 3%**
- Vesicovaginal fistula 1%**

A more recent Ipas study from Kenya (*The Magnitude of Abortion complications in Kenya, International Journal of Obstetrics and Gynaecology*) supports the Nigeria data, declaring unsafe abortion as "one of the most neglected health care issues in Africa".

Over 80 per cent of the 809 case studies from all levels of Kenya's health care system had complications as a result of unsafe abortion. Of the seven deaths recorded, six were due to second trimester complications; underlining the need for safe and accessible abortion services as early as possible during the pregnancy. The study estimates that annually 20,893 Kenyan women will be hospitalized from complications from unsafe abortion.

Worldwide unplanned pregnancy and unsafe abortion

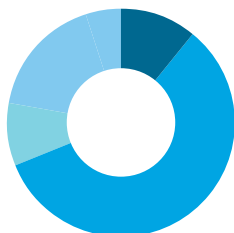
There are approximately 211 million global pregnancies annually; 87 million women become pregnant unintentionally, with approximately 46 million pregnancies ending in induced abortion. A further 31 million pregnancies miscarry or result in stillbirths.

Women in all parts of the world seek to end unwanted pregnancy through abortion: of the 46 million women who choose to have an abortion each year, 78 per cent are from developing countries, 22 per cent from developed countries. Annually 19 million abortions are considered to be unsafe, over 96 per cent of which occur in developing countries.

A number of independent studies have shown that, while there may be country-to-country differences,

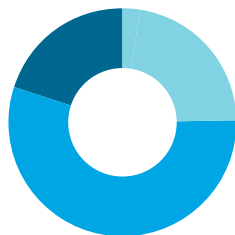
across the world women choose to end pregnancies for very similar reasons.

- They choose not to have any more children
- They are too young or have too few economic resources to have children
- They wish to complete their education
- They wish to postpone childbearing to space births
- Their relationship with their partner has ended or is unstable
- Childbearing would adversely affect their health
- The pregnancy was a result of rape or incest
- Social or religious beliefs make it impossible for unmarried women to continue pregnancy



All abortions by global region

Africa 11 per cent
Asia 58 per cent
Europe 17 per cent
Latin America and Caribbean 9 per cent



Unsafe abortions in developing countries

Africa 4.2 million
America and the Caribbean 3.8 million
Asia 10.5 million

Alan Guttmacher Institute, *Sharing Responsibility: Women, Society and Abortion Worldwide*

“In the face of growing conservatism in many parts of the world, as well as competition for resources, the great challenge is to maintain the focus of development efforts, as embodied in the Millennium Development Goals, on the centrality of sexual and reproductive health and rights for poverty reduction. This requires that IPPF step up its advocacy efforts, in partnership with like-minded governments and organizations, even as it expands its services in traditional family planning and especially safe abortion.”

Dr. Jacqueline Sharpe, President IPPF.

Unsafe abortion in Europe

WHO estimates that there are between 500,000 – 800,000 unsafe abortions in Europe each year. Women are still dying in Eastern Europe from unsafe abortion, but the situation is improving. Between 6 and 23 per cent of maternal deaths in Eastern and Central Europe are as a result of unsafe abortion.

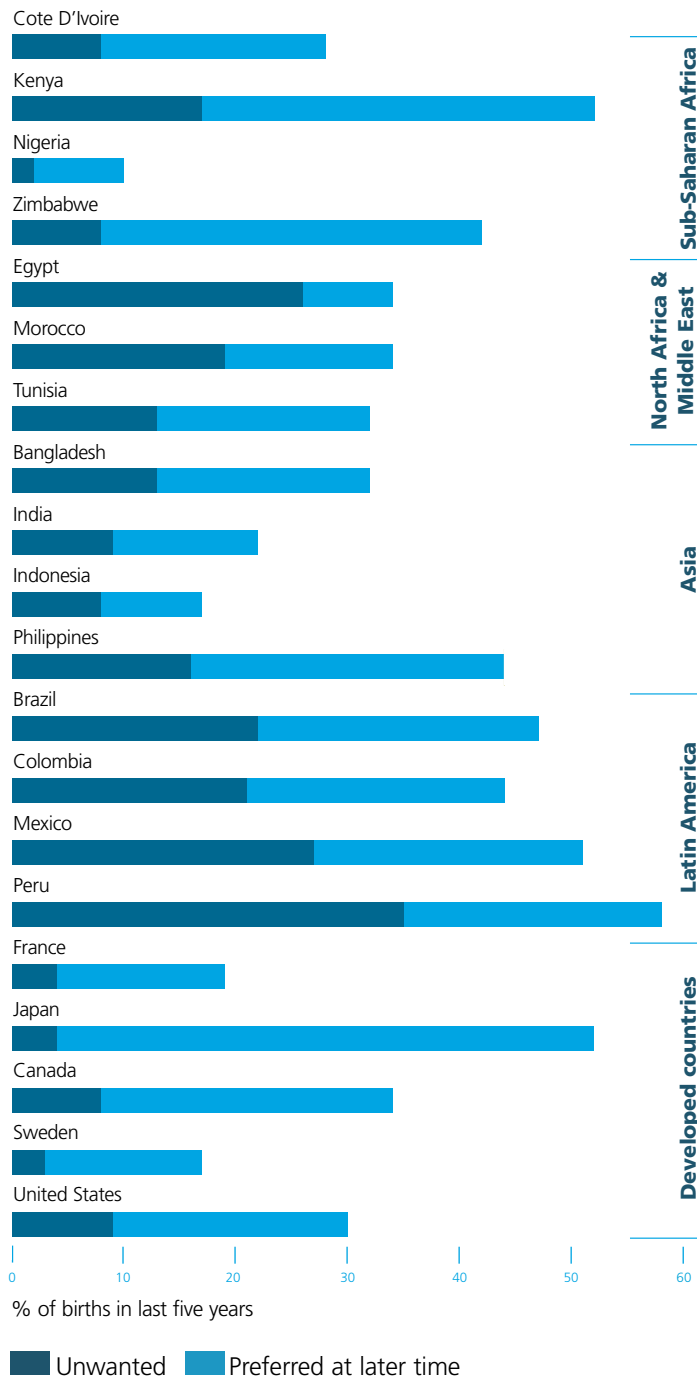
In order to improve women’s access to safe legal abortion, IPPF European Network, in partnership with other organizations, organized a two-day workshop of staff and volunteers from the Member Associations of Albania, Armenia, Bosnia and Herzegovina, Georgia, Kazakhstan, Poland, Tajikistan and Uzbekistan. An additional meeting was held with other European Member Associations to assist them in improving the quality of abortion services provided.

A law banning abortion was passed in Romania in 1966. There was a dramatic rise in maternal mortality from 80 deaths per 100,000 live births in 1964 to 180 in 1988. After the repeal of this law in 1989, the maternal mortality ratio fell to around 40 deaths per 100,000 live births in 1992. This fall was almost entirely due to women being able to access safe abortion services and consequently fewer deaths caused by the complications of unsafe abortion. During the period 1966-1988, some 20,000 Romanian women are estimated to have died as a result of unsafe abortion.

In compiling this report, IPPF has relied on statistical data from a number of sources, most extensively from the Guttmacher Institute’s landmark publication *‘Sharing Responsibility: Women, Society and Abortion Worldwide’*, 1999.

Unplanned births are common events for women around the world

Increasingly women desire smaller families. With the exception of sub-Saharan Africa and a handful of other countries this largely means having two or three children. In much of the developed world a small family size is the cultural norm. Yet many women throughout the world still have more children than they would desire.



Alan Guttmacher Institute, Sharing Responsibility; Women, Society and Abortion Worldwide

The causes of unplanned and unwanted pregnancy

- Gender inequality means women have less control over their own bodies
- Lack of access to family planning services
- Lack of information on modern contraceptive methods and reliance on traditional methods
- The failure of, or irregular use of, contraception
- Stigma surrounding single women and contraceptive use
- Lack of a woman's control over the circumstances of sexual intercourse
- Sexual violence, rape and incest
- Cultural and religious norms mean women have less power to negotiate contraception

Better contraceptive choices

To have full control over the spacing of children and to achieve desired family size, women and men must use, correctly and consistently, reliable contraception for the majority of a woman's fertile years.

Evidence suggests that globally the number of married and unmarried women regularly using modern methods of contraception to avoid unplanned pregnancy is well below the numbers who wish to delay or better space their pregnancies.

The reasons for this are complex, ranging from ingrained social and cultural attitudes, economic circumstances and the inability of women to negotiate contraceptive use in relationships. Another reason is that in large parts of the world there is an unmet contraceptive need, and women and men simply cannot access the family planning services they want and need. Many couples are forced to rely on traditional methods which are not effective in preventing pregnancy. This inevitably leads to unplanned pregnancies.

Case studies: unplanned pregnancies

Nepal

In Nepal early marriage and multiple unplanned pregnancies have led many women to seek secret and unsafe abortions. Abortion was legalized under specific conditions in 2002, and the implementation of the legislation was approved in early 2004. This legal reform was contained within the Pregnancy Protection legislation which addressed other rights for women. IPPF Member Association, the Family Planning Association of Nepal (FPAN), began providing abortion services in 2004 in three different clinics.

A 14-year old girl arrived at FPAN's Valley clinic and requested an abortion. Initially she was reluctant to speak to the staff, but she eventually revealed that she had been involved in a sexual relationship with a distant relative and had become pregnant. A bright student, she was worried that a pregnancy would affect her forthcoming exams and would prevent her from completing her education.

It was the first time that such a young person had requested these services from the clinic, so staff did not have a standard procedure to follow. A meeting was quickly called with service providers and senior staff to discuss the legal implications and how best to help the girl. In Nepal it is illegal to provide abortion services to anyone under the age of 16 unless she has the consent of her parents or guardian. The staff decided that they would provide safe abortion services the following day, so long as the girl could return to the clinic the following morning with a guardian's consent letter.

The next day, she did not come back to the clinic and staff became worried. FPAN field staff made discreet enquiries, and they met with the girl in confidence and provided additional counselling.

They discovered that she had not returned to the clinic that morning because she had been sitting an exam. By now it was the weekend, and although the clinic was officially closed for the day, the branch manager was concerned about further delays and opened the clinic especially for the girl, who was accompanied by her guardian.

A 36 year old pregnant woman who had learned about the services of the Family Planning Association of Nepal through outreach workers, came to a clinic in mid-2005. She and her husband, a labourer, were poor and were already struggling to bring up their seven young children. She was clearly distressed that an eighth child would mean that none of her children could be provided for adequately.

Unfortunately, FPAN is unable to offer free services for all clients, and the woman could not afford the 750 rupee (approximately £6) fee. Realizing that she was in an extremely vulnerable condition, and fearing the woman might resort to an unsafe, 'traditional' abortion method, FPAN staff decided to raise the money for the operation themselves.

For many women, safe abortions are very expensive and unaffordable, and going into debt is not an option. This is one of the many reasons women resort to unsafe abortion.

The woman received a safe abortion and post-abortion counselling, including contraceptive counselling. The woman told staff that had she known about FPAN's family planning services sooner, she would have taken steps to have fewer children.

Peru

Carmen, a 19-year-old woman, came to a clinic of IPPF's Peruvian Member Association, INPPARES, depressed and emotionally upset. She revealed during the conversation that she had been raped six weeks earlier, but had not reported it or sought medical care because she felt ashamed. In desperation, she had attempted to induce an abortion using medication and was suffering from vaginal bleeding.

Carmen's boyfriend and mother were with her during the visit, and she was able to talk openly about what had happened and to discuss the options available to her. In addition to information on post-abortion care, she was offered counselling on testing for HIV and other sexually transmitted infections. The woman decided to have a manual vacuum aspiration, which was completed without complications. When she returned for a follow-up visit, she was counselled on different contraceptive methods. She said that her boyfriend had left her due to the stigma associated with rape and abortion, and that she no longer needed contraception.



IPPF/Chloe Hall
Women access contraceptive services in the Nouadhibou clinic of the Mauritanian Member Association, these services are fundamental to preventing unwanted pregnancies



IPPF/Christian Schwetz
The Member Association in Thailand ensures that women are educated about different methods of contraception

IPPF/Chloe Hall
Buzensu walks for several hours to attend the market day outreach services in Wondogonet, Ethiopia. The Saturday clinic is her only point of access for contraceptive services



The global commitment to family planning

At the International Conference on Population and Development in Cairo in 1994, the international community pledged to make universal access to family planning and sexual and reproductive health services a reality by 2015. Over a decade later, and despite further pledges to deliver universal access,

world leaders are as far away as ever from delivering on their commitment. Indeed, funding for global family planning services has actually fallen during this period.

Non-existent or poor quality family planning services, whether from inadequate funding or political and

religious opposition, contribute directly to unintended and unwanted pregnancies and to subsequent high levels of maternal mortality and ill health from unsafe abortion.

The Global Gag Rule

First introduced in 1984 and reintroduced by President George W. Bush in 2001, the Global Gag Rule puts non-governmental organizations from outside the United States in an untenable position, forcing them to choose between carrying out their work safeguarding the health and rights of women or losing their funding from the US. The Gag Rule prohibits organizations in receipt of US funds from using their own money to provide abortion information, services and care, or even discussing abortion or criticizing unsafe abortion. It even prevents organizations from working on these issues at the request of their own governments.

The Gag Rule severely restricts freedom of speech; it interferes with the doctor-client relationship; and hinders balanced consideration of liberalizing abortion laws based on public health concerns and human

rights. Around the world this has had a dramatic impact on the ability of IPPF Member Associations, and many other organizations, which have rejected the Gag Rule, and consequently lost much of their funding, to provide full sexual and reproductive health services. The policy has restricted the freedom of speech and association of those organisations who are bound by its regulations. However, anti-abortion advocacy is allowed, underscoring the ideological nature of the Gag Rule.

The Gag Rule fails in its stated intent to reduce the global incidence of abortion. Rather, by dramatically impairing the delivery of sexual and reproductive health services, its actual impact has been to increase the number of unintended pregnancies and the abortions that inevitably follow.

“It has never been easy to fully quantify the impact of the Gag Rule. Its ramifications are insidious and have occurred over many years. It is impossible to track how many deaths have been associated with services that could have been provided in the absence of a Gag Rule, how many advocates were silenced from speaking out about a devastating public health issue, or how many organizations were prohibited from working with their governments and other Non-Governmental Organisations to meet the serious health care needs of their own communities.”

Planned Parenthood Federation of America, Report on Global Gag Rule 2003.

Country profile: Kenya

The need to access contraceptive services

IPPF is committed to a two-pronged approach to reducing, and eliminating, abortion-related maternal mortality. The first is to provide those services that reduce the need for abortion; where good contraceptive services are provided abortion rates decline. However, no matter how effectively contraceptive services are provided and used, unintended pregnancies will still occur.

IPPF's second goal is to make abortion legal and safe everywhere. The evidence is clear: only when women have the right to access safe abortion services do medical complications from unsafe abortion and maternal mortality become truly rare.

This approach is dramatically highlighted in Kenya. Between 1980 and 2000, driven by demand from couples to limit their family

size and the government's launch of a national family planning programme, Kenya saw a rapid decline in its birth rate, on average from eight children per woman to slightly over four. Yet maternal mortality hardly declined and abortion rates remained high (estimated at over 300,000 per year).

As abortion is severely restricted under Kenyan law, the only exception being to save the life of the mother, the vast majority of abortions are illegal and unsafe, accounting for some 30-50 per cent of national maternal mortality rates. The impact on the resources of Kenya's healthcare system is enormous, with as much as 60 per cent of the resources of Kenyatta National Hospital's maternity ward taken up by victims of unsafe abortions.

Unmet need for family planning throughout Kenya remains very

high, with 24 per cent of couples unable to access the services they desire, and family planning services have been reduced, largely due to the imposition of the Global Gag Rule. Yet the abortion rate remains high, indicating that Kenyan women continue to turn to abortion to manage their fertility.

Access to contraceptive services reduces the number of unplanned pregnancies and subsequently the number of abortions. Where there is an unmet need for family planning and contraception, as the Kenyan experience demonstrates, women resort to abortion to avoid childbearing. In countries where abortion is illegal or restricted, this means women put their lives and well-being at risk by resorting to unsafe abortion. Safe and legal abortion services must exist alongside effective family planning and reproductive health services to prevent deaths and tackle the health impact of unsafe abortion.

Kenya and the Global Gag Rule

IPPF's Member Association in Kenya, the Family Planning Association of Kenya (FPAK), provides a significant share of the country's contraceptive and reproductive health services. Faced with a choice between losing all its funding and technical aid from the US Agency for International Development and stopping all its work on safe abortion, FPAK chose to forfeit the aid to be free to advocate for the health and well-being of Kenyan women. The resulting loss of funding saw the closure of three FPAK clinics, the scaling back of services in its remaining clinics and the slashing of funding to outreach programmes. This has made it much harder for poor Kenyans to access family planning services and information, and must inevitably lead to more unwanted pregnancies and unsafe abortions.

The need to review abortion legislation

In early 2004, a number of Kenyan medical practitioners, accused of performing abortions, were put on trial for murder. In response the Kenyan Reproductive Health Steering Committee was established, comprising representatives from across Kenyan society, to defend the accused and to extend reproductive health and rights in Kenya.

Through the Steering Committee's work, a draft motion to liberalize the law on abortion will soon be tabled in the Kenyan parliament and a comprehensive national review of abortion is being undertaken. The mobilization of those who support improved access to safe abortion has led directly to the challenge to Kenya's abortion laws. Had those organizations, including FPAK, signed the Gag Rule this challenge could not have happened, even at the behest of their own government.

“Continuing unmet contraceptive need and contraceptive failure will invariably be associated with high rates of unplanned and unwanted pregnancies, forcing many women to resort to unsafe termination of pregnancy with a consequent unacceptably high rate of complications including infertility, long term morbidity and death.”

The Magnitude of Abortion complications in Kenya, RCOG International Journal of Obstetrics and Gynaecology

IPPF/Asociación Civil de Planificación

The Venezuelan Member Association and their volunteers are key players in the campaign to decriminalize abortion in Venezuela



Abortion law reform efforts in Venezuela

South America has long experienced the ravages of severe restrictions on abortion with some of the highest maternal mortality rates from unsafe abortion in the world. In Venezuela, abortion is legal only to save the life of a woman, and there are no exceptions for rape, incest or to preserve a woman's health. Additionally, the law prescribes up to two year's imprisonment for a woman who undergoes an abortion and up to 30 months' imprisonment for the provider.

On 1 December 2004, a proposal to decriminalize abortion was presented publicly before the National Assembly. For health professionals, weary of seeing women die from complications resulting from unsafe abortion, this was a momentous event. The bill represented the efforts of many women's organisations, universities, obstetrics and gynaecological societies, the Ministry of Health and reproductive health providers, including the IPPF Member Association in Venezuela,

Asociación Civil de Planificación Familiar. In a country where the Catholic Church exerts a powerful influence over society, the proposal for decriminalization is a first step in opening up a much needed public and legislative discussion on abortion.

The Asociación Civil de Planificación Familiar helped draft the proposals and presented the public health concerns of unsafe abortion to the Congressional Commission on Women, Family and Youth, which now supports the proposals. The Commission changed its position significantly once members heard the stories of women who needed access to safe abortion facilities, and saw first hand the impact of maternal mortality and morbidity. They recognized that criminalizing abortion was neither preventing it from taking place nor reducing the demand for it, but only making women suffer; they subsequently agreed that current legislation needed to be reformed.

29 Countries have liberalized their abortion laws despite the imposition of the Global Gag Rule in 1984

Albania - 1996
Algeria - 1985
Australia - 2002 (two States)
Belgium - 1990
Benin - 2003
Botswana - 1991
Bulgaria - 1990
Burkina Faso - 1996
Cambodia - 1997
Canada - 1988
Chad - 2002
Czech Republic - 1986
Ethiopia - 2004
France - 2001
Ghana - 1985
Guinea - 2000
Greece - 1986
Iran - 2005
Malaysia - 1989
Mali - 2002
Mexico - 2000 (two States)
Mongolia - 1989
Nepal - 2000
Pakistan - 1990
Romania - 1989
Slovakia - 1986
South Africa - 1996
Spain - 1985
Switzerland - 2002

Opposition to family planning undermines efforts to reduce unwanted pregnancy and unsafe abortion



IPPF/Chloe Hall
The free family planning services offered by the Member Association clinic in Nouakchott, Mauritania are fundamental to ensuring that women like Mimoona do not become another maternal mortality statistic.

The sexual and reproductive health and rights community faces increasingly hostile political opposition from the United States, the Vatican and other conservative governments and religious leaders. This has ensured that universal access to reproductive health services remains a distant hope for the majority of the world's poor. The direct result is that women and girls across the globe continue to bear the brunt of policies that fail to address the nature and scale of maternal mortality and unsafe abortion.

“Accessible, effective family planning services may avert up to 35% of maternal deaths”
Reducing Maternal Death: Evidence and Action, A Strategy for DfID, September 2004.

A study of 15 West African countries found that those with the highest contraceptive prevalence had the lowest maternal mortality rates, and vice versa.

Where access to comprehensive family planning services and information is available abortion levels have fallen:

The number of abortions in Armenia, Kazakhstan, Kyrgyz Republic, and Uzbekistan could be halved if women who do not use contraceptives or use traditional methods switched to modern contraceptives.

Bangladeshi women with good access to high quality family planning services have an abortion rate of 2.3 per 1000 compared with 6.8 for women without access. (Duff Gillespie, *The Lancet*, Vol. 363, January 2004).

Creating the platform for change: evidence-based interventions

The ideological debate surrounding abortion masks an unspoken truth: when faced with an unwanted pregnancy many women will seek an abortion regardless of its legality or safety. The deadly consequences of this are all too evident; women's lives are put at risk and all too often they die or suffer lifelong disability. The illegality and the stigma attached to abortion make evidence difficult to find. However, when research is undertaken and the facts are analyzed, the case for

liberalizing abortion laws and simultaneously increasing access to safe services is compelling.

Proof that criminalizing abortion does not reduce abortion rates, but instead endangers women's lives, can be seen across all global regions. In Latin America abortion is illegal or severely restricted in virtually every country, yet the abortion rate is one of the highest in the world, far exceeding that of Western Europe or North America.

Colombia, which prohibits abortion even to save a woman's life, averages one abortion per woman throughout her reproductive years. In Peru, this rises to an average of two abortions per woman. For poor women, unable to afford safe treatment, this means resorting to illegal unsafe abortion at the hands of unqualified people in unsanitary conditions.

Country profile: Uganda

The controversy surrounding when and how abortion should be legal in Uganda hides a vicious reality for women. Currently abortion is illegal with the exception of saving a woman's life, or to preserve her physical and mental health. However, additional administrative barriers exist as an abortion has to be performed by a registered physician, and the consent of two additional doctors is usually sought. Under the Ugandan penal code, performing an illegal abortion is punishable by up to seven years in prison for both the woman and the doctor, yet this has done little to reduce the level of unsafe illegal abortions.

Uganda is one of the world's poorest countries, with nearly 40 per cent of people living below the poverty line. DfID funded research released in 2005 has shown that one third of Ugandan women are denied contraception because they have no access to services. This supports evidence from the Family Planning Association of Uganda and builds a real and tangible argument to generate public

support and political commitment for legal reform of abortion laws.

The result of restricted access to family planning services is that the average Ugandan woman gives birth to seven children during her lifetime, two more than she would prefer. Many women break the law to end unwanted pregnancies in unsafe and unhygienic conditions. The greatest impact of this is felt by the poorest women in Ugandan society, especially those living in rural areas who are driven to using sharp instruments and herbs in a desperate attempt to end an unwanted pregnancy. Upwards of seventy-five per cent will suffer health complications, and unsafe abortion now accounts for one third of all maternal deaths in Uganda.

Such strong factual evidence cannot be ignored. There is already a groundswell of support for change. In September 2005, IPPF and the Family Planning Association of Uganda facilitated a fact-finding mission by some Norwegian Members of Parliament. The

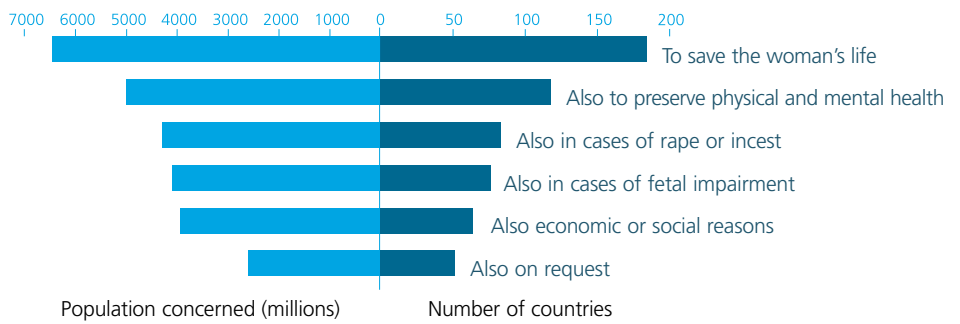
findings led the delegation to make a declaration that stressed the importance of increasing access to safe, legal abortion, particularly for poor, vulnerable and rural women. This declaration was publicly discussed with Ugandan Members of Parliament, Ministry of Health officials and the media which stimulated considerable public debate. This has led the Head of the Reproductive Health Programme to acknowledge publicly that legal abortion would reduce the maternal death rate. The Ministry of Health is planning to review the abortion law and is considering how the current abortion law can be better interpreted so as to prevent further unnecessary mortality and morbidity from unsafe abortion complications.

Using evidence to support the case for reducing rates of unwanted pregnancy through improved access to safe abortion, IPPF's Member Association has appealed to the Government for repeal of the current restrictive abortion laws on public health grounds – something that could not have happened had the Family Planning Association of Uganda signed the Global Gag Rule.

Worldwide abortion law: A public health concern

- Prior to 1950 safe abortion was illegal or severely restricted in virtually every country worldwide
- Growing concerns about the impact of unsafe abortion saw a rapid increase in the number of countries liberalizing or legalizing abortion, primarily in the developed world but also in other countries
- This trend slowed after 1984 when the Global Gag Rule was first introduced
- Between 1985 and 1997 another 19 countries eased abortion laws
- More recently, another 11 countries have liberalized their abortion laws
- At the same time five countries have tightened their laws
- 25 per cent of the world's population continue to live in countries where abortion is illegal or severely restricted
- In other countries, access to services and information is being severely restricted while abortion remains legal under certain conditions
- The interpretation and enforcement of national laws, and the attitude of the medical community towards abortion, critically affect access to services
- Studies have proven that legalizing or liberalizing abortion laws does not lead to an increase in the over all abortion rate

Grounds on which abortion is permitted around the world



The World Health Report 2005, WHO

Access to safe and legal abortion services

Ensuring adequate information about abortion and access to safe and affordable abortion services are as important as legalizing abortion; unless these things are concurrent, unsafe abortion will continue to devastate the lives of millions of women worldwide.

In countries where abortion is allowed, legal barriers can significantly delay access to safe services which can have negative consequences for a woman's well-being. Mandatory waiting periods, the need for spousal or guardian consent and the need to travel long distances to an authorized provider all act as impediments to accessing safe abortion.

This is equally true of affordability. High costs involved in acquiring a safe abortion affect poor women the most and can lead to women delaying an abortion until a later, more dangerous stage of pregnancy.

In India, despite 30 years of legal provision of abortion services, there continues to be a ratio of approximately 6:1 of illegal to legal abortions, contributing to over 15 per cent of the maternal death rate. This is largely due to lack of awareness of the legal status of abortion, a lack of access to safe, hygienic abortion services and a shortage of skilled medical personnel, especially in rural areas.

Country profile: Mongolia

Abortion is legal in Mongolia, although government policy does not always translate into concrete services to decrease unsafe abortion. The strict rules for service provision state that abortions must be carried out at a medical facility certified by the government. While this may ensure high quality services, the reality for women is that few legal options are available apart from the services at government hospitals. This situation serves to restrict access to services.

Long queues and bureaucratic procedures force many women to go to private uncertified clinics where abortions can be procured quickly, but there are higher fees and they operate illegally. Access, particularly in rural areas, remains poor. Because of this situation, IPPF's Member Association the Mongolian Family Welfare Association (MFWA) is advocating for an alternative system where simpler clinics could also provide safe legal abortion, with measures in place to ensure that health and safety standards remain high.

As a first step in this process, MFWA undertook a survey of over 1,700 people to find out more about public opinion and experiences around abortion. A cross-section of the public was interviewed, which revealed that most of the respondents had high awareness of abortion availability and eligibility. Residents in rural areas, where there are no private clinics or public hospitals within easy reach, supported plans to make abortion services more accessible, indicating that there was a significant demand for access to safe abortion services.

Country profile: Ethiopia

Gete (not her real name), a 22 year old Ethiopian woman, came into a Family Guidance Association clinic in Addis Ababa because she had been raped. She originally came from Gondor in the north but moved to Addis to find work, living with her aunt and uncle since 2004.

Gete was raped by a friend of her cousin. At the time abortion was illegal in Ethiopia other than in cases of rape and incest, and to access abortion services a woman needed to obtain a police report confirming rape (this law has recently been liberalised). The stigma surrounding rape and abortion is great and she was reluctant to go to the police, thinking they would not believe her. When she told her uncle she had been raped he threw her out.

When she found out she was pregnant Gete decided she wanted an abortion and, overcoming her fears, she went to the police. They sent her to the clinic to get confirmation, but because she was already four months pregnant clinic staff were unable to confirm whether she had been raped and were limited to providing counselling and confirming pregnancy for the police.

“If the woman does not receive the correct documentation from the police, the clinic will be unable to refer her for a safe abortion. In cases like this it is common for women to visit illegal abortionists.”

Sister Mekele, head nurse of the Addis Ababa model clinic.



IPPF/Chloe Hall
Gete preferred not to have her identity revealed in this photograph

Medical abortion: Saving lives in resource poor settings

Medical abortion, a combination of medications, is a safe and highly effective method for ending an unwanted pregnancy, and is increasingly the preferred method in many developed and some developing countries. At present it is largely unavailable to women living in the latter. Provided by trained personnel, complications are rare.

Using the antiprogestogen, mifepristone, in conjunction with a synthetic prostaglandin analogue, the effects of medical abortion are similar to those of spontaneous abortion. In countries where surgical abortion presents severe medical or financial difficulties for primary healthcare systems, medical abortion has proved to be effective and user friendly, and offers real hope of making safe abortion much more accessible to those women who need it most.

Medical abortion up to nine weeks' gestation requires two clinical visits to administer two separate drugs, but can also be administered at home which is increasingly the case for its second administration. Following administration of the prostaglandin on the second visit, 90 per cent of women will abort within 4-6 hours. The procedure has a 98 per cent efficacy rate. Beyond the nine week period there is a requirement for additional treatment, although never as invasive as surgical abortion, and it has a 97 per cent efficacy rate.

One of the major benefits of medical abortion in developing countries is that, for the vast majority of women, the procedure can be carried out on an outpatient basis, requiring far fewer medical resources.

Sarawati, a 37 year old health care worker from India said
“I wish this method [medical abortion] was available when I was young and had an unwanted pregnancy. I went to a Dai [traditional healer] because I did not want to have surgery done by the male doctor; I had pain and fever for many days. I never could get pregnant after that, and my husband left me.”

Medical abortion has been used for over a decade in many European countries. In some countries it now accounts for over 50 per cent of abortions undertaken (Sweden 51 per cent; France 56 per cent; Scotland 61 per cent).

HIV-positive women and their right to choose



IPPF/Chloe Hall
Itensesh is HIV positive and visits Youth Centres run by the Family Guidance Association of Ethiopia to talk to young people about what being positive means for their future reproductive health

Women of childbearing age living with HIV are as likely to have an unplanned pregnancy as those who are HIV negative, and are equally faced with the question of whether to have a child or not. However, in the case of the HIV positive woman, the issue is more complex, for personal, familial, social, cultural, religious and medical reasons.

Women living with HIV are often stigmatized for being HIV positive and, if pregnant, for irresponsibly being sexually active and becoming pregnant while HIV positive. Sometimes they are under pressure by family or health workers to have their pregnancy terminated, while in other cases they are pressured by partners and society to have children. Women living with HIV can also be demonized for seeking or having an abortion. In the absence of

access to comprehensive prevention of mother-to-child transmission programs, HIV positive women who give birth to HIV positive children are often blamed.

The right to have a family and decide whether and when to have children is a fundamental part of a woman's sexual and reproductive freedom. Yet, women living with HIV are frequently denied this right because society and service providers do not believe that HIV positive women should have children, or should even be sexually active.

This is a tragic picture, which paints HIV positive women as both culprits and victims, and implies a degree of coercion in the decision-making process. To date, few studies have explored how HIV positive women make childbearing

decisions. However, what emerges from current research is the lack of respect and value placed on HIV positive women's lives.

It is clear that provision of services needs to be based on the respect for the woman's sexual and reproductive rights and decisions, including, if needed, the right to safe and legal abortion. Making available safe abortion services is extremely important for HIV positive women as unsafe abortions become significantly less safe due to the greater risks HIV positive women face of suffering complications such as sepsis and haemorrhage.

No matter what their status women should have the right to decide for themselves whether or not to bear a child.

IPPF/Jenny Matthews

Although abortion in Nepal has been decriminalised and many women imprisoned for illegal abortion have been released, they are still aware of the potential stigma surrounding abortion

“That’s how so many women confront the problem: ALONE.”

Dr. Gladys Bazan – Gynaecologist, IPPF Member Association in Peru.



Country profile: Brazil

Every week at the Hospital das Clinicas in Sao Paulo, Brazil’s largest public hospital, women are rushed to the emergency room with severe vaginal bleeding.

Most are in their teens or early 20s and live in the dirt-poor slums that encircle South America’s biggest city. Some say they have no idea what caused the bleeding. Others tell elaborate stories of menstruation gone awry.

But hardly any own up to the truth; scared of being turned in to the authorities in a country where abortion is illegal, they are reluctant to admit they induced miscarriage by inserting a black-market ulcer medication into their vaginas.

Although abortion is outlawed in Brazil except in rare circumstances, the country has one of the highest abortion rates in the developing world. The Health Ministry estimates that 31 percent of all pregnancies end in abortion. That works out to about 1.4 million abortions a year, mostly clandestine.

In the United States, where abortion was legalized in 1973, about 25 per cent of all pregnancies end in abortion. In the Netherlands, a country with some of the world’s most liberal abortion laws, the ratio is closer to 10 per cent.

Despite its prevalence, abortion largely remains a taboo subject in Brazil, the world’s biggest Roman Catholic country. But that is now changing as civic groups and some medical professionals prompt a public debate on abortion by championing a woman’s right to end an unwanted pregnancy. They want to prevent women from dying from clandestine abortions.

Currently, abortion is only allowed in cases of rape or when the mother’s life is in danger. But even then, getting a judge to authorize the procedure can be difficult, and some doctors refuse to perform abortions on religious grounds.

Botched abortions are the fourth-leading cause of maternal deaths

in Brazil. In 2004, some 244,000 women were treated for complications from clandestine abortions in public hospitals, costing the government 35 million reais (£9 million).

Brazil’s abortion laws also highlight its gaping social inequalities. Well-to-do women resort to clandestine but safe clinics to end their pregnancies, paying as much as 1,500 reais (£400) - five times the monthly minimum wage - for an abortion.

Most poor women, by contrast, turn to an ulcer drug called misoprostol, better known by the brand name Cytotec. When inserted into the vagina Cytotec causes the uterus to contract, expelling the embryo or fetus.

Reuters news agency report, 10 January 2006

A future free from death and denial?

IPPF advocates for:
“A universal recognition of a woman’s right to choose and have access to safe abortion, and a reduction in the risk of unsafe abortion.”

IPPF Strategic Framework

When abortion is legal and services are both accessible and safe, the chance of a woman dying or being physically harmed from either surgical or medical abortion is negligible. Indeed, abortion is one of the safest medical procedures. It is a public health tragedy then that almost 200 women around the world continue to die each and every day due to complications from unsafe abortion, virtually all of them living in the developing world.

Women who are already facing a future of limited opportunities and social inequalities, who find themselves with an undesired pregnancy, must also encounter the often deadly risk of an abortion performed by someone without any medical training in unsanitary conditions, or by attempting to end an unwanted pregnancy themselves with traditional methods.

This report has sought to highlight some of the key issues related to abortion in countries where it is either illegal or severely restricted. Our hope is that one day women will no longer have to put their lives and health at risk from unsafe abortion; for this to be a reality abortion must be both legal and safe everywhere. It is IPPF’s belief that a woman’s right to choose whether to have an abortion should never be compromised by unwarranted intrusion from the law, or the very real risk of death due to the lack of minimal medical standards and skills.

It has been shown that by making family planning and reproductive health services available, the rate of unintended pregnancy drops significantly, thus decreasing the need for abortion.

However, even with the most efficient use of contraception unwanted pregnancies will still occur.

The most important message from this report for governments to understand is that by criminalizing abortion the issue does not go away; women will continue to seek abortions for all the reasons outlined in this document, and women will continue to die. We therefore need to make sure that if a woman chooses to have an abortion, it is both safe and legal.

This report has highlighted that we need to create the political will to:

1.Reduce unwanted pregnancies

- Build upon past gains in sexual and reproductive health
- Increase access to family planning
- Focus on the needs of poor and rural women and men
- Promote women’s status and rights

2.Make safe and legal abortion available to every woman who wants it

3.Address gender inequality

- Create the circumstances in which women are socially, politically and economically empowered

4.Ensure that post abortion care services to women who have incomplete abortions or medical complications following an abortion are included in both public and private health services

5.Eradicate unsafe abortion

- Increase access to safe and legal abortion
- Reduce legal and social barriers to safe abortion

6.Hold governments in both developed and developing countries accountable for progress

- Document the impact of unsafe abortion on women, families and society
- Educate the public about the consequences, the costs and the social injustice of unsafe abortion

7.Tackle the stigma and discrimination attached to abortion and promote the open and frank discussion of abortion and its impact on women

The commitment of the Department for International Development means that the United Kingdom continues to promote a global approach to legalizing abortion based on public health evidence. IPPF strongly supports this approach and will continue to work with the Government of the United Kingdom, as well as other donors, to spearhead this undertaking.

Without the hard work of so many of our Member Associations who have refused funding from the United States due to their belief in safe, legal abortion, and who continue to confront policy makers around the world, the future for women in many countries would remain unchanged.

There is a gradual shift in the abortion paradigm and a movement towards liberalizing abortion laws. This report should help to keep up this momentum. By providing real evidence demonstrating the public health impact of unsafe abortion, particularly its links to social inequality and poverty, we can hope to persuade governments to make abortion both legal and safe. We must continue to make the arguments for a woman’s right to choose whether to have an abortion and to ensure that, if she does, she is not putting her life or health in jeopardy. Only then can we look towards a brighter future where women no longer face the risk of death and denial.

Who we are

The International Planned Parenthood Federation (IPPF) is the strongest global voice safeguarding sexual and reproductive health and rights for people everywhere. Today, as these important choices and freedoms are seriously threatened, we are needed now more than ever.

What we do

IPPF is both a provider and an advocate of sexual and reproductive health and rights. Our voluntary, non-governmental organization has a worldwide network of 151 Member Associations in 183 countries.

Our vision

We see a world where women and men everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they'll have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV.

We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

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