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PRECONGRESS WORKSHOP

Addressing barriers to safe abortion

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ABSTRACT

The latest World Health Organization data estimate that the total number of unsafe abortions globally has increased to 21.6 million in 2008. There is increasing recognition by the international community of the importance of the contribution of unsafe abortion to maternal mortality. However, the barriers to delivery of safe abortion services are many. In 68 countries, home to 26% of the world's population, abortion is prohibited altogether or only permitted to save a woman's life. Even in countries with more liberal abortion legal frameworks, additional social, economic, and health systems barriers and the stigma surrounding abortion prevent adequate access to safe abortion services and postabortion care. While much has been achieved to reduce the barriers to comprehensive abortion care, much remains to be done. Only through the concerted action of public, private, and civil society partners can we ensure that women have access to services that are safe, affordable, confidential, and stigma free.
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1. Introduction

While the latest World Health Organization (WHO) data [1] estimate that the number of deaths from unsafe abortion has decreased from 56 000 per year in 2003 to 47 000 per year in 2008, the total number of unsafe abortions globally has increased. In 2008, it is estimated that 21.6 million unsafe abortions took place, 98% of which were in low-resource countries. The decrease in mortality from unsafe abortion without a corresponding decrease in the number of unsafe abortions is likely due to several factors. First, there has been a concerted effort by many organizations to improve access to quality postabortion care, including treatment of postabortion complications. Second, the rise in clandestine use of misoprostol, particularly in Latin America and the Caribbean, may be replacing other less-safe methods of "unsafe abortion." In fact, the definition of unsafe abortion in the context of medical abortion is complex, as many women are able to safely terminate their pregnancies using misoprostol, often with little or no medical supervision. Therefore, it may be that some procedures that are classified as unsafe (clandestine use of misoprostol), might in fact be safer than surgical procedures in those same countries, particularly in restrictive settings [2]. However, it must still be considered that even if women are able to safely self-induce their abortions with misoprostol, they will likely be hesitant to seek emergency medical services in the event of complications, particularly in countries with restrictive laws. And even if they were to seek emergency services, they may not receive timely or high-quality postabortion care services in these settings.

There is increasing recognition by the international community of the importance of the contribution of unsafe abortion to maternal mortality and that efforts to combat maternal mortality in the final years of work to achieve the Millennium Development Goals (MDGs) must address this issue. The UN Secretary General's Strategy for Women and Children explicitly includes safe abortion services as one of the interventions to address maternal mortality (though with the caveat "where not prohibited by law") [3]. Beyond mortality and the public health impact of unsafe abortion, there have been several high profile instances of acknowledgment of the human rights abuses created through a lack of action to improve access to safe abortion services globally. In October 2011, a landmark report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was submitted to the UN General Assembly by Anand Grover, the UN Special Rapporteur on the Right to Health, which included specific reference to the issue of abortion as a human rights issue, as follows: "Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health" [4]. Unfortunately, some of the world's major donors in reproductive health still do not allow their funding to be used for safe abortion services, which can often cause difficulty in ensuring that safe abortion services are integrated into a comprehensive package of sexual and reproductive health interventions.

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2. Barriers to safe abortion services

The barriers to delivery of safe abortion services are many. Approximately 40% of the world's population lives in countries where abortion is permitted regardless of reason, though usually with gestational or other restrictions such as mandatory counseling or waiting periods [5]. In contrast, in 68 countries, home to 26% of the world's population, abortion is prohibited altogether or only permitted to save a woman's life. With very few exceptions, the countries in this category are low-resource countries, many of which inherited their restrictive laws on abortion from former colonial powers that have all since liberalized their own abortion laws. In these countries, as well as the 58 countries that allow abortion to protect the physical or mental health of the woman, indications that would technically allow for a legal safe abortion (including in many cases rape or incest) are often unknown by providers or women or essentially meaningless in the face of no trained providers or facilities able to provide safe abortion services. Even in countries with more liberal abortion legal frameworks, additional social, economic, and health systems barriers prevent adequate access to safe abortion services and postabortion care.

2.1. Legal barriers

It has been well demonstrated that abortion rates are not related to the legal status of abortion [1]. In fact, the lowest abortion rates in the world are in regions with some of the most liberal legal frameworks for the provision of abortion services (Western and Northern Europe). What does vary by legal status is the number of unsafe abortions. In countries with restrictive laws regarding the provision of abortion services, while these laws do not lead to fewer abortions, nearly all of the abortions performed in those countries are unsafe. Even in a country with continued difficult access to safe abortion services, such as South Africa, abortion-related maternal mortality was shown to decrease by 90% just 2 years after legalization of abortion in 1996 [6]. Similar decreases in mortality have been seen after legal reform combined with efforts to increase access to safe abortion services in other countries [7].

Advocates and public health officials working to decrease abortion-related mortality may strategically choose to work within existing legal frameworks in programs known as “risk reduction” or “harm reduction.” One of the most well documented of these efforts was started in Uruguay by a team of obstetrician-gynecologists who founded the program, *Iniciativas Sanitarias contra el Aborto Provocado en Condiciones de Riesgo* [8]. This initiative was later endorsed by the National Ministry of Health and is implemented in all public sector facilities. The basis of the model is the “before abortion” and “after abortion” visits in which women are provided with evidence-based information about the risks of different methods of illegal abortion, including misoprostol as a safer option. Women are then asked to return after self-administration of misoprostol for confirmation of complete abortion, assessment for any complications, and initiation of postabortion contraception. The “harm reduction” model is now implemented by nongovernmental organizations including International Planned Parenthood Federation (IPPF) Member Associations in several other countries in Latin America. The Dutch nonprofit organization “Women on Waves” initiated the Safe Abortion Hotline in multiple countries in Latin America and Asia with restrictive abortion laws, and the website “Women on Web” provides online consultations to women seeking abortion services from countries with restrictive abortion laws and sends medications through the mail for women to self-induce their abortion at home [9]. While lauded for their progress toward ensuring women have access to accurate information, human rights advocates stress that such efforts, if they do not work alongside parallel efforts to improve restrictive legislation, are only addressing the public health concerns of unsafe abortion without addressing the human rights abuses of criminal abortion laws that violate a woman's right to self-determination and personal integrity [10].

2.2. Access to services

The reality is that even in countries where legal frameworks permit provision of safe abortion services, access to these services is limited by many factors. There are problems in general with nonfunctioning health systems and logistical barriers in many countries that hinder access, such as lack of trained healthcare providers, lack of services in rural areas, lack of transportation, and inadequate supplies of commodities and medications at the service delivery sites. In addition, access to safe abortion services is hindered by lack of knowledge by women of the availability of these services and lack of knowledge by providers, program managers, and policy makers of the conditions under which abortion services can be legally provided. There may also be a lack of trained health providers willing to provide abortion services, particularly in the public sector, based on a reported “conscientious objection,” which may be more accurately described as conscientious refusal of care.

Poor women suffer complications from unsafe abortion disproportionately compared with women who are not poor [11]. The causes for this are likely multifactorial. Owing to high costs charged by private abortion providers, particularly in countries with restrictive legal settings, only rich women may be able to access a safe abortion service. In addition, poor women are far less likely to receive the care they need should they have complications following an attempt to self-induce abortion or abortion provided by an unskilled or traditional provider. Abortion services are unlikely in most countries, even those with liberal legal frameworks, to be covered by national health insurance schemes. In many countries, even contraceptive services are not covered, the costs of which may be one reason why poor women are also more likely to have an unmet need for contraception leading to more unwanted pregnancies [12].

Unnecessary administrative barriers such as requiring spousal or parental consent, signatures from multiple doctors, waiting periods, and strict non-evidence-based requirements as to the type of facility or provider who can provide services (such as limiting services to only be provided by gynecologists or in hospitals) also reduce access to safe abortion services, even when services are otherwise allowed by law. These barriers might be officially in laws or regulations or may unofficially be enforced by individual providers or facilities.

Concerns about quality of services, particularly in government healthcare facilities, may lead women to avoid facilities with trained providers and instead seek services in their communities from traditional healers. For example, in India, where abortion is permitted for a wide range of indications, including socioeconomic reasons, government facilities designated for provision of abortion services in many cases operate under conditions of poor hygiene, with shortages of medications, equipment, and inconsistent electricity supply [12]. A perceived lack of privacy and confidentiality in public facilities may also lead women to seek services from private providers. Private providers who are adequately trained to provide abortion services will likely charge high fees, leaving poor women with concerns about quality of services in public facilities to seek services from private, untrained providers. The issues of privacy and confidentiality are even more important for young people, whose sexuality is even more stigmatized in many countries than that of adult women.

2.3. Stigma

Abortion stigma is a complex issue that complicates initiatives aimed at improving access to safe abortion services. The obstacles to delivery of safe abortion services are worsened by the impact of abortion stigma and associated secrecy, shame, guilt, and fear. Stigma prevents or delays access to safe abortion as well as making lawmakers

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