RESPECT CHOICE

Safe Abortion a Prerequisite for Safe Motherhood

The International Conference on Population and Development (ICPD) was held in Cairo from 5 to 13 September 1994. The Conference was convened under the auspices of the United Nations and was organized by a secretariat composed of the Population Division of the UN Department for Economic and Social Information and Policy

ICPD – the Foundation for the Millennium Development Goals

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RFSU

The Swedish Association for Sexuality Education (RFSU) is a politically and religiously independent non-governmental organization, promoting an unprejudiced, tolerant and open approach to sexuality and personal relationships. We are striving for an open, equal society, where people are not sexually exploited or discriminated against, but instead where sexuality is a source of pleasure and joy. RFSU comprises experts, individual members, local associations and member organizations. It also runs a clinic focusing on sexual medicine, sexual counselling/psychotherapy and supervision. RFSU is a member of the International Planned Parenthood Federation (IPPF).

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Contents

Time to move the safe abortion agenda forward

Every year around 20 million unsafe abortions are carried out, and around 70,000 women die each year because of this. The Programme of Action (PoA), adopted by 179 countries at the International Conference on Development and Population (ICPD) in Cairo states that where abortion is legal it should be safe. And, at the ICPD+5, governments agreed that health systems should train and equip healthcare providers to ensure that legal abortions are both accessible and safe.

Since Cairo, service delivery organizations and advocacy groups have strived to move the safe abortion agenda forward. Post abortion care (PAC) has become widely recognized as a means of saving the lives of women who have undergone an unsafe abortion. Advocates in many countries have raised their voices to challenge repressive legislation, norms and values related to the issues of women's sexuality and fertility. Despite the impact of the global Gag Rule non-governmental organizations have kept on working for the health and lives of women. And some governments like Nepal´s have decided to grant women access to safe abortion services.

But the issue of safe abortion still remains in the shadows, and women who become pregnant unintentionally often carry a heavy burden of guilt and shame due to the stigma related to abortion. Many desperate women carry out an abortion themselves, and many seek help illegally. Illegal abortion services are often provided in unsafe and unhygienic environments, and associated with severe risks.

The majority of unwanted pregnancies could be prevented if women had access to contraceptive services and the power to negotiate condom use with their partners. Gender inequalities contribute to the high rate of unwanted pregnancies. The responsibilities of men who have sex with women have to be addressed, and men have to be aware of their obligations with regard to sexual and reproductive health. Men can never impose a decision on women regarding whether or not to terminate a pregnancy, but they have an important role to play in protecting women from unintended pregnancies.

Access to safe abortion is a rights issue. That a

woman has command over decisions regarding her sexuality, fertility and general health must be seen as a human right. The right to health is a universally recognized human right to which all people are entitled. Accordingly, the protection of women's health is one of the rationales for advocating that safe abortion becomes an accessible, comprehensive reproductive healthcare service for all women – including young women and those who are HIV-positive.

It is estimated that 13 per cent of maternal deaths world-wide are due to unsafe abortion, and mortality related to unsafe abortion in some African countries is as high as 40 per cent. In only too many countries young women are the victims of self-induced abortions. Safe abortion is a prerequisite for the achievement of Millennium Development Goal 5 – that of improving maternal health, including a reduction in maternal mortality.

In order to meet the challenges ahead, grassroots organizations have an important role to play in influencing legal reforms and reshaping social values for the purpose of ensuring broad-based respect of abortion laws. Young people and their organizations must become, and be regarded as, equal players in the process of attitude change needed in society at large to prevent unsafe abortions and to secure the right to safe abortion.

The prevailing moral values regarding women's sexuality and fertility must be defined in terms of the UN declarations, conventions and programmes of actions that the global community has pledged to follow. One can only hope that yet more political leaders will recognize the significance of safe abortion in conjunction with the agreements. In marking ICPD at 10, governments and NGOs must join forces in the fight for all women to have the right freely to access safe abortion services.

Ann Svensén
Director of External Relations,
Swedish Association for Sexuality Education (RFSU)

Moralistic attitude makes women suffer

Despite thousands of Kenyan women dying as the result of unsafe abortion every year, a liberalization of the law is far from certain. But many women rights groups are trying to make a difference. ''We cannot continue to sit on the fence while woman and young girls die from a problem that can be prevented,'' says Dr Eunice Brookman-Amissah at Ipas Africa Alliance for Women´s Reproductive Health and Rights.

On May 26, 2004, residents of an estate in Kenya's capital, Nairobi, woke up to find 15 aborted foetuses wrapped in polythene bags and dumped beneath a bridge on the Ngong River.

Alongside the foetuses were documents implicating one Dr John Nyamu, a prominent private gynaecologist operating two reproductive health clinics in Nairobi. Dr Nyamu was promptly arrested, even though he denied involvement in the affair, and his case is still pending.

The ghastly scene sent shockwaves throughout the country, and opened a new, contentious debate on the abortion issue.

Pro-choice activists immediately seized the opportunity and started calling for a review of the abortion laws, blaming the existing legal framework for having encouraged back-street abortion to skyrocketing proportions, and contributing to a high maternal mortality rate.

Unsafe abortions behind maternal mortality

According to statistics from the Kenya Medical and Education Trust (KMET), a grassroots medical organization, Kenya has a maternal mortality rate of 1,000 per 100,000 live births. In comparison, 2002 data from the Population Reference Bureau indicates that the country has a maternal mortality rate of 1,300 per 100,000 live births. These figures appear to ridicule those of the latest (2003) Demographic Health Survey by the government, which put maternal deaths at 590 out of 100,000 live births.

Why is it so difficult for women to get access to their human rights? Unsafe abortion is killing thousands of women every year. Most maternal deaths in Kenya emanate from unsafe abortion. It is estimated that 300,000 abortions are carried out in the country every year, resulting in 20,000 women and girls being hospitalized annually for related complications.

Most of the maternal deaths, according to independent reproductive health rights bodies, emanate from unsafe abortion. And, according to a recent report, an estimated 300,000 abortions are carried out in the country every year, resulting in 20,000 women and girls being hospitalized annually for related complications. This translates into 800 abortions daily.[1]

Abortion, currently an emotive issue in Kenya, is prohibited by law in the country. It is only allowed in situations where the mother's life is in danger. This provision is found in Section 240 of the Penal Code (CAP 63 of the laws of Kenya), which states: "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his/her benefit, upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable having regard to the patient's state at the time and to all the circumstances of the case."

Untold suffering

Pro-choice activists say this legislation, which does not allow abortion out of choice, is the reason many women have resorted to having back-street abortions. More often than not, such abortions are performed by untrained persons, who use all manner of crude procedures. The outcomes usually plunge the women into untold suffering. It is at this stage that they seek hospital treatment to rectify the damage done.

Melanie Achieng (not her real name) is a case in point. Lying on a bed in the corner of Ward 1B, a post-abortion care unit at Kenyatta Hospital, the largest referral hospital in Kenya, she was hesitant to agree to this interview, and more so accept that she was a victim of an unsafe abortion. But upon persuasion, she opened up. The date was June 22, 2004.

She struggled to say, "I'm dying. I feel like my stomach is coming out." As she rolled on the bed in a bid to control the pain, the 23-year-old Achieng narrated her story: "I recently went to a doctor in a private clinic not so far from where I live. As I waited to see him, I relaxed by reading literature on reproductive health neatly laid out in reception. Upon being informed of the presence of a client, a man in a white coat came to receive me and led me into his office. I told him of my predicament and asked him if he could solve it."

"After some hesitation, he obliged. He asked me how far gone the pregnancy was, and I said two months. He then asked me to follow him to some dingy room at the back of his clinic. Sensing that I was nervous, he smiled and urged me to relax, saying that the procedure was simple and would take just 10 minutes. 'How simple?' I asked myself."

"Nevertheless, I changed into some tattered green gown he gave me, and climbed onto the adjacent bed with old stained sheets. He then took out a torch, shone it in the direction of my vagina before pulling out what I am convinced was a curved coat-hanger. To my horror, he inserted it inside me as I watched. I have never

1 Kenya Medical Association, the Kenya Chapter of the Federation of Women Lawyers, Ministry of Health and the International Projects Assistance Services, *A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya*, Nairobi, May 2004.

felt such pain before, but I endured it because I had no other option.

"Even though I did not want to do this, I did not have a choice because my boyfriend disappeared when I told him that I was pregnant. Since I am only a freelance house-help, I struggle to make ends meet. I did not want to burden my parents who are also struggling to get by. I was convinced that terminating the pregnancy was the only way out.

"I paid 1,200 Kenyan shillings (about USD 15) for it, and because I was in so much pain, I was given some paracetamol and told to rest on a hard bench. For about two hours, I endured the pain. But I noticed that when I tried to stand, litres of blood containing massive pieces of flesh oozed from my private parts. I did not find relief and had to come here for proper medication."

At this juncture of the interview, Achieng was wheeled out for a menstrual regulation (cleaning of the uterus in post-abortion care). Achieng's case is representative of the 300 women who visit the hospital every month with abortion-related complications. According to Dr Peter Gichangi, Head of Obstetrics and Gynaecology at the hospital, and Senior Lecturer at the University of Nairobi's School of Medicine, an average of 10 patients a day receive treatment for abortion-related complications.

To much to bear

Lena Kiilu's (not her real name) abortion story is not much different. She had an abortion seven years ago, and now cannot conceive because she no longer has a uterus.

"I was introduced to a doctor in 1997 by my friend. I was four months pregnant at that time. I had to get it done because I did not want to shame my parents who had sacrificed so much to see me through to university. So I borrowed 2,000 shillings (about USD 25) and paid a doctor, who ended up rupturing my uterus in the process of removing the foetus.

"It was really painful because I was not put under any anaesthetic. I saw everything, all kinds of tools, of different shapes and sizes, being inserted into my vagina. I could feel the way the doctor stirred my uterus with force, grappling about to remove the mass inside. I screamed in pain. It was too much to bear.

"My continuous shouts for him to stop fell on deaf ears. Then finally he inserted his gloved arm inside me, pulled out with force a bloody tattered mass, which he threw in a bucket placed strategically at the end of the bed."

Not only in the back streets

The damage that Kiilu experienced later necessitated the complete removal of her uterus. Now Kiilu is depressed. According to her, her husband is becoming impatient with her for not conceiving a baby, and wants to marry a second wife. She has been afraid to tell her husband the reason.

Contrary to belief, abortion is not only carried out in the back streets, but is also widespread in established private medical institutions in Kenya. According to Dr Gichangi, services in such hospitals are quite costly but are more professionally performed.

He notes that abortion services in these facilities are performed by highly trained gynaecologists, whose charges are high because of the quality of service.

The costs of one abortion in these institutions can

be as high as KES 50,000 (about USD 630) or more. The doctor's fee alone would be KES 15,000 (about USD 190). The procedure, in these places, is nevertheless said to be safe.

This revelation means that abortion is conducted underground in Kenya across the board — from institutions run by quack doctors to those managed by professionals, the two being separated by style and cost.

According to Dr Gichangi, "the fee depends on who is performing the procedure, and where it is being done. It can be as low as 500 shillings (about USD 6.3) if done by untrained personnel in the back streets."

A Nairobi-based doctor, who does not wish to be named, notes that abortion is safe during the first 12 weeks of pregnancy, and the procedure should be done within that time-frame if necessary. This also conforms to World Health Organization (WHO) standards.

Lunch-hour abortions

The doctor, a middle-aged gynaecologist who once in a while offers this service at his private clinic, states that "abortion of a 12-week foetus is a 30-minute affair – 15 minutes procedure and 15 minutes rest. Women can walk in during their lunch break and still go back to their offices in the afternoon in one piece. It is painless because it is administered under a local anaesthetic."

The most common method used by such professional medical practitioners is Manual Vacuum Aspiration (MVA), which uses suction pressure to suck the contents out of the uterus.

The doctor confesses that he now performs abortion, albeit low-key. After having declined several requests, he realized that those he advised against the procedure would still do it elsewhere and then have to come back to him for post-abortion care when things went wrong. "The woman or girl would walk away and go elsewhere to induce abortion. Then she would come back later with severe complications and tell me, 'You refused to help me, now fix this mess'," explains the doctor.

According to him, women he attends to are often taken to the clinics by their spouses. "Most of the time, the women are pressured into undergoing abortion. They sometimes may not be willing to terminate the pregnancy, but are forced to do it by their husbands or boyfriends."

Students perform the procedure themselves

The abortion situation in Kenya is so bad that in colleges, girls often perform the procedure themselves. As a college student in 1994, I once witnessed a grisly scene of an abortion being performed by one student on another. On the evening in question, we (my roommate and I) heard screams emanating from the second floor of our hostel at around 8.00 pm. We followed the sound and it led us to a room, which had been locked from the inside. A curious crowd was beginning to gather. After persistent unanswered calls, the group forced the door open.

We were shocked. The macabre picture of a fellow student lying on a blood-soaked bed with her legs wide apart greeted us. Her face contorted, she was clearly in pain, large drops of sweat streaming down her cheeks as she tried to battle possible death.

While some students became hysterical at the sight and took off, some of us remained and tried to inquire what the mess was all about. It soon became clear to us

Happy people celebrating in 2002 after Mwai Kibaki was declared Kenya's president. Unfortunately he has not made any changes regarding the country's abortion law, women are still dying from unsafe abortion.

that her roommate was attempting to carry out an abortion on her, using an iron rod and a hanger that were lying on the side of the bed.

Apparently, the procedure had become too complicated for the self-proclaimed abortion expert, who was now obviously worried. As she pleaded with us to bear with her and not to report their 'mission', she threw her naked arm inside her 'patient' and eventually pulled out the damaged foetus. The 'patient' lost consciousness. She was later rushed to hospital, and only managed to return to college three weeks later.

In Dr Gichangi's view, abortion is quite widespread in Kenya, accompanied often by grave complications such as serious reproductive tract injuries, injuries to the bladder, urethra, rectum and intestines. These can have long-term effects such as infertility, blockage of the fallopian tubes and chronic pelvic inflammatory diseases, which might cause ectopic pregnancies.

Critics contend that these are serious complaints afflicting scores of girls and women from poor backgrounds,

who die in shady health facilities trying to terminate pregnancies illegally. The critics opine that this scenario warrants serious calls for interventions to change the trend, in other words a review of the country's abortion laws. They maintain that as long as the legislation remains restrictive, women and girls will continue to bear the brunt of unsafe abortions.

In an interview in May 2004, Dr. Eunice Brookman-Amissah, former Minister of Health of Ghana, now Director of the Ipas Africa Alliance for Women´s Reproductive Health and Rights, underlined: "We cannot continue to sit on the fence while women and young girls die from a problem that can be prevented. Despite the restrictive law in Kenya, unsafe abortion will continue to happen unless we take steps to address the problem."

Health minister supports change

Her remark has been backed by a section of women parliamentarians in Kenya, among them Health Minister Charity Ngilu, who last year called on the government to spearhead a public debate on abortion. She was concerned that women did not have a say when it came to matters concerning their reproductive health.

"I personally feel that continuing to deny women free choice regarding their reproductive health life is wrong, and the policy should be reformed to allow that freedom," she said in late 2003.

The Kenya Chapter of the Federation of Women Lawyers has also thrown its weight behind proposals calling for the government to review abortion laws. "It is important that we start lobbying the government to enact laws that facilitate women's reproductive health rights. When we have 300,000 women dying annually in the country from abortion, then we have a serious problem," the organization's chairperson, Joyce Majiwa, noted.

However, there has been opposition on this issue. A poll conducted by Steadman Research Services in March 2003 revealed that 81 per cent of Kenyans were opposed to legalizing abortion.

This opposition includes the anti-choice movement, which has been in the forefront of fighting any attempts to amend the abortion law. Last year, the Christian Medical Fellowship of Kenya organized a silent procession to contest a clause in a draft constitution, which in their interpretation suggested the legalization of abortion.

Chapter Six, Part 2, Section 61 of Kenya's draft constitution states.[2] "Every person has the right to health, which includes the right to healthcare services, including reproductive healthcare."

Strong crusade against abortion

In an interview, Dr. Jean Kaggia, director of the institution and chairperson of Protecting Life Movement of Kenya (a anti-choice movement) said: "We want the words 'reproductive healthcare' struck out of the draft

2 *The Draft Constitution of Kenya 2004:* Adopted by the National Constitutional Conference on March 15, 2004. The draft document is yet to be ratified by Parliament.

constitution because apart from family planning and management of infertility, they also imply access to abortion services. We do not want to have a pro-abortion constitution, and that is why we are raising our voices now."

She says the draft constitution states clearly that even the unborn baby has the right to life and that this should be respected.

The religious community is against any amendment of the abortion legislation in a way that may allow the practice out of choice. All along, Christian and Muslim communities have loudly maintained their opposition to the idea of legalizing abortion, saying there are other ways of dealing with unwanted pregnancies. Such include carrying the pregnancy to term and giving the child up for adoption.

The anti-choice movement is a great supporter of the global so-called Gag Rule, which saw, among others, the Family Planning Association of Kenya and Marie-Stopes International-Kenya lose about USD 1 million in support for family planning activities.

The organizations, which were reportedly offering abortion services, went on the defensive saying they only offered post-abortion care, which is also available in virtually all public health institutions.

The Gag Rule, which was reinstated by U.S. President George Bush upon his election in 2001, seeks to ensure that American taxpayers' money is not used to facilitate abortion in other countries, nor to promote the institution of pro-abortion laws.

Going by the prevailing mood in the country, the rule silently enjoys the support of the majority population that is against the legalization of abortion. Calls for liberalization are likely to subside in Kenya, a highly religious society in which religious institutions fight a strong crusade against the practice.

In addition, the two successive polls conducted by Steadman Research Services (2003 and 2004) confirm that people increasingly do not support abortion, a fact that heightens the probability of the status quo being maintained.

Joyce Mulama
Freelance journalist based in Nairobi, Kenya

Break the silence

Rashida Abdullah, Executive Director at ARROW on why we need to report the deaths of women dying from unsafe abortions

Increasing access to safe legal abortion is the most neglected reproductive health need and right of women. It is also the most contentious, which is why it has received so little attention in many countries. Typically seen more as a moral and ideological issue than a public health and human rights issue, the unwillingness to talk about it openly and address it practically continues to prevail.

Deaths from abortion are preventable. Safe medical technology has existed for the last 20 years. Despite this, unsafe abortion continues to be a major cause of women's mortality and morbidity in many developing countries. Most countries however, do not report the number of unsafe abortions or the number of women dying. Deaths from unsafe abortion are subsumed under maternal mortality data. Only the maternal mortality ratio is reported, not the actual number and causes of maternal deaths.

A critical first step to being open about unsafe abortion is to document and publicize the number of unsafe abortions and the resulting deaths. According to WHO, most of the 19 million unsafe abortions each year occur in developing countries. Just over half of these or 10.5 million are in Asia, compared to 4.2 million in Africa and 3.7 million in Latin America. Young women aged 15-19 account for at least a quarter of these abortions. Poor women, who cannot afford a safe abortion, are also disproportionately represented.

Studies have shown that women seek abortions generally when their contraceptive method has failed, or they have not used contraceptives in a moment of unplanned passion. They also decide on an abortion if their social and economic circumstances will not enable them to be a good parent. For young women, the reasons also include plans to study and work. Women who have been raped, experienced incest, or coerced sexually and become pregnant also seek abortions. Women thus do not plan in advance to have an abortion.

The decision to take charge of their fertility, although difficult, is one that many women are comfortable with and able to reconcile with their beliefs about parenthood, religion and their own well-being. Despite this families want to be in control of their fertility, bodies

and lives, many countries deny safe abortion, by restrictive laws or by not providing access to safe unbiased services.

Liberal laws are essential for abortions to be safely carried out, and to show public acceptance of abortion and the responsibility of the health sector to provide safe services. Deaths from abortion tend to be highest in countries where laws are very restrictive, as in Sri Lanka and the Philippines.

Although progress at policy level in Asia is encouraging, implementation of many of the laws has been very problematic. In India, abortion was legalized in 1972, to be provided for any health or socio-economic reason, yet 17,500 women still die annually from unsafe abortion.

Negative attitudes of providers and poverty are obstacles to women accessing post-abortion services for incomplete abortions. A number of studies have shown that women are often treated very rudely and disrespectfully by moralistic and judgmental nurses and doctors.

The Programme of Action (PoA) adopted at the International Conference on Population and Development (ICPD) agreed "…to reduce the recourse to abortion through expanded and improved family planning services" (ICPD, PoA, 8.25). Good access to high quality, affordable and appropriate family planning services is very important. Nevertheless, it is also known that there are always unwanted pregnancies when using contraception due to method failure or incorrect use.

According to a study in Asia, only the Chinese government report stated that progress was achieved in improving the quality of family planning services. An indicator of improved quality was significant change in contraceptive methods chosen, and a decline in sterilizations. In the other countries, contraceptive use is still low while use has increased since Cairo in Cambodia, Nepal and Pakistan. In general, there remains a large unmet need expressed by women for contraceptives.

In order to advance women's right to abortion, we need to sharpen our advocacy strategies. This means making unsafe abortion an issue of its own, not only related to reduction of maternal mortality and safe motherhood goals. The right of young unmarried women who are not yet mothers will thus be included. It is an urgent public health concern for preventing women's deaths and a human rights issue, which contravenes the right to life, the right to health and the right to access necessary health services.

We need to highlight women's experiences and reality through research and in the media to improve public awareness and opinion. Women who have tried unsuccessfully to access abortion need to speak out publicly, together with families of women who have died due to unsafe abortion. Telling these real and tragic stories publicly was a significant part of abortion advocacy in Nepal. And policy-makers and service providers need to be more open to understanding women's needs and empathize with them, especially poor, single and young women. We can change this but there is no time to lose. Women are dying from unsafe abortions as you read this.

Rashida Abdullah
Asian Pacific Resource and Research Centre for Women (ARROW)

Political arguments

Access to safe abortion is quite simply a human right. Such a statement is like a red rag to a bull for many anti-choice people. Within the EU, abortion is seen only as a health issue and is hence a matter for each individual member state on the national level. As a result, pro-choise countries cannot exert any political influence on the abortion laws of other member states.

But the rights perspective is important when arguing for women throughout the world to be allowed access to safe abortion. Governments that cite religious and moral arguments not only threaten women's health but also discriminate against them on grounds of gender. The arguments are on our side. Here are some of them.

It's simply a human right

Out of a total of 200 million pregnancies occurring each year, an estimated 75 million are unwanted.[1] When a pregnancy is unwanted, it can take a heavy toll on a woman's physical and emotional well-being. The right to health is safeguarded under principle 8 of Programme of Action (PoA) of the International Conference on Population and Development (ICPD) as well as in many international treaties. During the ICPD, countries acknowledged that reproductive rights embrace certain human rights already recognized in national laws, international human rights documents and other consensus documents. This acknowledgment was put in writing in paragraph 7.3 of the PoA. A woman's right to freely decide over her reproduction and sexuality is safeguarded through many human rights. Among these are:

The right for all couples and individuals to decide the number, spacing and timing of their children. This right

1 UNFPA, *The State of World Population 1997*, New York, 1997.

can be found in article 16.1 (e) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979. For women who live in settings in which family planning services and information are unavailable, access to safe abortion services may be the only means of controlling their family size. Governments should therefore ensure that women have access to information and all safe, effective means of controlling their family size, including abortion.

A woman's right to privacy entitles her to decide whether or not to undergo an abortion without government interference. The woman concerned is the only relevant decision-maker. She knows what her life is like and she is able to judge if she can bring the pregnancy to term. The human right to privacy is ensured in many international treaties, among them article 12 of the Universal Declaration of Human Rights (UDHR), article 17 of the International Covenant on Civil and Political Rights (ICCPR) and article 16.1 of the Convention on the Rights of the Child (CRC). The European Court of Human Rights has ruled that a pregnant woman's right to privacy includes the right to decide over her childbearing. A woman's right to privacy when deciding to have an abortion has priority over the man's decision.[2]

The right to benefit from scientific progress is denied many women in the world. Medical abortion is proved safe and effective in western Europe, but women in the new EU member states and developing countries are not allowed access to the same benefits. This right is ensured in the International Covenant on Economic, Social and Cultural Rights (CESCR) in article 15.1(b).

A woman's right to liberty and security entitles her to decide whether or not she will carry a pregnancy to term. A Canadian supreme court decision ruled that restrictive abortion laws violated women's right to liberty and security.[3] This human right is ensured in UDHR article 3, and in ICCPR articles 9.1 and 7.

Because illegal and unsafe abortion is closely associated with high rates of maternal mortality (see below), laws that force women to resort to unsafe procedures infringe upon a woman's right to life. The Human Rights Committee, which oversees countries' compliance with human rights recognized in ICCPR, has concluded that some restrictive national abortion laws violate a woman's right to life. Right to life is found in many international treaties, for example article 3 of UDHR, article 6 of ICCPR, and article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms.

- *UDHR: art. 3, 12*
- *ICCPR: arts. 6, 7, 9.1, 17*
- *CEDAW: art. 16.1*
- *CRC: art. 16*
- *ICPD PoA: principle 8, paras. 7.3, 7.45*
- *Beijing Platform of Action: paras. 96, 106(f), 106(g), 107(e), 223*

2 Case of Paton v. UK, App. No. 8416/78, Eur. Comm. H.R., 13 May 1980, 3 EHRR 408 (1981), Dec. paras. 7-9, 1981 (also cited as X v. UK).

3 Case R. V. Morgentaler, Decision of the Supreme Court of Canada, 1988 1 Supreme Court Reports 30. www.lexum.umontreal.ca/csc-scc/en/pub/1988/vol1/html/1988scr1_0030.html

Denying women access to abortion is gender discrimination

The right to be free from discrimination is a fundamental human right, ensured in almost all international treaties and documents. Article 2 of UDHR, article 2.2 of ICESCR, article 2.1 of ICCPR and article 1 of CEDAW are just a few examples. It is discriminatory to force women to undergo unwanted pregnancies. It is also discriminatory that an action like abortion, which is only relevant to women, is criminalized. Not being able to terminate a dangerous pregnancy denies women healthcare that only they need. It therefore denies women access to a procedure, which is necessary for their health. Women are consequently exposed to health risks not faced by men. Restrictive abortion laws prevent women from exercising their human rights, thus preventing them from being on an equal footing with men.

CEDAW describes discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the purpose of impairing or nullifying the recognition, enjoyment or exercise by women…of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field".[4] In general, women are the ones to suffer the physical, emotional and economic consequences of unwanted pregnancies. This makes it more difficult for women to participate in the areas of political, economic, social, cultural, and civil affairs. Societies that have welcomed women's participation in affairs outside the home have increasingly recognized that reproductive decision-making is best left to women themselves.

The uneven access to safe abortion for women in the world is also discriminatory. Out of all 19 million unsafe abortions performed in the world, 99 per cent are performed in developing countries.[5] The Human Rights Committee, surveying countries compliance with the CPRC, has recognized that the restrictive abortion laws in poor, rural areas are discriminatory for women living there.

UDHR: art. 2
ICESCR: art 2.2
ICCPR: arts. 2.1, 26
CEDAW: arts. 1, 3, 11.2
ICPD PoA: para. 4.4
Beijing Platform for Action: para. 232

4 CEDAW, art.1

5 Ipas, *Unsafe abortion – Issue in brief*. www.ipas.org/publications/en/UnsafeAbortion_IssueBrief_en.pdf

The arguments are on our side. Every year around 75 million unwanted pregnancies occur. Many are terminated in an unsafe way. Countries that fail to make sure women have access to safe abortion discriminate against them on several grounds. To save lives, it is time to recognize women's rights as human rights.

Women's life and health are threatened by unsafe abortion

It is widely acknowledged that in countries where abortion is legally restricted, women seek abortions in secret, under conditions that are medically unsafe and therefore life-threatening. About one-third of the women who have abortions performed under these circumstances experience complications that pose major risks to their lives and health.[6] According to the World Health Organization (WHO), unsafe abortions are responsible for the deaths of almost 70,000 women each year. Where death does not result from unsafe abortion, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, or pelvic inflammatory disease.

Women who have abortions performed in developing countries run 100 times the risk of death compared with women having abortions in developed countries. This is due to a much greater shortage of material and financial resources.[7] In addition, the stigma attached in many countries where abortion is illegal forces women to seek abortions underground. This results in poor women having to delay the procedure in order to gather the necessary money. Abortions performed in the latter stages of pregnancy become increasingly dangerous.[8]

Women dying as a result of an unsafe abortion make up a considerable proportion of maternal deaths. According to WHO, 13 per cent of maternal deaths are related to unsafe abortion. In Latin America, this figure is 21 per cent,[9] in Bolivia, it is in the region of 25–30 per cent,[10] while in some parts of Kenya between 30 and 35 per cent. Reducing maternal mortality by two-thirds by the year 2015 is one of the UN Millennium Development Goals (MDGs). Without recognizing the link between unsafe abortion and maternal mortality, this goal cannot be reached.

- *UDHR: art. 3*
- *ICCPR: art. 6.1*
- *ICESCR: arts. 10, 12*
- *CRC: arts. 6, 24*
- *CEDAW: art. 12*
- *ICERD: art. 5(e)(iv)*
- *ICPD PoA: principle 8, para. 7.2, 8.25*
- *Beijing Platform for Action: paras. 89, 92, 97, 106(j)-106(k)*
- *Millennium Development Goals 3 and 5*

6 Alan Guttmacher Institute Factsheet: *Induced Abortion Worldwide*, citing Christopher Tietze & Stanley K. Henshaw, Induced Abortion: A World Review 32 (6th ed. 1986).

7 Excluding China.

8 Alan Guttmacher Institute, *Sharing responsibility Women, Society and Abortion, Worldwide.* www.agi-usa.org/pubs/journals/2503499.html

9 Ibid.

10 UNFPA, *Proposed Projects and Proposals, Bolivia 1998-2002.* www.unfpa.org/latinamerica/bolivia/2bol9802.pdf

Unsafe abortion costs a lot of money

Making abortions legal is a prerequisite for making them safe. For example, in Rumania, the number of deaths caused by unsafe abortions rose dramatically between 1975 and 1989, during which time abortion was banned under Rumanian law. During the last year in this period, the rate was as high as 142 per 100,000 women. Only twelve months later, when most of the restrictions had been lifted, the figure fell by two-thirds.[11]

However, making abortions legal is not enough. Unsafe abortions are also performed in countries where access is limited or morally condemned. Governments should therefore provide women with information and services, such as access to contraceptives that prevent unwanted pregnancies. But they should also guarantee the right to safe and legal abortion. It is important that governments secure access to clinical services with trained medical staff and materials.

Ensuring women's access to safe abortion services reduces medical costs. In some low- and middle-income countries, up to 50 per cent of hospital budgets are used to treat complications of unsafe abortion. The treatment of abortion complications uses a disproportionate share of resources. [12]

As long as governments refuse to see the facts behind unsafe abortion, women's lives are jeopardized and state budgets wasted.

ICESCR: art. 12
CEDAW: art. 12
ICPD PoA: para. 7.17 8.25
Beijing Platform for Action: paras. 106(j)–106(k)
Millennium Development Goal 5

Julia Schalk
Swedish Association for Sexuality Education (RFSU) [13]

11 Alan Guttmacher Institute, *Sharing Responsibility Women, Society and Abortion, Worldwide.* www.agi-usa.org/pubs/journals/2503499.html

12 WHO, *Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data 1995-2000 – Third edition*. www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html

13 Text edited from *Breaking Through – A Guide to Sexual and Reproductive Health and Rights,* RFSU, 2004.

Days and nights of negotiations

Katarina Lindahl, Secretary-General of RFSU on the sensitive issue of women's right to choose

"What do you do when a pregnant girl comes here needing help to get an abortion?" I asked the nurse at the small clinic in Addis Ababa.

She looked at me and then said:

"Abortion is illegal in Ethiopia."

After a while, she then added:

"It costs so many girls their lives and health. They'll do anything to have an abortion. I recently had a visit from a young girl who had a watch she was very attached to, but she sold it on the street for virtually nothing. The rest of the money for an abortion she obtained by selling her body but we were unable to help her".

"Without saying anything, I put a business card in front of her with the address of a place where she could afford to have an abortion. She memorized the text and I haven't seen her since."

Throughout the world, those who can afford it can have a safe abortion. The more you pay, the safer the abortion. But many unsafe abortions are performed in places where poverty is rife. These constitute a serious threat to women's lifelong reproductive health and make up a substantial proportion of the world's maternal mortality, especially among young, unmarried women.

At the large hospital in Addis Ababa, as well as at many other major hospitals in countries with strict abortion laws, you can see that a great deal of resources are spent taking care of women who have risked their lives by having an illegal abortion.

The issue of legal and safe abortion was the most controversial aspect of the International Conference on Population and Development (ICPD), held in Cairo ten years ago. And so it has continued at a large number of UN conferences throughout the 1990s.

However, during these ten years some countries have taken important steps towards safer health for women. But still the issue is extremely sensitive and few donors are supporting safe abortion projects. And in many UN conferences, the issue is still too controversial to agree upon.

The planning process in the run-up to Cairo began two years prior to the conference and many of those who had received the agenda of decisions to be taken felt it would be impossible to broach the subject at all. I remember going to dinner with some of these

decision-makers and bringing up the issue. I was told I had far too much of a Swedish attitude and was being too idealistic. But this changed in time. Pressure to include abortion as an item on the conference agenda was increased when women's pressure groups and health and family planning organizations around the world entered the frame.

It is doubtful whether abortion would have been an issue in Cairo had not women's pressure groups and other non-governmental organizations (NGOs) lobbied governments so intensively. It was completely impossible to agree on the abortion issue at the pre-Cairo preparatory conferences and things looked ominous when the main conference opened in Cairo. Powerful fundamentalists headed by the Vatican put all their effort into preventing a decision. But resistance came from both religious and political quarters.

The abortion issue was clearly proving a particularly hard nut to crack. Otherwise progressive delegations on issues such as sexuality education had major problems accepting the wordings on safe and legal abortion. Mostly, however, the delegations that were against an abortion paragraph were also against sexuality education, reproductive healthcare clinics and universally available contraception, irrespective of age or marital status. The sexual and reproductive rights of young people also proved to be difficult terrain.

Work done in the negotiating chamber was of course under close surveillance. In the end, a small group sat day and night in a small, poorly ventilated room and hammered out negotiations under considerable pressure, not least from NGOs standing outside the door. We pounced on the government negotiators whenever they came out for a break. We put forward new wording proposals and tried to squeeze information out of them. After three days and nights, a solution was at hand: paragraph 8.25. Even when I read it today, I still think it is good: "In circumstances where it is not against the law, abortion should be safe".

But still there is a lot missing from my point of view, of course – a human rights perspective on abortion being a case in point. But the Cairo negotiations were an unqualified success, nevertheless, and the results have played an important role in subsequent conferences. There are naturally those who have tried, unsuccessfully I might add, to undermine and play down what was agreed upon and we must be extremely wary to ward off such attempts. The paragraph in the Cairo document is important and it is not about words but about the life and health of women. It is about the young girl in Addis Ababa and her life.

Global determination to strengthen the sexual and reproductive rights and health of women has weakened in recent years. The world's only superpower, the U.S. was instrumental in formulating paragraph 8.25, yet the Bush administration is now repudiating the text, referring instead to the reservations expressed at the time, though not by the U.S. itself.

This new political situation makes it even more important to defend and keep the agreed text on the agenda, to remember that women's organizations and progressive governments joined forces in this struggle, which must continue.

Katarina Lindahl
Swedish Association for Sexuality Education (RFSU)

Why is it a human right?

People still argue whether abortion is a human right or not. Human rights are not something consistent, never changing. On the contrary they are under constant development depending on the world's ability to recognize new issues that were not included when the first human right drafts were made. Today human rights include a lot more than the concept did back in 1948 when the UN adopted the Universal Declaration of Human Rights (UNDHR).

Christina Zampas, legal adviser at the Center for Reproductive Rights explains why abortion should be considered a human rights issue.

What defines a human right?

"Human rights are expressed in international treaties, and in national constitutions and laws. They are tools that direct governments and individuals towards ensuring that the rights of people are respected in their laws, policies and in practices. Human rights are a means by which individuals and groups can advance and protect their interests and hold governments accountable to certain standards of how people should be treated."

Who decides when something becomes a universal human right?

"Universal human rights are generally formed in two ways. States ratify international human rights treaties and they are then bound by international law to comply with the provisions of the treaty. And there is also customary international law, which includes human rights. This is binding not because of a formal treaty that was signed but because of wide acceptance and implementation by states. Customary international law applies to all states worldwide, regardless of whether they have explicitly accepted or agreed to a treaty that governs these rights. For example, the Universal Declaration on Human Rights is not a treaty but is

considered legally binding because of its wide acceptance around the world. It is also very important to note that human rights are found in national laws and constitutions."

Genital mutilation, rape as a war crime and gender persecution have been generally accepted as violations of women's human rights during the last ten years. How did this come about?

"There are several reasons. One is the growing activism of women's rights groups around the globe, especially around the activities leading up to and including the International Conference on Population and Development (ICPD). Another reason is the increasing role women are playing in politics – we are certainly not there yet but the more women we see in political office, the more their experiences will come to bear on the laws and policies they are working on in their own countries and eventually ensure the adequate implementation of human rights when applied to women. I would say that it is women's organizations that have played a significant role in pushing governments and international bodies to recognize that reproductive rights are human rights."

How can you argue that access to safe abortion is a human right?

"Abortion implicates four key human rights that can be found in various international human rights treaties and in most national laws and constitutions. They are:

• *the right to life.* In countries where abortion is legally restricted, women seek abortions underground, under conditions that are medically unsafe and therefore life-threatening.

• *the right to health*. International law guarantees women the right to the 'highest attainable standard of health'. Unsafe abortion can have devastating effects on women's health – women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, etc. The right to health can be interpreted to require governments to take appropriate measures to ensure that women are not exposed to the risks of unsafe abortion.

• *the right to equality and freedom from gender discrimination*. Denying women access to abortion is a form of gender discrimination pursuant to the Convention on the Elimination of all forms of Discrimination against women (CEDAW). According to CEDAW, 'discrimination against women' includes laws that have either the 'effect' or the 'purpose' of preventing a woman from exercising any of her human rights or fundamental freedoms on the basis of equality with men. Laws that prohibit abortion have just that effect and that purpose.

• *the right to autonomy in decision-making in private matters*. Provisions in human rights instruments include protection of the right to physical integrity, the right to decide freely and responsibly the number and spacing of one's children and the right to privacy. Decisions one makes about one's body, particularly one's reproductive capacity, lie squarely in the domain of private decision-making. The right to private life as laid down in the European Convention on Human Rights has been interpreted to include the right of a woman to have an abortion, in a country where abortion is legal, over any interests that the 'father of the foetus' has in wanting the woman to carry her pregnancy to term."

How can ICPD help in making abortion accepted as a human right for women?

"The ICPD Programme of Action (PoA) clearly states that reproductive rights encompass certain human rights already present in binding international treaties. This document was agreed to by over 170 nations; I think that the ICPD can help hold governments accountable to what they have agreed to."

Why are many people so reluctant to expand our human rights? How do they argue?

"Those opposed to reproductive rights, including the right to abortion, are opposed to women's rights – they want to keep women subordinate in many aspects of life – in the workplace, in the political sphere, in education and in the home – they see women as care-givers and bearers of children, and the way to do this is to just keep having them reproduce, even against their will. Just look at the recent document coming out of the Vatican which states that feminism destabilizes the family unit to the extent that 'homosexuality and heterosexuality [are] virtually equivalent'."

A lot of people keep saying abortion is not defined as a human right. Why?

"Basically, human rights are always evolving. Take, for example female genital mutilation (FGM), I am sure that the drafters of the International Covenant on Civil and Political Rights did not intend to include FGM in the inhumane and degrading treatment provision (Article 7). But the law evolves to recognize abuses that in the past have not been acknowledged – maybe because of ignorance, silence, or for political or economic reasons. The UN Committee that monitors state compliance with the ICCPR has recently recognized that FGM is a form of inhumane and degrading treatment in violation of the Convention. The same thing could happen to abortion."

So is safe abortion a human right?

"Yes, from my organizations point of view. Our conclusion is that safe abortion, has been interpreted as a human right by various human rights bodies on several times. But not strong enough, it needs to be even clearer that it is a human rights issue. One problem is that this is not known or accepted, and we need to get this knowledge out to policy-makers, politicians and non-governmental organizations".

Who can ensure safe abortion is accepted as a human right?

"I think it will have to come from women's groups who lobby for this both at the international and national level. It will be organizations that challenge their governments to comply with international human rights treaties and I also believe that the more universally women's rights are accepted and implemented, the more recognition we will see for abortion as a rights issue.

"I also believe that there is generally a lack of understanding of how to use human rights to prevent wrongs and to remedy abuses that have already occurred, especially in the healthcare context. But this lack of understanding is slowly diminishing thanks in part to the momentum gained at the ICPD."

Silvia Sjödahl
Swedish Association for Sexuality Education (RFSU)

Ten years on – have the promises been fulfilled?

When the Programme of Action (PoA) on sexual and reproductive health was adopted in Cairo ten years ago, there were great hopes for amended legislation and a change in attitudes regarding abortion. Senior policy adviser Leila Hessini from Ipas, a non-governmental organization working to increase women's ability to exercise their sexual and reproductive rights, tells us what has happened since then.

At the International Conference on Population and Development (ICPD), 179 governments agreed for the first time that unsafe abortion was a major public health concern. They pledged that women facing unwanted pregnancies should have access to reliable information, quality counselling and safe abortion services in circumstances where it is not against the law. In addition, they agreed that women who undergo abortions should have access to quality services for the management of complications that may arise from the procedure and to post-abortion counselling and family planning services. Although a decade has passed since the ICPD, an estimated 19 million women, close to 14 per cent of whom are under the age of 20, continue to undergo unsafe abortions every year.[1] Nearly 70,000 of these girls and women die, and five million more are permanently injured. Numerous challenges, including political, economic, cultural and social factors, interfere with implementing the ICPD abortion-related recommendations. Many also feel that the Cairo consensus did not go far enough, as it did not recognize abortion as a woman's right.

On a national level, different approaches to increasing women's access to safe abortion services – using

1 UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, *Research on reproductive health at WHO: Pushing the frontiers of knowledge: biennial report: 2002–2003*, Geneva, 2004.

public health, women's rights and social justice models – have been developed by key government officials, policy-makers, health professionals, legal experts and women's groups. These include: conducting research on the impact of unsafe abortion; decriminalizing and otherwise reforming restrictive abortion laws; introducing new abortion technologies; and, raising community and religious leaders' awareness of the impact of unsafe abortions.

Guidelines are important tools

In reform efforts, it is critical that the social injustice of unsafe abortion be made visible, despite the lack of reliable data, insufficient research methodologies and the stigma associated with its practice. Well-designed efforts have made a significant impact on policy change: In South Africa, research in the mid-1990s demonstrating that black South African women had much less access to safe abortion services and were dying at a much higher rate from illegal procedures than their white South African counterparts played a key role in abortion law reform.[2]

The legal and policy frameworks pertaining to abortion vary widely from country to country, and are a critical factor in women's ability to access abortion care, as well as the safety of that care. Currently, over two-thirds of all women live in countries where abortion is highly restricted by law.[3] Studies show that highly restrictive abortion laws lead to more maternal deaths from unsafe abortions, not fewer abortions. Statistics from Romania show that the rate of maternal deaths caused by abortion decreased from 149 in 1989, before the abortion law was reformed, to nine in 2002.[4]

Since the ICPD, over a dozen countries have expanded the indications for legal abortion.[5] In South Africa, the abortion law was reformed the same year as the introduction of a new constitution, thus demonstrating the government's commitment to abortion law reform, women's rights and democracy.[6] In Cambodia, the notion of 'family welfare' was a guiding principle behind abortion reform in 1998.[7] In Nepal, a sweeping women's rights bill covering issues of women's property rights, inheritance, divorce and abortion was passed in 2002.[8]

In addition to laws, norms and guidelines are

2 Women's Health Project, *Advocating for abortion access: Eleven country studies*, The Johannesburg Initiative, Johannesburg, 2001.

3 Center for Reproductive Rights (CRR), *The world's abortion laws 2003: Wallchart*, New York, 2003.

4 Horga, Mihai, personal communication, November 2003.

5 Katzive, Laura, *Abortion and the law, 10 Years after Cairo* (unpublished update), Center for Reproductive Rights, New York. [Including: Albania (1996) Benin (2003), Burkina Faso (1996), Cambodia (1997), Chad (2002), France (2001), Guinea (2000), Guyana (1995), Mali (2002), Nepal (2002), South Africa (1996) & Switzerland (2002).]

6 Women's Health Project, *Advocating for abortion access: Eleven country studies*, 2001.

7 Lester, Felicia, *Threads of a common cloth: Abortion and human rights in Cambodia,* University of Berkeley/USCF Joint Medical Program, Berkeley, CA, 2003.

8 Center for Reproductive Law and Policy (CRLP) and Forum for Women, Law and Development (FWLD), *Abortion in Nepal: Women imprisoned*, New York and Kathmandu, 2002.

important tools for healthcare providers in understanding their obligation to implement the law. In 2003, building on the ICPD recommendations, the World Health Organization (WHO) issued Safe abortion: Technical and policy guidance for health systems, a comprehensive action guide for ensuring access to quality abortion services. Several governments have used or are using WHO's policy and technical guidance to develop rules and regulations based on their laws.

Ensuring that women have access to services at all levels of the healthcare system is essential. Post-abortion care (PAC)[9] services have been introduced in 62 countries since the ICPD.[10] PAC and in some countries, safe, legal abortion services have expanded through training programmes for a variety of health professionals and an increased focus on scaling up services.[11] Planning for sustainable access to abortion technologies, however, continues to be a challenge. While the United States Agency for International Development (USAID) provides significant support for PAC, it will not cover the costs of purchasing abortion commodities such as manual vacuum aspiration (MVA) instruments necessary to provide these services.

Because there are so few doctors in most developing countries, particularly in rural areas, health workers and mid-level providers are critical to expanding women's access to PAC and elective abortion services and are increasingly being trained and authorized to provide abortion-related care.[12]

Incorporating new abortion technologies into existing reproductive health services makes them safer, more cost-effective and ultimately more accessible to women. Medication abortion[13] and vacuum aspiration are the two preferred methods of abortion during the first nine and twelve weeks of pregnancy, respectively.[14] Medication abortion terminates a pregnancy through the use of mifepristone and a prostaglandin, usually misoprostol. Mifepristone and misoprostol have been introduced in 29 and 87 countries respectively.[15]

Additional work is needed to raise community

9 Post-abortion care (PAC) is a package of critical reproductive healthcare services necessary for reducing morbidity and mortality from unsafe abortions.

10 United Nations Population Fund (UNFPA), *Investing in People, National Progress in Implementing the ICPD Programme of Action 1994–2004,* New York, 2004.

11 Cobb, Laurel et al., *Global evaluation of USAID's postabortion care programme,* Washington, DC, The Population Technical Assistance Project, 2001.

12 Billings, Deborah L. et al., *Midwives and comprehensive postabortion care in Ghana*. In D. Huntington and N.J. Piet-Pelon (Eds.), *Postabortion care: Lessons from operations research*, The Population Council, New York, 1999 and Dickson-Tetteh, Kim and Deborah L. Billings. *Abortion care services provided by registered midwives in South Africa*, International Family Planning Perspectives, 28(3): 144–150, 2002.

13 Medication abortion – also known as medical abortion, pharmacological abortion, pharmaceutical abortion, RU-486, and the abortion pill – is the use of one or more medications to end a pregnancy.

14 World Health Organization (WHO), *Safe abortion: Technical and policy guidance for health systems*, Geneva, 2003. www.who.int

15 Ipas, *Medication Abortion: Frequently Asked Questions,* 2004. www.ipas.org

awareness of how to avoid unwanted pregnancies and ensure that women have access to safe abortion services. Efforts to deconstruct the myth that religious leaders oppose abortion are underway in several countries. Women theologians, religious leaders and religious-based groups are bringing to the fore the diversity of religious thought regarding abortion over time and across religious traditions.[16]

Lessons learned

Several key lessons have emanated from country-level experience of implementing the abortion-related PoA recommendations.[17] These include:

• Documenting the social costs of unsafe procedures, such as the negative impact on women, families, existing children and community members; the loss of health, work and income; and the use of scarce medical resources to treat abortion complications.

• Prompting debate with informed, balanced and unbiased information on the impact of unsafe abortion.

• Countering the myths about abortion – particularly regarding conservative religious teachings, morality and abortion.

• Addressing fundamentalist opposition to abortion; documenting examples of abortion law reform in predominantly Muslim countries – such as Turkey and Tunisia – is a good way to challenge fundamentalist approaches to women's choices and rights.

• Situating abortion within the broader context of women's lives and the choices and options they do or don't have in relation to their sexuality and reproductive choices. And finally,

• Including those whose interests are most at stake in the process of social change is necessary in order to create real, long-lasting transformation. It is important to recognize women's different interests and needs across race, class, geographic location, religious affiliation and disease status.

Some lobby against reforms

Increased secular and religious fundamentalisms have negatively affected the implementation of the Cairo recommendations. In 2000, the Bush administration re-enacted the global Gag Rule, which denies U.S. funding to non-American non-governmental organizations (NGOs) that include abortion care, referral, or counselling services in their programmes, even if those services are paid for by their own resources. The Catholic Church has lobbied against the reform of restrictive abortion laws in countries such as Nicaragua; and, in the Philippines, foetuses have been granted the same constitutional rights to life as women. Movements in countries with more liberal laws, including the U.S., Hungary and Russia, are also working to inhibit

16 International Committee for the Peace, *Chiang Mai Declaration. Religion and women: An agenda for change* (approved at the Peace Council's 2004 annual meeting), Chiang Mai, Thailand, 2004. www.peacecouncil.org

17 Hessini, Leila, *Advancing reproductive health as a human right: Progress toward safe abortion care in selected Asian countries since the ICPD*, Ipas, Chapel Hill, NC, 2004.

women's access to safe abortion services by implementing restrictions such as parental notification requirements and gestation limits that disproportionately and negatively affect poor, young and rural women.

Public health systems have deteriorated in some countries since the ICPD, and funding for reproductive health and family planning has fallen drastically in real terms since 1994. While international donors agreed to cover one-third of the costs of implementing the Cairo recommendations, by 2000, they had committed less than half, or only USD 2.6 of the USD 5.7 billion required.

Preventing unsafe abortion is essential if we are to achieve the UN Millennium Development Goal of reducing the maternal mortality ratio by three-quarters by 2015. All actors – governments, donors, healthcare providers and community groups – must reaffirm their commitment to the ICPD. This would include, at the very least, ensuring that comprehensive, high-quality, safe services are available to all women for all legal abortion indications, as agreed to at the ICPD.

Leila Hessini
Senior Policy Adviser, Ipas, Chapel Hill, North Carolina, U.S.

Examples from the world

Africa

One quarter – or close to five million – of the world's unsafe abortions take place in Africa each year, causing the deaths of approximately 34,000 African women.[1] In addition to this shockingly high number of annual deaths, unsafe abortion causes millions more women to suffer serious illnesses and injuries, and renders many infertile. Despite this public health crisis, Africa has some of the most restrictive abortion laws in the world, most of which are remnants of colonial rule. In Africa, abortion is available on request in only three countries – Cape Verde, South Africa and Tunisia. Twenty-eight nations allow abortion only to save the life of the woman, and the remaining countries impose various restrictions on whether a woman can choose to terminate an unwanted pregnancy.[2]

The ICPD increased awareness about unsafe abortion in Africa, and networks of policy-makers, activists, women's groups, healthcare professionals, the media and others have since worked to develop strategies to confront this crisis. Debates on the importance of legal reform have been held in Ethiopia, Kenya, Namibia, Nigeria and South Africa; increasing numbers of

1 World Health Organization (WHO), *Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data*, third edition, Geneva, 1998 (WHO/RHT/MSM/97.16).

2 Center for Reproductive Rights (CRR), *The world's abortion laws 2003: Wallchart,* New York, 2003.

health professionals throughout the region have been trained to provide post-abortion care (PAC) and safe abortion services; advocacy efforts, designed to break the silence around abortion, have been launched in Cameroon, Ethiopia, Kenya, Mauritius, Namibia, Nigeria, Uganda and Senegal; and medical abortion has been introduced in South Africa and Tunisia.

Building on the momentum generated by the ICPD, the first-ever regional consultation on abortion – 'Action to Reduce Maternal Mortality in Africa' – was held in Ethiopia in 2003. At that meeting, over 100 high-level African health leaders, lawyers, medical professionals and women's advocates convened to address the tragic consequences of unsafe abortion for African women, their families and communities. Participants cited restrictive abortion laws, U.S. foreign policies, and lack of safe abortion services as the major reasons why so many women die and suffer injuries from unsafe abortion.

Another major step in Africa was the approval of the Protocol to the African Charter on Human and People's Rights Relating to the Rights of Women in July 2003, which calls upon states to authorize a wide array of protections for women's rights, including abortion in cases of sexual assault, rape, incest and foetal impairment, or when the pregnancy endangers the life or mental and physical health of the woman.

The challenges facing Africa include widespread poverty; overwhelming debt burdens; the HIV/AIDS pandemic; poor health infrastructures; and persistent gender bias, which leaves many women without decision-making power in many areas of their lives, including sexuality and related healthcare.

Asia

Unsafe abortion is a leading cause of maternal death in Asia. The region has the world's highest number of unsafe abortions, with an estimated 10.5 million being performed in 2000,[3] and accounts for 50 per cent of the world's abortion-related deaths.[4] Indications for legal abortion vary widely across the region. Abortion is legal on request in China as well as in Cambodia, Nepal and Vietnam, and is permitted on broad grounds in India. Liberal laws, however, do not necessarily translate into increased access for women. Although abortion is legal in India, the proportion of maternal deaths due to unsafe abortion remains unnecessarily high.[5] Numerous barriers – political, social, medical and physical – obstruct women's access to abortion services, and between two and eleven times more illegal abortions than legal ones are performed each year[6] Asia is

3 Åhman, Elisabeth and Iqbal Shah, *Unsafe abortion: Worldwide estimates for 2000*, Reproductive Health Matters, 10(19): 13–17, 2002.

4 World Health Organization (WHO), *Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data*, third edition, Geneva, 1998 (WHO/RHT/MSM/97.16).

5 Jain, Vanita, et al., *Unsafe abortion: A neglected tragedy. Review from a tertiary care hospital in India*, The Journal of Obstetrics and Gynecology Research, 30(3): 197, June 2004.

6 Hirve, Siddhi, *Policy and practice*, Seminar 532: Abortion, 2003. www.india-seminar.com

also home to countries with some of the world's most restrictive laws.[7] In the Philippines, foetuses are entitled to the same constitutional rights to life as women.

Since the ICPD, researchers and activists in India, Indonesia, Malaysia and Thailand have documented the impact of unsafe abortion on women, their families and their communities.[8] Policy-makers, women's groups and healthcare professionals have created coalitions to confront this public-health and women's rights crisis. Research findings have been documented in community educational materials and other publications, and disseminated through various media channels. New reproductive health bills have been proposed in the Philippines and Indonesia, and Cambodia and Nepal have legalized abortion.

Until recently, abortion was widely prohibited in Nepal, and abortion service providers as well as women seeking abortions were penalized. Women's groups advocated for abortion law reform as part of a bigger package of women's rights, equality and gender discrimination issues. This campaign ended successfully in March 2002 when the Nepalese Parliament approved legislation recognizing women's rights to property, divorce, education, and legalized abortion. The new law provides women with access to legal abortion in the first 12 weeks of pregnancy for any reason, and up to 18 weeks with some limitations. The law also protects women's privacy and their right to make independent reproductive choices without requiring the husband's consent.

Despite progress regarding abortion in certain Asian countries, increased conservative trends, lack of political commitment, financial barriers and stigma continue to restrict open discussions on abortion across the region.

Eastern and central Europe

Abortion laws in eastern and central Europe (ECE) are among the most liberal in the world, with the exception of Poland where abortion is highly restricted. Despite abortion's legality, approximately 800,000 unsafe abortions take place annually, accounting for 24 per cent of maternal deaths in the region.[9] The needlessly high complication rates for illegal abortion are due to shortage of family planning commodities and medications, crowded facilities, poor hygienic conditions, lack of proper abortion training, and inadequate standards of care.[10] In addition, reliance on abortion for fertility control is widespread in ECE and the use of modern contraceptives remains low.

As fertility rates have fallen below replacement level in most countries in the region, some policy-makers have placed limitations on comprehensive contraception and

7 Center for Reproductive Rights (CRR), *The world's abortion laws 2003: Wall*chart, New York, 2003.

8 Hessini, Leila, *Advancing reproductive health as a human right: Progress toward safe abortion care in selected Asian countries since the ICPD*, Ipas, Chapel Hill, NC, 2004.

9 World Health Organization (WHO), *Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data*, third edition, 1998 (WHO/RHT/MSM/97.16).

10 Ipas, *Ensuring women's access to safe abortion care in Europe*, Chapel Hill, NC, 2003.

abortion programmes. In addition, pressures from conservative forces have led to restrictions on approved methods of safe abortion and legal indications for terminating pregnancies.

Romania provides an excellent example of the link between liberal abortion laws and improvement in women's health. After restrictive abortion laws were overturned in 1989, the maternal mortality rate decreased by 50 per cent over a one-year period, and has since continued to decline.[11] Nevertheless, women living outside urban areas experience serious difficulties in obtaining comprehensive reproductive healthcare, and there are very few links between contraception and abortion.

Poland is an anomaly in the region in terms of reproductive health, due to its restrictive laws and policies governing access to abortion and contraception.[12] Women's groups believe that the current law, which is the most restrictive in eastern Europe, has led to an annual number of as many as 200,000 illegal and unsafe abortions.[13]

Challenges facing ECE include ensuring that women have access to a full range of comprehensive reproductive health services, modernizing outdated abortion techniques, and restricting the role of the Catholic Church regarding reproductive health issues.

Latin America

Latin America has some of the most restrictive abortion laws in the world. Most countries only permit abortion to save a pregnant woman's life, and two countries, Chile and El Salvador, prohibit abortion under all circumstances. Building on the momentum of the ICPD, Guyana became the first country in South America to liberalize its abortion law; however, only two other countries in the region – Barbados and Cuba – allow legal abortion for a wide range of indications.[14] Legal reform movements are underway in a number of countries, including Brazil, Mexico, St. Lucia, Trinidad/Tobago and Uruguay. Laws have been partially reformed in Brazil and Mexico and, in Nicaragua, health professionals and women's groups have fought conservative initiatives to restrict abortion even further.

Although abortion is extremely legally restricted in the region, millions of procedures take place each year and most of them – 95 per cent – are unsafe. According to data from six Latin American countries, five to

11 Serbanescu, Florina, Leo Morris and Mona Marin (eds), *Reproductive health survey: Romania, 1999*, Romanian Association of Public Health and Health Management (ARSPMS), Bucharest, Romania, and Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC), Atlanta, GA, 2001.

12 Center for Reproductive Rights (CRR), *The world's abortion laws 2003: Wallchart*, 2003.

13 Ipas, *Achieving ICPD commitments for abortion care in Eastern and Central Europe: The unfinished agenda*, 2003.

14 International Women's Rights Action Watch (IWRAW), *Country report, Guyana*. www.iwraw.igc.org

15 Henshaw, Stanley K., et al., *The incidence of abortion worldwide, International Family Planning Perspectives*, 25 (supplement): pp. 30–38, 1999.

ten out of every 1,000 women are hospitalized annually for treatment of complications from induced abortion.[15]

Since the ICPD, women's groups in Latin America have brought attention to the relationship between sexual violence, unwanted pregnancy and abortion. In the region, one in five women have been physically abused in their lifetime and six per cent of women are survivors of sexual violence.[16] Young women between the ages of 15 and 24 are disproportionately affected by sexual violence.[17] Laws in 11 countries, however, permit abortion following rape or incest.[18] In Mexico, non-governmental organizations (NGOs) have developed a model of comprehensive, high-quality care for survivors of sexual violence, which is being introduced by the Ministry of Health to facilitate women's access to a range of services including legal abortion.

New organizations, coalitions and networks have also been created in Latin America to focus on abortion. In Mexico, a coalition of organizations that was formed to coordinate efforts has initiated a series of mutually reinforcing activities related to safe abortion, including advocacy, information for decision-makers, research and training for service providers, and outreach to religious and community leaders. To complement the work of this coalition, the National Alliance for Choice (Andar) was created as a forum for discussions of the intersection between reproductive health, bioethics and health education.[19] Bolivia and Brazil have long-standing abortion working groups, comprised of women activists, health professionals and NGOs.

Challenges facing the Latin America and Caribbean (LAC) region include a highly conservative political climate throughout the region, with strong influence exerted by the Catholic Church, and limited public debate on abortion. Discussions about unsafe abortion have increased since the ICPD; however, they are led primarily by women's groups, while the medical community has just begun to mobilize in some countries to address the issue. The region also suffers from declining support from the donor community.

Leila Hessini, Ipas

16 Center for Reproductive Rights (CRR), *Women of the world: Laws and policies affecting their lives. Latin America and the Caribbean, Progress Report*, New York, 2000. www.crlp.org

17 Center for Reproductive Rights (CRR). *Women of the world: Laws and policies affecting their lives. Latin America and the Caribbean, Progress Report*, New York, 2000.

18 United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies, New York*, United Nations, 1999.

19 Ipas. *Achieving ICPD commitments for abortion care in Latin America: The unfinished agenda*. Chapel Hill, NC, 2004.

We need to expand access

Dr. Sangeeta Kaul from India HIV/AIDS Alliance on unsafe abortions despite a liberal law

India was one of the first countries globally to introduce pro-abortion legislation by enacting the Medical Termination of Pregnancy Act of 1971 on broad social and socio-medical grounds. Despite this, India has identified unsafe abortion as a major public health problem in the country. Unsafe abortion is one of the major causes of maternal mortality, accounting for 8.9 per cent of maternal deaths annually.

Despite a liberal abortion law, India experiences an estimated 4 million unsafe abortions each year out of an estimated 10.7 million abortions. However, the data available are not very reliable. Although an estimated 6.7 million induced safe abortions take place each year, national Medical Termination of Pregnancy (MTP) records report only approximately 0.6 million.

Although unsafe induced abortion is a major cause of mortality among women, it is also the most preventable. Women need not die or suffer because of the consequences of abortions. Abortions do not kill women; it is unsafely performed abortions that kill.

The MTP Act was liberalized in 1972 with a view to legalizing abortions, and hence reducing unsafe abortions. The purpose was to define the situations and conditions under which safe abortions could be legally performed and to empower qualified medical practitioners and institutions to supply the service. MTP rules were adopted in 1975, but were revised in 2003.

One of the limitations is that only doctors who have received training in MTP can perform the abortions. For pregnancies up to 12 weeks, certification by one qualified doctor is sufficient, whereas for pregnancies between 12 and 20 weeks, two doctors must give their approval. Abortion cannot be performed in any place other than a clinic or hospital established by the government or in a private institution approved by the government.

The Reproductive and Child Health (RCH) Programme launched by the government of India in 1997 includes safe abortion services as one of its important components. To ensure that safe abortion services are accessible to all women in the country, the government started training doctors in MTP procedures. According to a survey of facilities conducted by the Ministry

of Health & Family Welfare in 1998, the proportion of doctors at primary health centres trained in MTP ranges from 2 to 35 per cent.

Some of the strategies of the NPP 2000 have been translated into action, but there is still a long way to go.

India has a female population of over 200 million in the reproductive age group, and there are only just over 10,000 registered medical termination centres across the country.

The National Population Policy (NPP) of 2000 provides a comprehensive strategic framework to remove barriers and enhance access to MTP services. It emphasizes the promotion of community education targeting women, decision-makers and adolescents. It states that more and more primary healthcare centres and community centres should be capable of providing these services. The policy highlights simplifying the procedure of certification, and adopting updated and simple technologies, such as manual vacuum aspiration (MVA) or non-surgical techniques.

In order to have more doctors trained to provide safe abortion services, the government has introduced a MVA pilot project in two districts in each of the selected eight states of the country. Medical abortions were also introduced in the country in April 2002. The Drug Controller of India has approved mifepristone and misoprostol for early medical abortion. At present these drugs can only be prescribed by specialists (obstetricians and gynaecologists).

There is obviously a great need to increase the number of MTP facilities, improve the existing facilities and services by providing equipment and supplies, train more service providers, and also improve the utilization of MTP clinics. Quality standards need to be introduced and enforced to address factors such as safety, provider attitudes, responsiveness, and proper screening of clients.

Information about the availability of these services free of charge should be disseminated to women, particularly in rural and tribal settings. Women should be encouraged to access MTP services from trained providers. There should be community awareness sessions about the legislation. NGOs can also play an enhanced role to expand the services and to promote community awareness. Emphasis should be on the involvement of men and their responsibilities. Interventions are needed to enhance the role of men and women in exercising sexual and reproductive health responsibility. A wider range of contraceptives, including emergency contraceptives, should be made available alongside information on sexual and reproductive health.

Facts

Some of the barriers to safe abortion services are:

- Low level of education among women, which leads to ignorance about pregnancy issues.
- Lack of awareness of the MTP Act and its legality.
- Limited access to services in rural areas.
- Limited privacy and confidentiality at governmental MTP clinics.
- Low numbers of trained providers.

Dr. Sangeeta Kaul
Former National Consultant for Maternal Health,
Ministry of Health & Family Welfare,
Government of India

Everything is possible – changing laws will save lives

Changing a country's abortion law involves tough political dealings and there are no easy short-cuts. A deeply religious society can be more difficult to influence than a secular one. But, with a well thought-out strategy and working on a broad front, the task is not impossible.

The double standards associated with abortion laws cost women their lives and health on a daily basis. Abortions are performed in every country across the globe, regardless of whether they are legal or not. Of the 45 million abortions performed annually, 19 million are unsafe. Despite the bans, they are still performed – though often secretively and under medically unsafe conditions. This represents a major health risk to women and about 70,000 die every year as the result of unsafe abortions.[1]

Strict abortion laws pose the greatest risk to women on low incomes, since they are more likely to have unplanned pregnancies due to fewer family planning options.[2]

At the International Conference on Population and Development (ICPD) in Cairo in 1994, participating countries agreed that unsafe abortions constituted a public health problem. Yet many decision-makers in countries with restrictive abortion laws are turning a blind eye to the serious health consequences of unsafe abortions. A case in point was in Uruguay when, on May 5, 2004, the senate rejected a government bill that would have legalized first-trimester abortion. The act would also have provided for compulsory sexuality

1 Ipas, 2004. www.ipas.org/english/about/default.asp

2 Center for Reproductive Rights, *Women of the World: Laws and Policies Affecting their Reproductive Lives*, New York, 2004.

education in schools, free family planning and contraceptives. Between 30,000 and 50,000 illegal abortions are performed every year in the country, and maternal mortality is – as a result –very high. [3]

Abortion was illegal in Nepal until recently and women who have undergone the procedure have been put behind bars. Thirty women are still in prison as a result.

But, despite women putting both their lives and their freedom at risk, over 50,000 abortions were carried out each year. It is estimated that half the deaths among pregnant women in Nepal were caused by unsafe abortions.[4] A change in the law in 2002 opened the door to legalization and the first public abortion clinic, the Rajya Laxmis Hospital in Kathmandu, was opened in March 2004.

A favourable political climate

How can we liberalize abortion laws? What are the obstacles? What made Nepal liberalize its laws? And why didn't this happen in Uruguay?

Mary M. Luke is responsible for Ipas activities to promote women's sexual and reproductive rights in Nepal. The organization, in partnership with Nepalese NGOs, has been lobbying for a change in the law. She mentions a number of key factors which made the amendment possible.

"Strong local and international NGOs put their weight behind a message in a politically favourable climate and the abortion issue was included in an extensive bill on women's rights," she says. The bill was preceded by an intensive debate on women's rights and the abortion issue was not such a conspicuous part of this discussion and as a result perhaps did not attract so much controversy.

The Nepalese Forum on Women Law and Development (FWLD) also believes the victory can at least partly be put down to the fact that the bill went under the name of the Gender Equality Bill, and focused just as much on women's inheritance rights as on abortion.

Other important factors Mary M. Luke mentions include the involvement of prominent political figures who were in favour of legalization. Major international treaties, such as the Convention on Elimination of all forms of Discrimination Against Women (CEDAW), also facilitated a change in the law. [5] The Act, formally adopted on December 26, 2003, was preceded by several years of intensive lobbying.

"The preparatory work done by NGOs provided important facts and influenced the decision-makers. They documented the problem of the imprisoned women and the effects of unsafe abortions on the healthcare system," adds Mary M. Luke.

Nepalese politicians realized that unsafe abortion was a major health problem. They also saw that women who could afford to do so travelled to India to have an abortion whilst poor women had no option other than to have it done illegally.

3 *Uruguay rejects bill to legalize abortion*, Reuters Alert, May 5, 2004.

4 Center for Reproductive Rights, *Women of the World: Laws and Policies affecting their Reproductive Lives, 2004.*

5 Interview with Mary M. Luke, Ipas.

"The government's recognition of the problem was a crucial factor in allowing the law to be amended," says Mary M. Luke, underlines the importance of good preparation, perseverance and cooperation towards a common goal, as well as grasping the right political opportunity.

But different countries require different strategies. "If activists select their strategies after a thorough analysis of the factors that might facilitate or obstruct change, they will probably achieve their goal," say Barbara Klugman and Zanele Hlatchwayo from the South African Women's Health Project in their book 'Advocating for Abortion Access: eleven country studies'.

The book presents strategies for influencing abortion legislation devised by activists and researchers from different countries. Based on case studies, we can point to some general observations: 1) The ideological-cultural context. Religious attitudes are an obstacle to liberal abortion laws. 2) Clarifying the legal scope for abortion may help the liberalization process in the long term. 3) How the problem is described must be adapted to the target group: Approaching from a health perspective may well be more strategic than focusing on the rights angle. 4) Facts and research on unsafe abortions are important opinion-moulders, as is education both of the general public and of politicians. 5) Working from within the political system has its advantages but may well involve some uncomfortable compromises. 6) It is important to build broad coalitions.

Adrienne Germain and Theresa Kim from International Women's Health Coalition describe different strategies in 'Expanding Access to Safe Abortion – Strategies for Action'.[6] They also point out that international treaties are an underutilized yet important weapon in the debate.

Power of the church

One factor that renders liberalization of abortion laws more difficult in many countries is the Vatican's dogged resistance to contraception and abortion. Staffan Bergström is a professor and doctor at the Department of Public Health Sciences at Karolinska Institutet in Stockholm. According to him, the biggest obstacle to liberalization is made up of religiously founded concepts about abortion being murder, even if it is a question of a pregnant 12 year-old who has been raped.

In countries where there is no clear division between political and religious powers, or where the church has sympathizers in important institutions, religion becomes a very powerful force that can undermine access to abortion.

It was the Uruguayan Catholic Church, with its considerable political clout, that stepped into the breach to stop a liberalization of the country's abortion legislation. "No legislator who wishes to call him/herself a Christian can vote for this bill," boomed Archbishop Nicolas Cotugno in Montevideo.[7]

6 Germain, Adrienne and Theresa Kim, *Expanding Access to Safe Abortion – Strategies for Action*, New York, 1998.
7 Inter Press Service, May 5, 2005.

It is possible to change laws. But different countries require different strategies and some consider religiously founded concepts about abortion to be the greatest obstacle to liberalization.

The Vatican's struggle against abortion can be seen in the light of the church's dwindling political power; it needs to strengthen the spiritual stranglehold it has on its members.[8]

One successful strategy seems to be to challenge religious concepts on abortion from within. The fact that a small number of church representatives ally themselves with pro-abortionists and have gone public with their views on the matter has proven to be significant.

In many countries, the idea of abortion being contrary to national tradition, culture and morals is widespread. From a historical perspective, however, the restrictive laws of the 20th century are an exception to the norm, which has been a tolerant attitude to abortion. Opinion polls in Uruguay, a predominantly Catholic country, indicated that 63 per cent of the population supported liberalization of the abortion law.

Utilizing the legal scope

Contrary to the claims of anti-abortionists, abortion is legal under certain circumstances in the vast majority of countries. The governments that participated in Cairo 1994 agreed that abortions, where they were not against the law, should be performed in a medically safe way. This may be when the physical or mental health of the pregnant women is at risk or if she has been raped. In practice, however, the existing legal scope for abortion is seldom utilized.

In many cases, activists have chosen to concentrate on following existing laws, which allow abortion in certain cases. By clarifying the fact that abortion is legal, the abortion issue may well lose its taboo status and be pushed higher up the political agenda. Securing access to abortion in those cases where it is allowed under existing laws paves the way for liberalization, as Adrienne Germain and Theresa Kim point out.[9]

Adjusting the message

Because of its controversy, it is important to adapt the way the abortion issue is approached depending on the target group. A discussion about rights can lead the pro-choicer into a quagmire of ethical debate about what the right to life actually involves. Many activists choose instead to argue for free abortion from a health perspective. In Guyana, where liberal abortion laws were introduced in 1995, activists chose only to describe the problem in public health terms. They argued that liberal abortion legislation would reduce the number of abortions, improve women's health and save public funding used to take care of the victims of unsafe abortions.[10]

International human rights' declarations and treaties lend strong support to the reproductive health of women. The crux is that there is nothing forcing countries to keep to the praiseworthy pledges they have made. Recommendations are also negotiable. During

8 Childbirth by Choice Trust, *Abortion in Law, History and Religion*, Toronto, Canada, 1995.

9 Germain, Adrienne and Theresa Kim, *Expanding Access to Safe Abortion – Strategies for Action*, New York, 1998.

10 Nunes, Fred, *Implementation of Liberal Abortion Law in Guyana: Experiences and Lessons*. In Klugman & Budlender (eds) *Advocating for Abortion Access: Eleven Country Studies*, Johannesburg, 2000.

its accession negotiations with the EU, the Maltese government secured a binding agreement under which the country's strict abortion laws would take precedence over European legislation.[11]

The political game

But is it then best to work within or outside the political system? In countries where it is possible, working within the political system has its advantages. Barbara Klugman and Zanele Hlatshwayo say that it gives activists the chance to be involved in drafting the legislation and that it makes it possible to support decision-makers in their strategic thinking. They also say in their book that it provides scope for activists to build up personal contacts with important decision-makers and hence get them to use established facts and arguments.[12] An NGO working from within the political system can, however, be forced into uncomfortable compromises, risking a loss of contact with the grassroots level and being forced to tone down its ideals. In short, it is easier for activists to stick to their principles by working outside the political system.

The presence of one of more pro-abortion political parties can prompt liberalization, but not necessarily. Abortion is a sensitive issue and to maximize votes, politicians may choose not to discuss it despite being in favour of liberalization. An alliance of 40 Mexican NGOs presented the draft of a new abortion act to the parliament in Mexico City in 1999. The coalition felt the time was right; a favourable political climate prevailed and they had close contact with a pro-liberalization party that had a parliamentary majority.

Several politicians were in full agreement with the coalition's approach to the issue, but they did not want to discuss or make any public statements about abortion in the run-up to the imminent presidential election. In short, they were afraid of losing votes. Furthermore, the Pope visited the country in January 2000 and none of the parties wanted to make an enemy of the church.[13] Politics involves compromise. The left-wing government in Poland has, for example, avoided the abortion issue as a concession to the church by way of thanks for its support to the Yes-vote in the EU referendum.[14]

Facts provide political will

Experiences from several countries indicate that research findings and documentation on unsafe abortion are an essential part of opinion-moulding in order to influence the general public and decision-makers.

11 *Hårda abortlagar kvar på Malta* (Malta keeps its strict abortion laws), Reuters – Dagens Nyheter, December 15, 2002. In Swedish.

12 Klugman Barbara & Hlatshwayo Zanele, *Strategy and Action for Abortion Access: A Comparative Analysis.* In Klugman & Buddlender (eds), 2000.

13 Cortes Ana, Bissell Sharon, *August 2000 Reforms to Mexico City Abortion Legislation: The Long, Hard Struggle* In Klugman & Buddlender (eds), 2000.

14 Neveus Ingmar, *Polen hotar avvisa abortfartyg* (Poland threatens to turn away abortion ships), Dagens Nyheter, June 25, 2003. In Swedish.

"Reiterating facts about maternal mortality caused by unsafe abortion, and pointing to the mass deaths of women as a result of having one are most effective lobbying instruments," says Staffan Bergström.

In Nepal, a local NGO, the Centre for Research, Environment, Health and Population Activities, conducted opinion polls on abortion and calculated the costs of unsafe abortion. In South Africa, an NGO took the initiative to involve a medical research institute to compile national statistics on how many women had died as a result of an unsafe abortion. A South African organization described it as "an objective epidemiological basis for what we knew would be a political argument". The results of this study left a deep impression on South African politicians.

Restrictive abortion laws force women with unwanted pregnancies to look on the black market, putting both their life and their freedom at risk. Liberal abortion laws provide women with the possibility of terminating an unwanted pregnancy without jeopardizing their health. As Adrienne Germaine and Teresa Kim point out, "it is perfectly possible to prevent both death and invalidity caused by unsafe abortions." But what is needed is political will.

Pernilla Ståhl
Freelance journalist based in Lund, Sweden

Four countries, four experiences

Uruguay – partial success in the struggle for liberal abortion laws

In Uruguay, abortion is only allowed if the woman has been raped, if it is a financial necessity or if her life is in danger. Except in extreme cases when the woman's life is at stake, it is up to the court to determine whether the woman fulfils the requirements for having an abortion.

A coalition of activists in and outside the political system has been lobbying for free abortion for many years. They earned a victory in December 2002 when the parliament's lower chamber approved an act entitled 'Defending reproductive health'. The act was drafted by a commission consisting of religious groups, NGOs and the women's rights movement, and was presented by a number of women politicians.

A major campaign got underway in 2002 to obtain approval for the act in the senate, where resistance was expected from several conservative politicians, among them the Uruguayan president. On May 5 of this year, the senate voted by 17 votes to 13 to reject the bill. The decision was preceded by intensive lobbying from representatives of the Catholic Church and American anti-abortionists. Among the tactics employed, US senators sent a controversial fax to the senate in Uruguay urging it to vote against the bill.

Brazil – the step-by-step approach

Activists in Brazil have concentrated their efforts on safeguarding the current abortion law and clarifying the fact that abortion is legal under certain conditions.

Abortion has been against the law since 1940, apart from in cases where pregnancy is the result of rape or if there is no other way of saving the life of the pregnant woman. Very few women and healthcare personnel were aware of this option until 1990. This, combined with the fact that doctors were refusing to perform the procedure, made legal abortion practically impossible.

Many clandestine abortion clinics have as a result sprung up, where medical safety is in direct relation to the amount of money paid. Rich women can have a relatively safe abortion, whereas poor women risk their health and their life. By politicians, the women's movement and progressive doctors joining forces, the first legal abortion clinic for rape victims was opened in a poor, densely populated area of Sao Paolo. By being very active in the media, activists have managed to make abortion the subject of public debate.

South Africa – civil society and political change

South Africa is a typical example of how cooperation between civil society and decision-makers and a changed political situation can facilitate liberalization. The fall of apartheid and the first democratic election in 1994 meant that the African National Congress (ANC) and civil society began discussing future policies and principles for the new South Africa. Women's groups and other NGOs presented ideas for a new healthcare policy, which included a proposal for the liberalization of abortion laws. After the election in 1994, the government appointed a healthcare committee, which, among other activities, arranged public debates and hearings on a new abortion bill. A liberal abortion act was adopted in 1996, but it is disputed by religious forces, and the number of unsafe abortions in the country is still high.

Italy – mobilizing the women's movement, impacting the media

The mobilization of women at all levels of society played an important role in bringing about a change in the law. After having successfully challenged politicians and the Catholic Church on the issue of divorce, the women's movement took up the struggle for free abortion in the 1970s. In partnership with a liberal and anticlerical party, it collected the 50,000 signatures needed in Italy to enable the drafting of a new amendment to the law. The women's movement successfully highlighted the high prevalence of unsafe abortions on the black market (an estimated 800,000 a year). The magazine 'L'Espresso' published interviews with famous Italian women under the headline 'I have also had an abortion'. The new act of 1978 was influenced by a successful combination of working both within and outside the political system.

The Catholic forces in Italy were divided, as Antonietta Cilumbriello and Daniela Colombo write in 'Advocating for Abortion Access': "In a country assumed to be 100 per cent Catholic, there were many families in which a sister, daughter, or mother had undergone an illegal abortion". A referendum on the abolition of the liberal abortion act was held in 1981, in which 68 per cent voted to keep it as it was.

Pernilla Ståhl

Basic training not enough

Sandra Kabir, programme adviser at ICOMP, tells a story on the need to support programme managers in their work on safe abortions

My name is Amina. I am a twenty-three year-old Bangladeshi woman. I qualified as a paramedic two years ago after 18 months of training – both theoretical and practical. I work at a health centre in the remote village of Chandi. The nearest sub-district town is twenty miles away and it takes at least three hours to get there on foot, by country boat and bus.

This is the first time I have been in charge of a health centre. I am, therefore, both manager and service provider. There are three staff members – myself, a woman cleaner and a male guard. My supervisor is a man and he works from the sub-district town. I get to see him when he visits my centre every three to four months, or when I go to get supplies replenished.

As a paramedic I am authorized to provide basic healthcare for coughs, colds, diarrhoea, worms and other simple illnesses. Also, I provide family planning services, but not surgical sterilization for either women or men. Such requests are referred to the doctor in the sub-district town. As a part of my family planning responsibilities, I also provide safe abortion services known as menstrual regulation in Bangladesh. This is what I would like to talk about more.

I really feel a need for more training and skills enhancement. My basic training gave me adequate skills for service delivery. However, I have received no training for my recently enhanced responsibility of managing a health centre in a rural area with very little infrastructural support.

I would particularly like to learn more about abortion issues. Since I qualified two years ago, I have seen so many women suffer from incomplete or septic abortion or the inability to access safe services. I am expected to provide menstrual regulation services, but not given further training for this. I know senior officials in the Ministry of Health go abroad for meetings and training. They have access to national libraries, the internet and meet people visiting from other countries. As a manager, I need to be sensitized and made further aware of safe abortion and its context in sexual and reproductive health and rights. I require and want to know more about what is happening in other countries, different techniques used for abortion, etc.

Keeping abreast of arguments supporting or opposed

to safe abortion is important for managers so that we are prepared for questions or challenges from staff, members of the community and others.

I would feel more confident if I had some knowledge of the legalities of abortion. For instance, is abortion legal, under what circumstances, which laws govern termination, etc.

The success or failure of a health programme in which safe abortion services should be a component, lies with me, the manager. However, my responsibilities and authority are mismatched. Decisions are made by policy-makers without the input of managers. Managers are expected to make programmes work, whatever the shortcomings of decisions made on high.

Let me share with you the details of a recent case that I could have dealt with much more effectively if I had the support of my supervisor and doctor at the sub-district level. A young woman, just fifteen years old, was brought to my accommodation under cover of darkness. The girl was unmarried and twenty weeks pregnant. Her aunt had taken her to an untrained practitioner for an abortion that had been badly botched. Now she came to me in desperation. The girl was bleeding profusely, had a high temperature and abdominal pain. I realised rapid intervention was required, but did not have the facilities at my health centre. I rang my supervisor, but he was away. Then I rang the sub-district hospital and eventually got through to the duty doctor. He was not willing to come and told me to send the patient. I explained this to the aunt who said she had no money for transportation or costs at the hospital. The aunt would not allow me to ask for help from the community, even for a rickshaw van to the river to get a boat. There was nothing I could do other than rudimentary treatment for the fever and pain. By the morning the girl was dead. If only my supervisor had been there to guide me or the doctor available with blood, equipment and medication. If only I had had better skills to get support from the community – a life perhaps would have been saved.

I cannot provide quality abortion services without support – be it from the community, my supervisor, more qualified medical personnel, etc.

I hear that the provision of safe abortion, upon request, in other countries is increasingly being undermined by the influence of anti-choice supporters at the policy level, diminished funding, threats of defunding and even by intimidation of individuals working in clinics or women wanting to avail services. In more subtle ways, the right of women to abortion services beyond a certain number of weeks is also under scrutiny and potential restriction.

From my experience, it is certainly not enough to make post-abortion care available without information and services for contraception and safe termination. For women to have full choice regarding their reproduction, it is essential that a complete gamut of services is accessible and affordable, preferably in one location.

So, to finish – for me to be an efficient and effective manager/practitioner, I need a lot of support for my abortion work. And I am sure I am not alone in these needs. We must work together to prevent unsafe abortion and make abortion safe when it is required.

Story told by Sandra Kabir
International Council on Management of Population Programmes (ICOMP)

A double standards strategy

Paradoxically, the governments of many countries where women are forced to undergo unsafe abortions often turn a blind eye to clinics that perform the procedure in a safe way. There are those who feel that this hinders political efforts to liberalize stringent abortion laws.

Some images encapsulate the entire spirit of the age. This particular one depicts a successful Thai business leader with a baby on one arm and a condom artificially rolled onto the fingers of his opposite hand. The man staring at the spectator from the computer screen is Dr. Mechai Viravaidya, in popular parlance referred to as 'Mechai condom'. As head of the privately owned Population and Community Development Association in Thailand and with a long political history, he is a man of enormous clout.

This article examines how double standards manifest themselves throughout the world when it comes to abortion. Let's take Thailand as an example. How can a country that prohibits abortion have one of the steepest declines in population increase in modern times; from an average of seven children per family in the mid-1970s to today's level of just two? How can a clinic in Bangkok operate quite openly despite the ban on abortion?

Economics forms part of the explanation. A woman who is able to pay and has the right social contacts can often have a safe abortion despite the legislation. Doctors and other key groups make substantial profits from 'underground' activities.

Another explanation is that many governments view explosive population trends and high levels of maternal mortality with considerable apprehension and as a result allow abortion. It may well be easier to allow an illegal abortion market than to tackle the issue politically.

It is easy to think that abortions are safe, or are performed by trained medical personnel, in countries with liberal abortion laws. But it is not quite so simple. Many countries pursue an abortion policy that seems liberal

on the face of it, but which has very little to do with the demands for freedom and health, called for by the women's movement. The driving-forces are instead demographic.

India is a case in point. Abortion was decriminalized in the country in the 1970s as part of the government's strategy to stem a rapidly rising population. Despite this, the absolute majority of Indian abortions are currently illegal and take place outside the healthcare system.[1]

The general level of public health plays a part in this. Women in poor countries quite simply die from complications which in the context of western healthcare would be easily remedied. In some African countries, the mortality rate in relation to unsafe abortion can be as high as 25 per cent.[2]

All this means that abortion today is far from a straightforward issue. It is not enough to consider whether a government is for or against a woman's right to terminate a pregnancy. We must also look at how informal power systems interact with political interests.

The new potential of medical drugs

One of the proponents of a more pro-active abortion strategy is the Swedish professor of international health, Staffan Bergström, who works at the Department of Public Health Sciences (IHCAR) at Karolinska Institutet in Stockholm. His strategy is to encourage actors in the field of international healthcare to bear a responsibility for making even illegal abortions safe. According to him, the democratic powers of the international community cannot afford to wait until abortion is legalized in anti-democratically governed countries or in countries governed by ultra-conservatives. Whilst we wait, women are dying unnecessarily as a result of unsafe abortions. In such a situation, and with the help of new, cheaper abortion-inducing drugs, doctors and midwives have a moral obligation to act.[3]

Staffan Bergström reminds us of the fact that women have 'the right to life'. Among the tools at their disposal, trained midwives can use Cytotec – a drug that is not primarily intended for abortion, but which nevertheless induces it. At just one or two dollars per treatment, the price is also surmountable for poor women.

Christina Zampas, the Center of Reproductive Rights' legal adviser for Europe, gives sustenance to the idea that new drugs are starting to have an effect on the abortion issue.

As new drugs make abortion possible at an ever-earlier stage of pregnancy, a woman's right to self-determination is being strengthened. It is hardly surprising, therefore, that the opposition is so fierce. Christina Zampas quotes eastern Europe as an example, where the church today exerts considerable power:

"In many European countries, a woman's access to medical abortion is taken for granted. But we tend to forget that these drugs have not been approved in most

1 Siddhi Hirve, *Policy and Practice*, Seminar 532, December 2003.

2 United Nations Population Policy Data Bank, 2004.

3 Staffan Bergström, *Safer Illegal Abortion – An Ethical Challenge*, IHCHR, Stockholm 2003.

countries. The church has for example blocked such an approval in countries like Slovakia and Lithuania, despite abortion being legal there up until the 12th to 14th week of pregnancy."

The fact that many governments turn a blind eye to clandestine abortion clinics can be explained by population policy interests. This entire 'double-standards abortion policy' is founded on both parties keeping quiet about the agreement, despite 'everyone' knowing that abortions are performed at clinics that – using the 'sliding vocabulary' of the reproductive health sector – are said to perform 'menstrual regulation', or 'post-abortion care'.

In a country such as Bangladesh, the government views the fact that they have not succeeded in preventing unwanted pregnancies as a failure. 'Menstrual regulation" clinics are therefore allowed – this being the often used code word for healthcare offered to a woman to 'restart' her menstrual cycle.

Another example is the 'post-abortion care' clinic that offers women care after they have undergone an unsafe abortion, whilst women, cynically enough, are not offered help to perform the abortion itself.

Political efforts must accelerate

The strategy of using terms such as 'menstrual regulation' and 'post-abortion care' is mainly employed in countries where George Bush's global gage rule, and/or legislation and public attitude makes it impossible to speak openly about abortion. Women in many ultra-religious countries, for example, are subject to a vehemently enforced ban on sexual contact before marriage. The revelation of an unmarried women being pregnant can have very serious consequences both for the woman herself and for her family.

The western world's secular idea that sex is a woman's right, outside as well as inside marriage, appears completely alien in this context. Some interpretations of the Quran for example sanction the stoning to death of a woman who has been caught having extra-marital sexual relations. And we already know the views of the Christian right.

The desperate and often life-threatening methods some women resort to in order to terminate a pregnancy must be understood with this in mind. The feelings of shame and honour that surround women's sexuality, and which explicitly forbid her to have sex other than inside marriage, also explains why the existence of private (illegal) clinics as opposed to public, state-financed care is seen in such a positive light in many countries. What is dealt with 'under the table' can be kept a secret.

Ann Svensén, director of external relations at the Swedish Association for Sexuality Education (RFSU), certainly believes that it is important to satisfy needs 'on the ground', but also feels that political dialogue regarding safe abortion must be stronger. It is essential for many countries to liberalize their abortion laws and the issue must be high up on the political agenda.

"This can only be done if civil society speaks up and delivers the human rights, public health and economic arguments. NGO's must break the silence and put real faces to the problem of unsafe abortions," Ann Svensén says.

Many midwives and doctors who have experienced reality out in the field, not least in many African countries where the prevailing situation is disastrous,

paint a very alarming picture illustrating the imperativeness of rapid political action.

"If I, as a midwife, visit a delivery ward in Dar Es Salaam, Maputo or Lusaka, I almost faint. And the women there are very fortunate to have actually been given a bed at the hospital," says Cecilia Ekéus, a Swedish midwife, researcher and member of the African Midwifery Research Network.

"It stinks of blood, which of course any Swedish delivery ward could do," she adds, "the difference being, however, that here you have ten women lying in a row in excruciating pain. They are short in stature and often extremely young. Anaemia and other diseases mean that they easily succumb to complications which a healthy woman in the west would almost certainly survive. Furthermore, there is a lack of obstetricians, midwives, oxygen, antispasmodic and labour-inducing drugs."

A very critical period

How can we sum up the situation? Is it possible to obtain an overall picture?

Vicky Claeys is the regional director at the International Planned Parenthood Federation (IPPF) European Network, which organizes 39 NGOs in Europe and central Asia. She sums up the complicated situation quite succinctly:

"I have mixed emotions when it comes to practical strategies for promoting safe abortion in 'critical situations'. On the one hand, we must proceed with care, and realize the enormous risks run by clinics that talk frankly and openly about abortion, but on the other, we cannot simply sweep reality under the carpet. The choice of strategy depends very much on the location."

"As an organization, we hold the view that we should not just offer a service, but also support legislative change. These two things go hand in hand."

Vicky Claeys also points to the major differences in how we can approach the abortion issue in democratic versus non-democratic countries. She cites Belgium as a case in point:

"In Belgium, the law was amended as late as 1990 allowing abortion up until the 12th week of pregnancy. The practice of illegal abortion was already widespread, which brought pressure to bear for a changed agenda. Politicians were no longer able to evade the issue."

"Such a change process is possible in western democracies. But this is just wishful thinking in dictatorships or devoutly Catholic countries, where the prevailing spirit is very much anti-abortion."

"Quite simply, we are in a very critical period," Vicky Claeys concludes. "It is a question of building alliances on different levels. We are doing this between different powers that are at work within the parliamentary system, in women's organizations and in other spheres of power, and those who have experienced the negative consequences of restricted abortion laws at first hand."

Despite all our strategies and efforts, we will in all likelihood have to endure double standards for quite some time to come.

Edited by Silvia Sjödahl
Swedish Association for Sexuality Education (RFSU)
Research and interviews by Kristina Hultman

How can anyone justify the Pope and the Catholic Church having such an impact on women's rights? No-one but the woman herself can decide whether she should terminate a pregnancy or not. It is time for governments to stop giving religions the preferential right of interpretation.

Has the Pope a stranglehold on the EU?

The Catholic Church is undermining the struggle for sexual and reproductive rights in the EU. This is the claim made by Catholics for a Free Choice in a debated report. It is a controversial issue where opinions differ considerably. Swedish negotiators believe the influence of the Catholic Church is marginal.

"Everything has become more aggressive since the Christian Democrats (KDH) came to power," says Olga Pietruchova, director of the Slovak Family Planning Association (SSPRVR).

Slovakia is a new EU member state in which the government enjoys strong support from the Catholic Church. In 2000, the Slovak government signed an agreement with the church giving it the right to teach in schools and preschools.

"Sexuality education is controversial and is just a small part of biology teaching. The schools here are poor. The Catholic Church can offer teachers free of charge, who are then free to advocate abstinence and argue against contraception unchallenged."

The Slovakian justice ministry is currently drawing up a second agreement with the Catholic Church. This can give doctors the right to refuse to perform abortions, and allow teachers to decline to teach subjects that go against their religion.

Irresponsible women

The Christian Democrats have been working to restrict abortion rights in Slovakia since 1990, but so far, no amendments have been passed. Some hospitals already refuse to perform abortions, citing conscience clauses. The price for an abortion has risen to 40 per cent of the average monthly wage.

"The general public takes little notice of the agreement with the Catholic Church, but it has led to consequences on a number of levels," Olga Pietruchova adds.

Medical abortion has yet to be approved in Slovakia, despite the majority of European member states

having already done so. The country's national strategy for reproductive and sexual health has been postponed and a Catholic group of independent experts has been asked to develop an alternative.

"Women are being stigmatized in strongly conservative regions. A mother of five children committed suicide when the family refused to let her have an abortion. Last year, seven new-born children were found dead in a container," Olga Pietruchov says.

The ensuing debate centred on a proposal to introduce hospitals where women could give birth anonymously and put the children up for adoption.

"The general reaction is that these women are irresponsible. No-one understands them," Olga Pietruchov points out.

Most Slovaks, however, have a pragmatic attitude towards religion. According to a 2002 study, the majority saw themselves as Catholics but only 13 per cent of the women were against abortion.[1]

Too sensitive for the EU

Slovakia, along with nine other countries, acceded to the European Union on May 1, 2004. The present union is built upon respect for human rights. On several occasions, member states have also signed legally binding international conventions and morally binding declarations. New EU member states must live up to these standards. Turkey, for example, was criticized for its lack of human rights in respect of torture and freedom of expression when it wanted to become a member of the EU. Its application was duly turned down. But no ministers objected on the grounds of inadequate reproductive rights when Malta and Poland secured dispensation for their abortion laws prior to them being approved as new EU members. The arrest and imprisonment of midwives who perform abortions in Portugal occur without reprimand from other EU governments.

This is partly because the EU has previously interpreted sexual and reproductive rights as a health issue, and decisions about health are a matter for each individual member state in accordance with the European principle of subsidiarity. The issue of abortion is therefore determined at the national level, and totally deadlocked. Not even Sweden comments upon this – despite sexual and reproductive health and rights (SRHR) being a priority issue for the Swedish government.

The former minister for development cooperation, Jan O Karlsson, has hinted that the issue might be being played down for tactical reasons; and that the extremely sensitive nature of the abortion issue could lead to deadlocked negotiations.

"It's possible that insufficient pressure was exerted on the new member states. On the other hand, however, it would be difficult to push these issues under present conditions," Jan O Karlsson says.[2] .

But the fact remains – prominent bodies have interpreted reproductive rights as being among the human rights with which EU member states are obliged

1 Slovak Family Planning Association, *Reproductive Rights in Slovakia, Present Political Situation*, 2004.

2 Sjödahl, Silvia, *Underlivsfrågor i storpolitiken ('Genital issues' in top-level politics)*, No. 4 Ottar, 2003. In Swedish.

to comply.[3] Still, issues like access to safe abortion seem to fall outside the EU's view of what is a human right.

The new European constitution – if approved – also includes a catalogue of fundamental rights to be adopted by all EU member states. The fact that the Pope and the Catholic Church wanted specific reference to be made to Europe's Christian heritage/roots in the new constitution's preamble became widespread knowledge at an early juncture. This was the subject of intensive lobbying by the church of all EU member state governments.[4] The Pope also sent an ambassador to Sweden.[5] But the final draft of the constitution presented on June 17-19, 2004 made no mention of Christian roots. Instead, the preamble makes reference to 'drawing inspiration from the cultural, religious and humanitarian inheritance of Europe'.

Something which did not become common knowledge, however – at least not in secular northern Europe – is Article 51.This refers to the status of churches and non-confessional organizations and states that "the Union respects and does not prejudice the status under national law of churches and religious associations and communities in the member states". The Union shall also "maintain a regular dialogue "with these churches and organizations. A large number of MEPs and national legislators signed a campaign by MEP Maurio Turco to have article 51 removed.[6] They feel that the article exempts the church, and in particular the Catholic Church, from other EU principles.

"In Germany, for example, the Catholic and the Protestant Church are together the second-biggest employer after the state. They have hospitals, schools, etc, with a total workforce of 1.3 million people, half of whom are Catholic and none of whom has the right to strike. If you work at a Catholic hospital, you do not have the right to marry a divorcee," Elfriede Harth of Catholics for a Free Choice Europe points out.

She feels that Article 51 excludes the country from the European principle of non-discrimination on the grounds of gender, religion, sexual orientation or civil status. In concrete terms, this might mean that the church in Germany will be able to continue to enforce special conditions on its employees, in contrast to other European employers.

In pursuit of formal consultative status

"If the church only wants dialogue, there is already an article that provides for it," Elfriede Harth says. In Article 46 of the new constitution (Principle of participatory democracy), the Union pledges to maintain an open dialogue with representative associations and the civil society.

"Why then does the church want a separate paragraph?

3 Center for Reproductive Rights, *Reproductive Rights in the European Court of Human Rights*, New York 2004.

4 Boe, Sigrid, *Ny EU-grundlag allt längre bort (New EU constitution no nearer)*, Dagens Nyheter, May 19, 2004. In Swedish.

5 *EU-länder tvistar om Gud (EU states wrangle over God)*, Tidningarnas Telegrambyrå, May 5, 2004. In Swedish.

6 136 MEP:s and 112 national legislators, signed the campaign. Radical Party, *Appeal against art 51 of the Future European Constitution*, 2004 www.radicalparty.org

Why should the Union pledge not to prejudice the status of the church in individual member states?" she asks.

Along with fellow critics, she is mainly worried about the Catholic Church advancing its positions.

In 2003, Catholics for a Free Choice released a report on the Vatican's agenda in the EU. It shows that the Vatican and conservative Catholics are lobbying against the EU's support for SRHR. It also highlights the Vatican's opposition to the EU's attempts to recognize the right of citizens to plan their families and the right of homosexuals to enter into partnerships. They are also trying to restrict access to abortion and sexual and reproductive health services. This is being done by trying to influence EU development cooperation policies, etc. Ten per cent of EU funding to development projects under NGO management went to the Catholic Church between 1997 and 2002.

The report also claims that the Catholic Church is in favour of the subsidiarity principle so that it can keep its special employee regulations. A statement was issued from the National Bishops' Conference in Germany in June 2002. It said that lesbians and homosexuals employed by the Catholic Church risked dismissal if they entered into registered partnerships – a right they otherwise enjoy as German citizens. It was also claimed that several European Commission officials regularly conducted a dialogue with the Catholic bishops' organization, COMECE, prior to putting forward various proposals, for example to make use of the church's expertise in refugee issues.[7] Religious advisers are also part of the Commission's think tank, GOPA (Group of Policy Advisers). But these informal ties are not enough for the church. It wants formal consultative status in the EU, the right to comment on all proposals from the Commission and Parliament, the report says.

No cause for concern

EU experts in northern Europe, think tanks, EU bureaucrats and Swedish government officials see things differently, however.

The Swedish government is not unduly worried about the Catholic Church. They feel that Article 51 does not give the church greater influence in the EU. Jens Odlander is a political expert at the Prime Minister's Office. According to him, the mandatory referral procedure currently being proposed in the EU will basically function in the same way as the Swedish procedure and the Catholic Church will be only one voice among many others.[8] Neither does Lars Danielsson, the state secretary who negotiated the new EU constitution on Sweden's behalf, believe that the church can influence the EU, despite the Catholic Church being a powerful political force in many of the new EU member states.

"I don't see the Catholic Church gaining much of a

7 Commission of the Bishops´Conference of the European Community, (COMECE), Catholics for a Free Choice, *Preserving Power and Privilege: The Vatican's Agenda in the European Union*, Washington DC, 2003.

8 Under Article 46, Union institutions shall by appropriate means conduct an open and regular dialogue with representative associations and the civil society.

In several European countries abortion is illegal. In Portugal women are put in jail for performing safe abortions and in Ireland the law is extremely restrictive. Every year many Irish women have to travel to the UK to get a safe abortion.

hearing in the negotiations and therefore see no cause for concern," Lars Danielsson comments.

Neither does giving the church an exemption as an employer, as in Germany, worry the Swedish negotiators.

"It is not the Union's task to tell member states how to organize their political systems," Jens Odlander points out.

How then should we assess the Swedish point of view? Pragmatism – to ensure the adoption of the new constitution? Optimistic confidence in liberal forces – or just mere naivety?

"The Catholic Church is clearly lobbying for issues that are closest to its heart. But don't forget that 'the other side' is also very well organized. I assess article 51 as a kind of 'placebo effect' to make up for the non-inclusion of the word 'Christianity'. Catholics may be able to exert some influence in the short term, but they will lose in the long run. Their attitude, for example in the abortion issue, will not permeate through to the United Kingdom and Germany, where even most conservatives are in favour of abortion," says Dr. Detmar Doering, director of the German think tank, the Liberal Institute of Friedrich Naumann Stiftung.

Current practice – lay low

Among EU member states, Poland has received the most media attention regarding its strict abortion laws. Wanda Nowicka is Executive Director of the Polish Federation for Women and Family Planning. She is disappointed that the EU allowed Poland to negotiate a declaration giving it the right to legislate on ethical and moral issues such as abortion in the future. She is

worried that Article 51 will give the church a better position and strengthen its status in eastern and central Europe.

"I believe the Catholic Church fought to get Poland into the EU because it wanted to have Polish conservative decision-makers in strong positions."

In several new EU member states, it is working hard to restrict laws, influence policies and actions that can limit access to SRHR. So far the Catholic Church has successfully limited abortion rights in Poland. It is now turning its attention to access to contraception, sexuality education for teenagers and registered partnership for homosexuals and lesbians, according to Wanda Nowicka. However, many are convinced that liberal forces are still at the helm of the EU. "We cannot export our view on the family, as Prime Minister Göran Persson said recently. Family ideals vary considerably throughout the EU. It is just not feasible to argue for a common family policy. On the other hand, Sweden has been relatively successful in arguing for gender equality. In that case we must endure the thought of Sweden losing its abortion rights," says Ursula Berge, director of the Swedish Social Democratic think-thank, Agora.

Who says we have to lose our right to abortion?

"Well, current practice is for each country to pursue its own family policy," Ursula Berge says.

Are abortion and homosexuals a family policy issue?

"No, they are essential a rights issue, but it is an interpretation of what constitutes a human right. In reality, however, it is a question of the EU finding it difficult to set down the route we are supposed to take. 'Muddling through' to avoid obstacles may well turn out to be the only accessible way forward," Ursula Berge believes.

As many in northern Europe, she sees Article 51 as very 'woolly' and not very binding.

Marco Cappato, Italian Euro-MP for the Radical Party disagrees. He has strongly opposed Article 51:

"Ask the researchers at Karolinska Institutet in Stockholm whether they think the Catholic Church has any power. They have had their research on the human embryo stopped thanks to Italy blocking the funding. Italy did so to please the Catholic Church.

He is surprised at the Swedish attitude.

"The Catholic Church exerts considerable influence on Italian politics, a case in point being the ban on medical abortion. We should be able to register partnerships throughout Europe, but this is not the case. This is of course due to other conservative forces as well, but to say that the Catholic Church has no real influence is naïve."

Sweden should have said no

Yet Marco Cappato doesn't believe that conservative Catholics one day will control Europe.

"But to win, we must know who our opponents are. The Vatican wants to have a clear status within the EU as it enjoys in the UN. If we make its actions public, they will lose. But do not let it exert influence behind the scenes," says Marco Cappato.

"But my message to Swedish and other northern European politicians is still to be careful. Article 51 is still in there, Sweden should have said 'no' to it."

Joachim Fischer is a correspondent in Italy and the Vatican for the conservative newspaper Frankfurter Allegemeiner Zeitung.

"The Vatican accepted and applauded Article 51.

Fast facts

Latvia

• Abortion on demand until 12th week – abortion questioned by the church publicly – right to life for the unborn on the agenda.
• Medical abortion not accessible, no company pushing for it to be accepted.
• Morning-after pill available.

Lithuania

• Abortion on demand until 12th week. It is not a written law.
• Medical abortion not legal.
• Morning-after pill available.

Slovakia

• Abortion on demand first trimester.
• Medical abortion not available, no political will to introduce it.
• Morning-after pill available only on prescription.

Poland

• Abortion not legal- public polls show that 60 per cent support abortion for social reasons.
• Medical abortion not accessible, not registered or legal.
• Morning-after pill available only on prescription.

(Facts based on interviews with member organizations to Ippf, except Poland; interview with the Polish Federation for Woman and Family Planning.)

But this was not enough for the Pope, who wanted mention to be made of Europe's Christian roots. But Article 51 is good. In a way, it perhaps carries more weight," says Joakim Fischer, who describes the power of the Catholic Church as indirect. It is a question of moulding public opinion, a fact Pope John Paul II realized early on in his papacy.

"But the Vatican obviously has power, both intellectual and spiritual, on a different level. It is a question of values. We are currently seeing far too many divorces in our society, and we have problems in these areas."

Joakim Fischer believes that people listen to the Pope and European politicians must also make people sit up and take note, and to vote for them.

"Compared to other lobby groups, the Vatican is probably one of the strongest."

An aggressive Catholic Church

The impact of the Catholic Church is already a reality in several of the new EU member states.

"The First Party was founded by priests and is now part of the government coalition. This means the party is now implementing its policies. It advocates Christianity studies in schools. As from September this year, parents will be able to choose between this and ethics. Sexuality education has been part of health studies and

we feel it will get worse now," says Gundega Gravite, assistant director of the Association for Family Planning and Sexual Health in Latvia.

She also says that the First Party is focusing on the abortion issue.

"They attacked our health minister because she was a practising gynaecologist. They claimed that, as a minister, she should be advocating for child-birth instead of performing abortions," she says.

It is bad to talk about sex

The climate in neighbouring Lithuania is perhaps even tougher. The new conservative government listens to the church and projects on sexuality education, youth-friendly services, abortion, contraception and artificial insemination are being criticized. Organizations like the International Planned Parenthood Federation are being discredited.

"The Catholic Church is being aggressive and the government doesn't want to be in conflict with it. And then I don't think people know that reproductive rights are also human rights," says Dr. Esmeralda Kuliesyte, Executive Director of the Family Planning and Sexual Health Association of Lithuania.

Her organization's planned sexuality education projects in partnership with the Swedish Association for Sexuality Education, RFSU, faced severe criticism. Dr. Kuliesyte herself was portrayed as a terrible person in the media. Few jumped to her defence – neither medical colleagues, nor radical intellectuals.

"It's bad to talk about sex here, especially for a woman. There are many conservatives in the medical profession as well," says Esmeralda Kuliesyte. "There are plenty of surreptitious supporters of reproductive rights, but no-one is prepared to stand up for it."

Perhaps representatives of Catholic countries are coloured by living in an environment where the church has a lot of influence. But their accounts must nevertheless be interpreted as the church having power over people's lives. If homosexuals are refused the right to enter into partnerships and women are denied access to abortions, the consequences can be extremely serious. The same will be true if abstinence is the main thing taught in some schools in eastern Europe, and young people do not learn how to protect themselves against HIV/AIDS.

This summer, in July 2004, Anna Zaborska of the Slovakian Christian Democrats (KDH) was elected to chair the women's committee in the European Parliament. Ms Zaborska has once described homosexuality as a health defect and is anti-choice.[9] Her father was former Slovakian ambassador to the Vatican.

"She proposed a constitutional ban on abortion in Slovakia. She will be the Vatican's mole on the committee," says Olga Pietruchova, director of the Slovak Family Planning Association.

Ylva Bergman
Swedish Association for Sexuality Education (RFSU)

9 Billings, Henrietta, *Anti-abortionist takes EU women post*, Eupolitix.com, 27 July 2004. www.eupolitix.com

Important court cases in Europe

Women still lack the right to make decisions over their own bodies. They are denied full access to modern medical methods and family planning information and services in many places in the world. The agenda of reproductive rights for youth, women and the gay, lesbian, bisexual and transgender community is not being pushed forward and in many places it remains restrictive and discriminatory.

Over the years, several cases regarding sexual and reproductive health and rights have been brought to international and regional courts that supervise human rights. The rulings from these cases are very important for how these rights are to be interpreted now and in the future – and what is to be regarded as a human right in this context.

Below is a short summary of important reproductive rights related cases from the case law of the European Convention on Human Rights, including decisions from the European Court of Human Rights and the European Commission for Human Rights. The summary comes primarily from a recently published paper by the Center for Reproductive Rights in New York.[1]

An important task is to get decision makers on high political levels to understand that sexual and reproductive rights have already been interpreted as human rights, according to legally binding international conventions and their monitoring bodies and international and regional human rights courts in Europe and around the world.

Restricting access to information about abortion

The right to freedom of expression is guaranteed by all European countries that have signed the "Convention for the Protection of Human Rights and Fundamental Freedoms". In 1992, the European Court of Human Rights found that Ireland's restriction on women's health clinics from spreading information on how to obtain an abortion in England was in violation of Article 10 of the Convention: freedom of expression and the right to receive and impart information. The verdict said that it is a nation's right to protect public morals but that this right is not unlimited and in this case this right did not include restraints on receiving and giving information. It also found that this restriction created a risk to the health of women whose pregnancies were a threat to their lives.
(Open Door Counselling and Dublin Well Woman v. Ireland. Ireland, 1992)

1 Center for Reproductive Rights, *Reproductive Rights in the European Court of Human Rights*, a briefing paper, New York, August, 2004.

Rape- without forceful resistance

In a recent case (2003), a 14 year old Bulgarian girl was repeatedly and violently raped. Bulgarian law enforcement did not prosecute the perpetrator, in part because the girl showed no physical resistance to the rape and the authorities consequently concluded that the girl actually consented. She took the case to the European Court of Human Rights, and complained that since rape cases could only be prosecuted when the rape victim has shown physical resistance, national law and practice did not provide effective protection against rape and sexual abuse. The European Court of Human Rights found that states have an obligation to investigate and punish rape. According to the law in most other European countries and in international criminal law, the victim is no longer required to resist physically. The Court noted that taking advantage of coercive circumstance to have sex is also punishable according to international criminal law. Bulgaria was called to implement reforms in this area to comply with international and European standards. *(M.C. v. Bulgaria, 2003)*

Compulsory isolation of a person who has tested HIV positive

A Swedish man was placed in compulsory isolation in a hospital for four years on the basis that he was prone to irresponsible sexual behaviour, and, being HIV positive, he was spreading the infection. Another reason was that he did not consult a psychiatrist to address this problem. He claims that Sweden has violated his right to liberty under the European Convention on Human Rights. Sweden's 1998 Infectious Disease Act, which allows for this compulsory isolation, is now being challenged on these grounds. A decision has yet to be made on this case. *(Enhorn v. Sweden)*

Forced sterlization of Romany women

In a report by the Center for Reproductive Rights, several Romany women tell how they were sterilized in hospitals against their will, in some cases having no knowledge of the sterilization being performed. Some women found out years later.[2] In 2004, a case was brought against Slovakia by three Romany women for failure of health personnel to obtain their informed consent before being sterilized. The European Court of Human Rights has yet to decide if the case should be heard. *(Ginová and Others v. Slovakia)*

Denied abortion, went blind

In 2000, a Polish woman was denied an abortion under the law despite the fact that her pregnancy would result in her going blind. She was forced to give birth and is now severely visually impaired, unable to work or effectively care for her three children. The case is pending at the European Court of Human Rights. (*Tysiac v. Poland*) The Court and Commission have consistently supported national laws allowing for abortion on demand in the initial stages of pregnancy, and

2 Center for Reproductive Rights and Poradna pre obcianske a ludske prave (Center for Civil and Human Rights, Slovakia), *Body and Soul, Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Sloakia*, New York, January 2003.

have recognized women's right to terminate her pregnancy over any "right to life" of the foetus, especially when the woman's life or health has been threatened. The Court has not as of yet decided on a case where a woman is denied an abortion she is legally entitled to.

Pharmacists refused to give out the pill

In France, two pharmacists refused to fill prescriptions for contraceptive pills claiming conscientious objection due to their religious beliefs against any use of contraceptives. The European Court of Human Rights found that Article 9, the right to freedom of religion, was not violated when the French courts concluded that ethical and religious principles were not legitimate grounds for refusing to sell contraceptives – as long as the sale is legal. *(Pichon and Sajous v. France, 2001)* In Eastern Europe, doctors and hospitals sometimes refuse to perform abortions or prescribe contraceptives claiming a conscientious objection.

Sexuality education – not against parental rights

There are no recent cases, but in 1976 the European Court of Human Rights found that Denmark's compulsory sex education programme did not violate "the right to privacy and freedom of religion of parents of school-age children". Importantly, the Court noted that the Danish state had a public interest in informing its youth about sex-related issues, including sexually transmitted infections and teenage pregnancy. On the other hand, the Court has also supported the United Kingdom's decision to ban a particular sexuality education book (1976). The book discussed issues such as homosexuality, abortion and masturbation. The Court did find the book factual and correct, yet stated that the UK was entitled to protect public morals according to its own judgement *(Kjeldsen, Busk, Madsen and Pedersen v. Kingdom of Denmark (1976); Handyside v. United Kingdom)*. The Court has never heard a case requiring a state to provide compulsory sexuality education where there is none.

Does a foetus have the right to life?

In Russia and Lithuania, legislation has been introduced to recognize that a foetus has the same rights as a born person. Such legislation has yet to be passed and approved by the governments involved.

Granting a foetus protection and rights may not seem controversial, or bad, at first glance. However these rights become extremely problematic. Granting a foetus rights could be totally contrary to the rights and health of the pregnant woman. It is often the first step towards making abortion illegal, and thereby denying women the right to choose over their bodies, fertility and lives.

No international instrument has so far clearly interpreted the right to life as it applies to the foetus. The previous European Court of Human Rights and the European Commission of Human Rights have acknowledged that the regulation of abortion is an interference with a woman's right to a private life,[3] So far,

3 Christina Zampas, *Reproductive Rights in the European Court of Human Rights*, Center for Reproductive Rights, 2004.

the claims of several fathers as to the foetus's right to life have been dismissed, and the courts have found that 'the person primarily concerned by the pregnancy and its continuation or termination' supersedes any rights of the father. In 2000 a French woman filed a case. Her doctor performed an abortion on her, after mistaking her for another woman who was there seeking an abortion. The French woman now claims that Article 2 of the European Convention, Right to Life, applies to the foetus. She was represented by a well-known European anti-abortion activist. Once again, the Court, refused to extend the right to life to fetuses. The Court declined to treat a fetus as a person under the Convention, reasoning that "the issue of such protection has not been resolved within the majority of the Contracting States themselves /… /there is no European consensus on the scientific and legal definition of the beginning of life." The Court noted that "the life of the foetus was intimately connected with that of the mother and could be protected through her." *(Vo v. France 2004)*

The Court took the case seriously enough to hear it in its Grand Chamber. Approximately 20 of a thousands of cases every year actually reach the Grand Chamber.

How to deal with violations of human rights

If someone believes his/her human rights have been violated, they can appeal the case to a human rights committee or to an international court of human rights. There are six major international treaties that address human rights, including sexual and reproductive rights.

Compliance to some of these conventions is monitored by committees of independent experts. These committees issue general guidance on implementation and make decisions as to whether a person's human rights have been violated. Some of them can provide compensatory damages There are also three regional courts; one for Africa, one for the Americas (South, North and Central America) and one for Europe. The rulings/judgements of these courts are very important for the interpretation of human rights.

In Europe, the 'European Court of Human Rights', in Strasbourg deals with human rights complaints from Council of Europe member states. The court's mandate is to enforce the 'Convention for the Protection of Human Rights and Fundamental Freedoms', (ratified in 1953).

Research by the Center for Reproductive Rights
Edited by Ylva Bergman
Swedish Association for Sexuality Education (RFSU)

Education – not enough to tackle teenage pregnancies

The UK has had one of the highest rates of teenage pregnancy in western Europe for years. But investing in sexuality education in schools is not enough. New research indicates that a teenager's social background is crucial to how early she/he chooses to start a family.

Emma Worgan is 19 years old. Her son, Lewis, is almost five. When Emma was 14 she slept with her best friend Mark and soon after discovered she was pregnant. Self-possessed and opinionated, she sits in the administrative office of the Meriton School in Bristol and tells her story with composure and wit. Lewis, a lively and immaculately turned out child, runs in and out during the conversation, eager to show his mother what he is doing.

"My parents were really upset when I got pregnant because I had been a straight-A student," she says in a soft Bristol accent. "Mark didn't want anything to do with it. He dumped me when I was six months pregnant. He did come back for a bit after I had Lewis to be a father to him, but then he left again and now we don't see each other any more."

To many people, Emma is simply a statistic. In 1998 it was announced that Britain had the highest teenage pregnancy rate in western Europe; one in every ten babies born in England was to a teenage mother. That rate has declined over the last few years, falling by nine per cent between 1998 and 2001, but, despite that, teenage pregnancy levels in Britain remain high and, in some areas have continued to rise; in some inner-city London areas the conception rates of under-18s have risen to almost ten per cent, while the statistics for 2002 show an overall rise throughout the UK of 39,286 teenage pregnancies.[1]

1 Office for National Statistics, 2004.

Small wonder then that the UK government has placed teen pregnancies high on its list of subjects to tackle. The government's Teenage Pregnancy Unit, established in 1999, announced this year that its aim was to reduce teenage pregnancies by 50 per cent by 2010, with an interim target of 15 per cent reduction by the end of this year.[2]

Among the strategies laid out by the unit are more explicit sex education classes in schools, confidential health checks for teenage girls and communication with the girls' parents – many of whom, a recent Teenage Pregnancy Unit study found, know less about subjects such as the morning-after pill than their children.

Yet, this strategy has come in for considerable criticism in recent months. A Family Education Trust report entitled 'Sex Education or Indoctrination?'[3] released in March, suggested that far from helping to cut the level of teenage pregnancies, the strategy had instead contributed to a rise.

Cornwall saw a 17 per cent rise in teenage pregnancies from 2001 to 2002 (from 306 to 359), Torbay rose 22 per cent (from 92 to 113), York 34 per cent (from 93 to 125) and Haringey in London rose 8 per cent (from 281 to 310).[4]

Valerie Riches, the author of the report, said at the time of publication: "The government's teenage pregnancy strategy is based on the premise that it is unrealistic to expect young people to abstain from sex. They have embarked on a damage-limitation exercise dependent on condom use and the use of the morning-after pill."[5]

Riches suggested that this was not the most efficient strategy. "The figures show that it might be wise to support the majority in abstinence and demonstrate to the minority the physical, emotional and psychological benefits of delaying sex."[6]

More bemused than enlightened

Riches's argument is gaining increasing weight in America. U.S. President George W Bush has earmarked USD 120 million for abstinence education, and many U.S. states have chosen to introduce abstinence programmes to access that money. The best known of these, the True Love Waits movement, formed ten years ago, has convinced more than 2.4 million teenagers to promise 'God, myself, my family, my friends, my future mate and my future children' to abstain from sex until marriage.[7]

Nor is it the only such group. The Silver Ring Thing, a U.S. abstinence group formed by Denny Pattyn in 1995 and rolled out nationwide in 2000, arrived in the UK in June, spreading its message of chastity, godliness and the rejection of temptation. The group has

2 Teenage Pregnancy Unit announcement, February 2004.

3 Riches, Valerie, *Sex Education or Indoctrination?*, Family Education Trust, March 2004.

4 Ibid.

5 Bamber, David, *Teen Pregnancies increase after sex education classes*, The Telegraph, March 2004.

6 Ibid.

7 True Love Waits. www.truelovewaits.com

attempted to move away from the idea of abstinence as 'boring' by using laser shows and Christian rap bands to convince teenagers to pay USD 15 for a bible and a silver ring symbolizing chastity. A banner strap across the group's website reads: "It's about guys, girls, dating, love, second chances and making the right choice." The organization also, more crucially, preaches against the use of contraception claiming that there is "no such thing as safe sex".[8]

So far, the Silver Ring Thing, which held meetings in Surrey, Manchester, London and Birmingham, has met with a muted response in the UK. British teenagers attending the roadshows appeared more bemused than enlightened, with many admitting that they could not see what the fuss was about.[9]

Doesn't work in the long term

A more serious criticism of the movement was provided recently when a study of 15,000 American youngsters aged 12 to 18, undertaken by Yale and Colombia universities and funded by national institutes of health, found that nine in ten of those who sign chastity pledges are likely to break them – and that when they did so they were less likely than non-pledgers to use contraception. [10]

"It's difficult to simultaneously prepare for sex and say you're not going to have sex," said Peter Bearman, of Columbia University, presenting his findings earlier this year. "The message is really simple: 'Just say no' may work in the short term but doesn't work in the long term."[11]

Nor are they the only ones to feel concerned about this method of dealing with teenage sexuality. Although in previous years Conservative MPs such as Tim Montgomery, the head of the Tory party's Renewing One Nation policy unit, have backed abstinence policies, shadow health secretary Andrew Lansley recently indicated a sea-change in Conservative thought.

Speaking in early August, he outlined Conservative plans for a national network of school nurses to give advice to teenagers about sex, and backed moves to issue over-the-counter tests for chlamydia, one of the most prevalent sexually transmitted infections among British teenagers.

"I'm not talking about abstinence," said Lansley. "I'm talking about something which empowers young people to choose. It's feeling that one has a greater sense of control over what one does with one's body and being able to resist peer pressure or pressure from boyfriends."[12]

Lansley also said that research had consistently shown that teenagers would delay sex for longer and are less likely to get pregnant when they are taught not just

8 The Silver Ring Thing. www.silverringthing.com

9 Television report BBC London Tonight, July 2004.

10 Bearman, Peter and Hannah Bruckner, *The Relationship between virginity pledges in adolescence and STD acquisition in young adulthood,* paper presented at the National STD Conference, March 2004.

11 Peter Bearman speaking at the National STD Conference, March 2004.

12 Hinsliff, Gaby, *Tory U-Turn to give teens control of sex lives*, The Observer, August 2004.

Today there are more young people in the world than ever before, about 1.3 billion. The right of young people to have access to information and services is a very important outcome of the ICPD. Information on sexuality gives young people the possibility to avoid unwanted pregnancies and STIs.

about contraception but also about self-esteem and how relationships work.[13]

It is an argument endorsed by the British charity, Oasis Esteem, which has argued that the differences in religious and cultural values between America and the UK are obscuring an important message.

"The Silver Ring Thing is a religious and cultural model for the U.S., but people associate the message of abstinence with that movement," said an Oasis spokesman. "So the positive message, which is young people don't have to have sex, is being lost." He added that Oasis Esteem prefer to teach sexuality education classes based on the World Health Organization's ABC model – A, Abstinence; B, Be faithful to one partner; C, Condom use for those sexually active.[14]

Yet, if abstinence is not a miracle cure, what then should be done to cut levels of teenage pregnancy within the UK? Carol Bowery, the headteacher of the Meriton School in Bristol, which provides education for 65 young mothers and pregnant teenagers, believes that the government needs to look as much at the backgrounds of these girls as at sexuality education classes.

"I do think it's important to understand that these girls have different needs," Bowery says. "So many of them have got lost in the system. We have girls here who didn't attend school for two years. I learnt that and I thought how can that be? How can someone not turn up to school for two years and nobody notices or cares. I think it's important that people understand that so many of these girls come from difficult family situations.

"For example, in some cases, the parents divorce and the girl who is the oldest in the family ends up looking after her brothers and sisters. The relationship between her and her mother changes so that they become almost more friends then parent and daughter. Then the mother meets somebody new and they move in and the daughter feels displaced. She wants her own family and so she goes out and gets one. That does happen and we pretend it doesn't. We need to take into account the fact that for many of these girls having a baby is a chance for a better life."

Less abortions in deprived areas

Bowery's beliefs are backed up by a recent study by the Joseph Rowntree Foundation into teenage pregnancy within the UK. That study, carried out by the Centre for Sexual Health Research in Southampton on behalf of the foundation, found that teenagers in affluent parts of the country were far more likely to have an abortion as those in deprived areas.[15]

The study, which looked at abortion and pregnancy data among 15 to 17 year-olds between 1999 and 2001, found that 44 per cent of conceptions ended in terminations, but that there were huge variations in attitudes around the country.

The lowest number of abortions was in socially

13 Hinsliff, Gaby, *Tory U-Turn to give teens control of sex lives*, The Observer, August 2004,
14 Ford, Liz *Abstinence 'lost' in sex education*, The Guardian, June 2004. www.oasistrust.org
15 Lee, Ellie et al., *A matter of choice? Explaining national variations in teenage abortion and motherhood*, June 2004.

deprived communities such as Merthyr Tydfil in Wales (28 per cent), Ashfield in Nottinghamshire (30 per cent) and Derwentside in County Durham (the lowest number with only one in five teenage pregnancies ending in termination).[16]

"The decision about whether to continue with a pregnancy appears manifestly related to social deprivation," the report stated.[17]

Gill Frances, the vice chair of the government's independent advisory group on teenage pregnancy, agrees that there are problems in poorer areas where girls view pregnancy as an escape.

"If I was a young woman growing up now – I'm not saying this would be conscious – but if I thought: 'I am not going to get any GCSEs (pass any high-school entry examinations), I am not going to get a fantastic job and the only way that I become grown-up is to be a parent' then I probably would get pregnant," she told one English newspaper recently.[18]

Chrissie Helmore is 17 years old. Her daughter Hailie-Jade is almost two. Chrissie is still with her boyfriend Dean. She became pregnant at 14 and gave birth at 15.

"I felt really happy when I found out I was pregnant," she says quietly. "I didn't set out to have a child, I didn't get pregnant on purpose but when I found out I was happy about it. I was happy that I was going to have my own baby."[19]

It is this attitude, some teachers and government officials believe, that makes tackling teenage pregnancies so difficult. "The things parents are worried about are their kids being safe on the street, getting pregnant or taking drugs," says Frances. "Yet the problem is that when people are terrified about something they don't talk about it."

Few parents talk enough with their children

Gill Frances believes that more needs to be done to encourage parents to talk to their children about sex and that it can not all simply be left to the school. Recent research from the Teen Pregnancy Unit found that few parents talk in enough detail to their children about the facts of life, leaving them instead to gather information through Internet websites or by talking to their peers.[20]

"I don't want to talk about what my parents said when they found out I was pregnant," says Chrissie. "Don't go there." She later admits that she was forced to leave home and moved in with her boyfriend's parents.

"This is one of the major problems I see with the girls at the school," says Bowery. "The parents don't talk to them about the problems behind getting pregnant but then, when it happens, there are arguments on both sides and many of the girls leave home, voluntarily or

16 Lee, Ellie et al., *A matter of choice? Explaining national variations in teenage abortion and motherhood*, June 2004.
17 Ibid.
18 Revill, Jo and Gaby Hinsliff, *Can Love Wait?*, The Observer, March 2004.
19 Interview with Chrissie Helmore, August 2004.
20 Revill, Jo and Gaby Hinsliff, *Can Love Wait?*, The Observer, March 2004.

otherwise. Of course there are some families who are very understanding and work at helping the girls but there are many others who are forced out of their homes and who just don't know how to cope with that. I do believe that if parents spent more time discussing these issues with their children then it could help cut the levels of teenage pregnancies down."[21]

Critical to abstinence programmes

Nor is it just the girls who need to be educated. Roger Ingham, Director of the Centre for Sexual Health Research at the University of Southampton, believes that teenage boys' attitudes towards sex is at least partially responsible. "They do put more pressure on women to have sex," Ingham told a British newspaper recently. "Put baldly, middle-class men are much less likely to put pressure on."[22] Ingham was equally critical of U.S.-style abstinence programmes. "If you have an abstinence programme which doesn't deal with contraception or which deals with it in a negative sense then when people do break the pledge they are not confident enough or informed enough to use it."

By contrast, the UK government believes that the way forward is to combat teenage pregnancy rather than condemning underage sex. In recent months initiatives have included handing out condoms and making the morning-after pill more readily available, ensuring compulsory sexuality education in secondary schools and providing detailed handouts regarding sex. The government policy also stresses that, while sex should not be rushed into, if you are going to do it then get contraceptive advice.

It is a method that has been equally praised and damned, but Anne Weyman, Chief Executive of the Family Planning Association, believes that it works.

"Good sexuality and relationships education is most effective as a multi-faceted approach from within the home, school and healthcare," she says. "Studies have shown that abstinence doesn't work; it makes young people more vulnerable because they don't have the knowledge to protect themselves against pregnancy or sexually transmitted infections."[23]

Sarah Hughes
Freelance journalist based in London, England

21 Interviews with Chrissie Helmore and Carol Bowery, August 2004.
22 Revill, Jo and Gaby Hinsliff, *Can Love Wait?*, The Observer, March 2004.
23 Bamber, David *Teen Pregnancies increase after sex education classes*, The Telegraph, March 2004.

The U.S. retreat from the Cairo consensus

Cynthia Dailard and Susan Cohen from the Alan Guttmacher Institute on the U.S. idealizing abstinence

Ten years ago, the United States helped to forge the groundbreaking consensus among the world's governments at the International Conference on Population and Development (ICPD). The consensus acknowledges the central role played by the empowerment of women in attaining the related goals of economic development and population stabilization, and recognizes that reproductive and sexual health are necessary for women to achieve their full potential. As the global community commemorates the first decade of the ICPD Programme of Action (PoA) and reaffirms its commitment to this 20-year plan, the U.S. has distanced itself from its own position in Cairo.

Driving this dramatic shift in U.S. policy is the far right's campaign to demonize abortion while idealizing abstinence as the cure to a host of society's ills, at home and abroad. Indeed, the social conservatives now in control of both the executive and legislative branches of the U.S. government have long believed that the desire to promote abortion is the true underlying motive of the most prominent sexual and reproductive health organizations operating within the United States and worldwide. Accordingly, President Bush reimposed the global Gag Rule on his first day in office, cut off U.S. family planning and reproductive health assistance to International Planned Parenthood Federation, Marie Stopes International and many indigenous non-governmental organizations (NGOs), and severed ties with the United Nations Population Fund (UNFPA). At the same time, the U.S. government has established 'abstinence until marriage' programmes as its single most important global HIV/AIDS prevention strategy, setting aside at least one-third of all global HIV/AIDS prevention funding for this purpose starting next year.

So far, strong public support for domestic family planning programmes, combined with the protection that the U.S. Constitution affords the right to free speech for U.S. citizens, have prevented conservatives from defunding Planned Parenthoods in the United States and from imposing a gag rule at home. In contrast, the government's promotion of abstinence as the answer to pregnancy and sexually transmitted infection (STI) prevention for all unmarried people – and among adolescents in particular – is a largely home-grown

phenomenon. Since 1996, federal law supporting school-based sexuality education has dictated that young people be taught that sex outside of marriage has harmful physical and psychological effects. Because programmes must exclusively teach abstinence, they cannot discuss the benefits of contraception or condoms.

To date, funding for this particularly narrow brand of abstinence-unless-married education that rejects any notion of risk reduction through contraceptive or condom use has totalled almost USD 1 billion. Yet there is no credible scientific evidence suggesting that abstinence until marriage education can help adolescents to delay the initiation of sexual activity.

The 2003 global AIDS law provided social conservatives with the opportunity they were seeking to 'go global' with their abstinence-only agenda. They discovered Uganda's successful and comprehensive 'ABC' strategy for preventing HIV/AIDS – promoting abstinence, being faithful and condom use – and have translated it to anything but condoms. Recently the administration and Congress steadfastly contend that condoms should never be promoted to the general population, even in high HIV-prevalence settings. They argue that doing so would undermine the 'A' and 'B' messages and might even increase the HIV infection rate by making it easier for individuals to engage in risky behaviour.

It is ironic that the far right is looking to Uganda to justify exporting its abstinence-only agenda overseas, and even to justify bolstering it here at home, since all the evidence in Uganda shows that it was positive changes in all three ABC behaviours that led to the decline in HIV infection rates there. Moreover, adolescent pregnancy rates remain extremely high in Uganda. Rather, the U.S. might consider looking to the success of the Nordic countries in attaining some of the lowest teenage pregnancy, abortion and sexually-transmitted infection rates in the world. There, unlike here, government and social institutions support sexuality education and healthcare services aimed at helping young people to avoid the negative consequences of sex. Contraceptive use is encouraged and easily available.

The U.S. government is just beginning to distribute funds through its new global AIDS initiative, so it is still too soon to say what proportion of the resources will be going to support programmes that emphasize a moralistic approach.

As the United States is poised to expand and enrich an international network of abstinence-only promoters, it has disqualified critical agencies from partnering with the U.S. to address the full range of sexual and reproductive health and rights issues described in the ICPD Programme of Action. Exhorting young people to abstain unless or until married cannot succeed for many or for long. Likewise, the global Gag Rule can never succeed in reducing abortion.

Clearly, the shift in U.S. domestic and international policy and the retreat from the Cairo consensus has dangerous implications for individuals both within and beyond U.S. borders.

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Struggle in a bullet-proof vest

Anti-choice groups are becoming increasingly conspicuous the world over and in the United States, they have the support of the highest political office, namely President George W Bush. With the support of established political circles, the 'anti-choice' movement has become less prone to violence and more politically active, but despite this, threats and harassment continue.

The words 'Family planning', 'Sexuality education' and 'HIV tests' are written in large, white letters across the black-painted windows. The word 'Abortion' is nowhere to be seen.

But this is why the doctors wear bullet-proof vests and carry a weapon.

"Some form of identification, please."

"My press card?"

"That's fine. We want to be sure you are who you say you are. You have to ring the doorbell, the door is kept locked."

It takes a great deal of time and a lot of explaining before I am allowed to visit the Planned Parenthood Clinic in St Petersburg, Florida. The policy of the Planned Parenthood Federation of America is to assure that all individuals have the freedom to make reproductive decisions,[1] and the organization and its personnel have been attacked by anti-choice groups and individuals several times over the years.

The reception at the St Petersburg clinic looks like any other dull waiting-room – PVC furniture, a few magazines strewn on the table, staff behind a glass panel. While I'm waiting for my identity to be checked, I study a newspaper article from the mammoth pro-abortion demonstration, held on April 25, 2004 in Washington DC. Among the million or so 'pro-choice'

1 Planned Parenthood Federation of America, *Policy statements*, 1998. www.plannedparenthood.org

demonstrators at one of the largest demonstrations in Washington of all time, I can spot Senator Hilary Clinton, former Secretary of State, Madeleine Albright, and the actresses Julianne Moore and Whoopi Goldberg.

Pro-choicers register for the election

In the U.S. in general and in Florida in particular, opposition to the free right to abortion is strong and very much alive. A few years ago, two doctors and an assistant were shot dead at a clinic in Pensacola in northwest Florida. A total of eight people have been murdered by so-called 'pro-lifers' in the United States since 1991.

"This is domestic terrorism," says Barbara Zdravecky, president of the Planned Parenthood Federation for south-west and central Florida and on a visit to the St Petersburg clinic.

She is the only person willing to comment. Clinic employees have no reason to do so; they are not activists and making comments may put them in danger. As for herself, Barbara Zdravecky has been escorted home by the police from many meetings.

"But the worst incident was when I was on the beach with my daughter and we were walking back to the car to go home. Someone had stuck anti-abortion pamphlets in the sand all the way to the car. They had been following me."

"Are you not scared?"

"If I let fear stop me, they have won. We have a high level of violence in our American society. I could just as easily be shot at the post office as outside the clinic. Standing up for one's views is very important."

"The war on choice in this country has begun," the Planned Parenthood president, Gloria Feldt, said from the rostrum at the Washington demonstration. "But we will win this war."

One way of winning is to ensure that pro-choice people register to vote in the presidential election this autumn. This is why information and enrolment forms are available in the clinic waiting-room, under the newspaper article about the demonstration. It is important for pro-choice supporters to register, both, if possible, to oust the anti-choise advocate George W Bush from the White House and on account of all the state referenda that normally coincide with the presidential election. In Florida, for example, there will a vote on whether teenage girls will be forced to have their parents' consent before having an abortion. This has so far not been the case, with the girls' right to privacy in healthcare having taken precedence.

"Conservative anti-abortionists have tried to have the law amended on two occasions so far but have lost in the high court," Barbara Zdravecky tells me. "We will try to stop such amendments via legal channels but if we are unsuccessful, there will be a referendum."

Frightening people into silence

The Republican state politician, Sandra Murman, from Tampa, is quoted in the local St Petersburg Times: "Parents have the right to vote on this issue. They have a right to know what their children are doing."

"This is a sensitive issue to pursue politically," Barbara Zdravecky adds. "Most adults feel they have good contact with their children and believe other parents are in the same position. They don't realize that there are so many exceptions; parents who are incapable of

making a single sensible decision as a result of substance abuse, families where incest occurs or those with a different code of honour. There are an awful lot of girls who cannot talk to their parents. No, if the proposal is passed, I am sure it will give rise to more back-street abortions – again."

According to Barbara Zdravecky, the anti-choise league is working in a new and more effective way. They are trying to have state laws amended, have anti-choice judges appointed to important courts and infiltrate the media and the healthcare service – with the aim of frightening people into silence. One example is the grow-ing lack of doctors willing to perform abortions.

"There are six clinics in our district, four of which perform abortions. The others mainly offer contraception counselling. Throughout the country, 87 per cent of the counties have no abortion services whatsoever."

Since 1982, the number of doctors performing abortions in the United States has dropped by 37 per cent, and there are several reasons for this. One such reason is that fewer doctors are being trained to perform abortions. At many medical schools, students receive either no, or at best very rudimentary, training in how to perform a safe abortion. A mere five per cent of all the country's abortions are performed at hospitals, where most medical students receive their practical training. Those doctors who can/are allowed to/want to perform abortions are also getting older; 57 per cent of them being over the age of 50. This is partly a question of interest and commitment. Older doctors saw what happened before abortion was legalized, whereas younger doctors have no experience of treating women who have undergone illegal and unsafe abortions. Fear is another influential factor. No-one can fail to notice how doctors and other personnel at abortion clinics have been threatened and harassed. Working as a doctor who performs abortions is neither particularly pleasant nor safe.[2]

Abortion doctor killed at home

The doctors at the Planned Parenthood clinic in St Petersburg carry weapons and wear bullet-proof vests on their way to and from work, but this is not always where the attacks occur. In March 2003 in Buffalo, James Kopp was found guilty of the murder of abortion doctor, Barnett Slepian. The murder took place in October 1998 when the doctor came home to his house with his wife and four sons after a memorial service in the local synagogue. He was standing in the kitchen emptying his pockets onto the kitchen top when a gunshot shattered the window and hit him in the spine. Barnett's wife and sons tried in vain to stop the bleeding. The murderer, James Kopp, was already suspected of other attacks on abortion clinics and while he was under arrest for these crimes, he confessed to the murder of Dr. Slepian in a newspaper interview. Kopp was well known and admired in militant anti-choice circles, but after his confession, most anti-choice organizations disassociated themselves from him.[3]

2Medical Students for Choice, *The provider shortage,* 2004. www.ms4c.org
3 New York Times, March 2003.

The anti-choice movement's violent past

The Planned Parenthood Federation of America has its own security department. Every month, they publish information on the latest harassments and attacks on clinics, employees and pro-choicers.

According to them, eight people were murdered (doctors, clinic receptionists and volunteers) between 1991 and 2001. Twenty-two others were injured – doctors, office personnel, security guards, police officers and paramedics.

A further 16 have been the victims of attempted murder, and many people were hurt in the 15 bomb attacks launched on clinics across the U.S. And this is not counting all the attacks that were either unsuccessful or foiled.

The violence has, however, receded – mostly because the more serious anti-choice organizations have strongly dissociated themselves from it. Their opposition is now much more legitimate and politically mainstreamed but clinic personnel are still attacked and demonstrators still try to persuade women looking for help to turn away.[4]

The murders at the end of the 1990s may well have changed the main thrust of the anti-choice people, from violence to politics, but despite this, demonstrations against abortion clinics continue. Barbara Zdravecky goes on:

"On Fridays and Saturdays, people are always demonstrating at our clinic in Sarasota. They carry placards, scream slogans and occasionally drive around in trucks with giant posters of foetuses plastered on the side. Our own vehicles have been vandalized and on several occasions anti-abortion activists have taken photographs of our employees and patients and published them on-line. The registration numbers of our patients' cars have often been photographed and also published on the Internet."

Not all the demonstrators are so vociferous, however, and there are those who have tried to quietly persuade patients to change their minds. The clinic personnel normally brace the patients for the likely unpleasantness that awaits them and encourage them to ignore the demonstrators.

"No-one has the legal right to use force to stop someone coming to have an abortion, and if this happens, we call the police," Barbara Zdravecky says me.

She also told me that the Planned Parenthood Federation in south-west and central Florida has good

4 Planned Parenthood Federation of America, *10-year History of Violence and Harassment 1991–2001*. www.plannedparenthood.org

contacts with the local police, but adds that the situation is much more precarious on a national level with George Bush in the White House and the outspoken anti-choise person, John Aschcroft, as Attorney General.

"The Clinton administration called the anti-abortionists 'domestic terrorists'. The current administration has on the other hand compared the pro-choice movement to terrorism."

As president of a regional Planned Parenthood Federation, Barbara Zdravecky keeps track of issues that concern sexuality in society and tells me that the Bush administration has also introduced changes in sexuality education given in schools. It is no longer possible to obtain funding from the government for any form of sexuality education other than that which preaches abstinence.

"In a country where 100,000 abortions are performed every year, we ought to have realized by now that the abstinence message hasn't exactly hit home."

"Are things different in different parts of the country?"

"Yes. The anti-abortion movement is much weaker in the north-west. It is in the mid-west, Florida and Texas where conservatism is strongest, in this field as in others. We still have the Klu Klux Klan in Florida," Barbara Zdravecky points out.

She tells me how last Easter, a catholic school in Minnesota decided to get the children to spend their vacation demonstrating outside an abortion clinic. They were driven to the clinic to hold up their placards in shifts.

"I do not deny people the right to protest against something they don't like – this is after all the United States – but anti-abortion protests are so menacing."

Strong desire to dominate women

Babara Zdravecky describes the typical anti-choice activist as a Caucasian male. He could well be a born-again Christian with a strong desire to dominate women. He is also an opponent of contraception and if he can keep the woman tied to the home by her apron strings in a state of constant pregnancy, he feels much safer. Homosexual marriage is something else that frightens the life out of him. Barbara challenges all anti-choice activists (not just the men) who claim to be fighting on behalf of unborn children to instead turn their attention to the plight of all the children who are born and then abandoned.

"Every fourth child in the United States does not have the right to healthcare. There are so many millions of children in this country who are so badly treated. Why not fight for them instead?"

Karin Alfredsson
Freelance journalist based in Stockholm, Sweden

The road to free choice in Sweden

In Sweden, safe abortion is a matter of course and hardly a controversial issue. Abortion is free of charge and women do not need to travel for several days to get to a hospital. But it has not always been so. Thirty years ago, women travelled to Poland to have abortions – a fact few people are aware of today. The question is whether a lack of a sense of history might jeopardize free abortion in Sweden.

Abortion was legalized in many countries including Sweden during the 20th century. Swedish women have had the right to free abortion up to and including the 18th week of pregnancy since 1975. Abortions are performed at hospitals, and the fee is the same as for a regular check-up at the gynaecologist's. The woman herself, and no-one else, makes the decision whether or not to have an abortion, and she does not need to justify her decision nor answer any questions. Should she so wish, the woman is, however, entitled to professional counselling. The price of contraceptives, such as the pill and coil, is often reduced or they are free of charge and emergency contraceptive pills are also available over the counter at the chemist's.

But development can take a different course, as we have seen over the last twenty or thirty years. A case in point is Poland, a country with a long tradition of legal abortion which introduced very restrictive legislation in 1993.

The Swedish Abortion Act is not under threat

The right to abortion cannot be said to be under threat in today's Sweden. All parliamentary parties, from the right to the left, support the Swedish Abortion Act. Nor does the Church of Sweden demand any change in the law. But there are individual MPs, from the Christian Democratic Party, for example, who do not support the act. Organized opposition to abortion can be found in the 'Ja till livet' (Yes to life) movement. The 'Alternativ till abort' (Alternative to abortion) organization also runs special clinics where pregnant

women are offered counselling to allow them to choose to give birth.

Abortion is sometimes portrayed as problematic in social debate, however.

The number of abortions is sometimes claimed to be too high. Just over 30,000 abortions or about 20 abortions per 1,000 women are performed in Sweden each year. The number of abortions has remained relatively constant since 1975. But whether this number is high is a subjective opinion and has to do with how people view abortion from an ethical point of view. What is an acceptable number of abortions? Can we also talk about too few abortions? [1]

Abortions are made even more problematic by the way in which foetuses are taken care of after later abortions. At some hospitals, they are cremated and the ashes spread in a memorial grove, unknown to the woman and without her having asked for such a service to be performed. Such funeral rituals put the foetus on a par with a child and introduce an aspect of 'killing' into the abortion issue.

A much-debated time limit

The time limit for when an abortion may be performed is also a moot point. Just over 90 per cent of all abortions are performed before the 12th week. After the 18th week, a woman may be allowed to have an abortion if she, for example, is a substance abuser, has mental problems, or if the foetus is seriously deformed. She must in such cases obtain permission from the National Board of Health and Welfare. The Abortion Act does not provide for an upper time limit but the practice has been not to perform abortions after week 22. Debaters have claimed that premature babies can be saved at ever-earlier stages of pregnancy and that the upper limit for when abortions may be performed should therefore be lowered. Claims that foetuses have survived outside the womb as early as during the 20th week of pregnancy have, however, never been substantiated. The issue of time limits for early abortions was also brought to the fore recently when the Young Christian Democrats demanded that the limit be lowered to week 10.

Another way of problematizing a woman's decision to have an abortion is to require her to undergo compulsory counselling beforehand. Every woman wishing to have an abortion is currently offered professional counselling. The counsellor may not try to influence her decision and is there purely to offer support. But behind the demand to make counselling compulsory is the idea that women take their decision too lightly, or that in their current state they are incapable of making a decision. There are also those who feel that deciding whether to have an abortion is always a mentally and emotionally difficult situation for the woman and should therefore always be subject to counselling. Research shows, however, that women generally feel relieved after an abortion, that mild mental problems after the event are few and far between, and that serious

1 Gustafsson, Barbro and Gisela Helmius, *Statistik (Statistics).* In Gustafsson, Barbro et al., *Erfarenheter och egna val. En bok om abort (Experiences and own choice. A book about abortion)*, Gothia, Stockholm, 2000. In Swedish.

psychiatric problems are virtually unheard of.[2]

The problematization of abortion can partly be seen as anti-abortionist tactics; by focusing on specific details such as time limits or how foetuses are disposed of, it may be possible to restrict the right to abortion. But a lack of a sense of history may also have contributed to the problematization of the abortion issue. Few people are aware of the conditions under which women live in countries where abortion is illegal; nor are people aware of the fact that the right to abortion is the result of a long, hard political struggle.

As in many other countries, many women in Sweden previously had illegal abortions, despite the threat of severe punishment and sometimes risking their life and health. In the 1930s, the number of illegal abortions was estimated at between 10,000 and 24,000 a year. About one woman every week died as a consequence of an illegal abortion and hospital wards were packed with women who had contracted infections.

The right to abortion – a priority issue

In the early 19th century, women who had an abortion faced the death penalty, but this was gradually reduced until, in the 1930s, the normal penalty was a one-month suspended sentence. Abortionists were, however, sentenced to several years in prison. The abortion debate was intensive. Sexual reformists, women's pressure groups and other political organizations demanded women's rights to abortion on medical, social and eugenic grounds. At that time, they were not demanding free abortion, i.e. the right of the woman to decide herself. The struggle for the right to abortion was a priority issue for the recently founded Swedish Association for Sexuality Education (RFSU). The call for legalized abortion was voiced together with a request for the introduction of sexuality education in schools and widespread access to contraception. At that time, it was forbidden to provide information on contraception, as its use was considered immoral. This law was in force from 1910 to 1938.[3]

The abortion issue was shrouded in controversy and the subject of fierce debating. But calls for reform gained ground and in 1938 abortion was legalized for women who were sick (medical grounds), carried a hereditary disease (eugenic grounds) or had been raped (humanitarian grounds). The main aim of the new abortion act was to improve health – the health of individual women on medical grounds, and public health and 'quality' on eugenic grounds. Allowing women to have an abortion on the grounds of being poor, unemployed, homeless or single, i.e. for social reasons, was not provided for under the act. As a result, there were few legal abortions and illegal procedures continued to be performed in large numbers.

Increased resources were invested in preventive

2 Trost von Werder, Anne-Christine, *Psykiska besvär (Mental problems)* in Gustafsson, Barbro, et al., *Erfarenheter och egna val. En bok om abort*, Gothia, Stockholm, 2000. In Swedish. See also: Kero, Anneli, *Paradoxes in legal abortion: a longitudinal study of motives, attitudes and experience in women and men*, Umeå University, 2002.

3 Lennerhed, Lena, *Sex i folkhemmet. RFSUs tidiga historia, (Sex in the welfare state. The early history of the Swedish Association for Sexuality Education (RFSU))*, Gidlunds, Uppsala, 2002. In Swedish.

measures during the 1940s. Contraception became more accessible. In addition, women considering an abortion could consult newly appointed abortion counsellors. The counsellor's main task was to persuade the woman not to go to an illegal abortionist and to inform them of the help and support available to pregnant women and mothers – namely, maternity benefit, access to antenatal and child welfare clinics, child welfare officers for unmarried mothers, etc.

A fight for freedom

It is clear that those in authority saw the call for legalized abortion as a problem. At that time, womanhood and motherhood were synonymous. It was assumed that a pregnant woman always wanted to give birth to her child should the circumstances allow it. The fact that some women did not want to give birth was normally explained in terms of mental or emotional instability on the part of the woman. The limited scope for legal abortion and the over-protective mentality she was faced with meant that most women never applied for one, and instead went straight to the illegal abortionist.

The call for free abortion was voiced for the first time in Sweden in 1963 and provoked a strong reaction. Giving the woman the right to decide herself were all seen as very radical measures. The call was voiced by two organizations, the Swedish Social Democratic Students' Association and the Young Liberals. They both saw abortion as a social issue and a fight for freedom. They upheld the right of the child to be wanted. They also stressed the class aspects of abortion – that rich women could buy themselves a safe, though still illegal abortion relatively cheaply. But above all, they emphasized the fact that free abortion would give women greater freedom and the right to self-determination. In other words, they underlined the emancipatory and feministic arguments for free abortion.[4]

A question of power and gender

The call for free abortion was controversial, but the longer the debate continued, the more organizations and political parties began to change their opinions. Two dramatic events were given considerable media coverage and probably helped to liberalize attitudes. One such event was the Thalidomide disaster. American Sherri Finkbine had taken the drug, which had by then been proven to be a serious danger to the foetus, but she was refused an abortion in the United States and travelled to Sweden for one in 1962.

This aroused considerable attention but was eclipsed by the so-called 'Poland scandal' of 1965. Abortion was legal in Poland at the time and Swedish women began travelling there to undergo the procedure. Young Liberals in Stockholm helped by providing addresses to Polish gynaecologists. Someone told the police and a preliminary inquiry into the affair was begun. The police searched the home of liberal newspaper editor

4 Lennerhed, Lena, *Från utsatthet till eget val" (From vulnerability to own choice)*. In Gustafsson, Barbro et al., *Erfarenheter och egna val. En bok om abort*, Gothia, Stockholm, 2000. In Swedish.

Hans Nestius and managed to get hold of the names and addresses of several women. The Poland scandal became headline news and the police and public prosecutor came in for some severe criticism. Neither Nestius nor any of the women was charged with committing an offence, however.

The scandal placed the abortion issue firmly on the social agenda but it took another ten years before the legislation was amended leading to the introduction of free abortion. The new women's movement had already been founded several years previously and had been instrumental in forcing the pace on free abortion.

What then can we learn from history? Among other things, it tells us that women who have unwanted pregnancies will either have or try to have an abortion no matter what, and it is the society in which they live which determines whether the abortion they have is either safe or unsafe. It also tells us that abortion politics are basically about power and gender and are linked to how society looks upon women, their sexuality and right to self-determination. Furthermore, rights that have been achieved can never be taken for granted but can easily be whittled away. Last but not least, we must keep abreast of knowledge and arguments to safeguard the right to abortion.

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Common myths about abortion

Depression, anorexia and suicide – anti-choice groups often talk about the serious problems afflicting women when they have an abortion. But a new study indicates that women actually experience very little distress at all after having had an abortion.

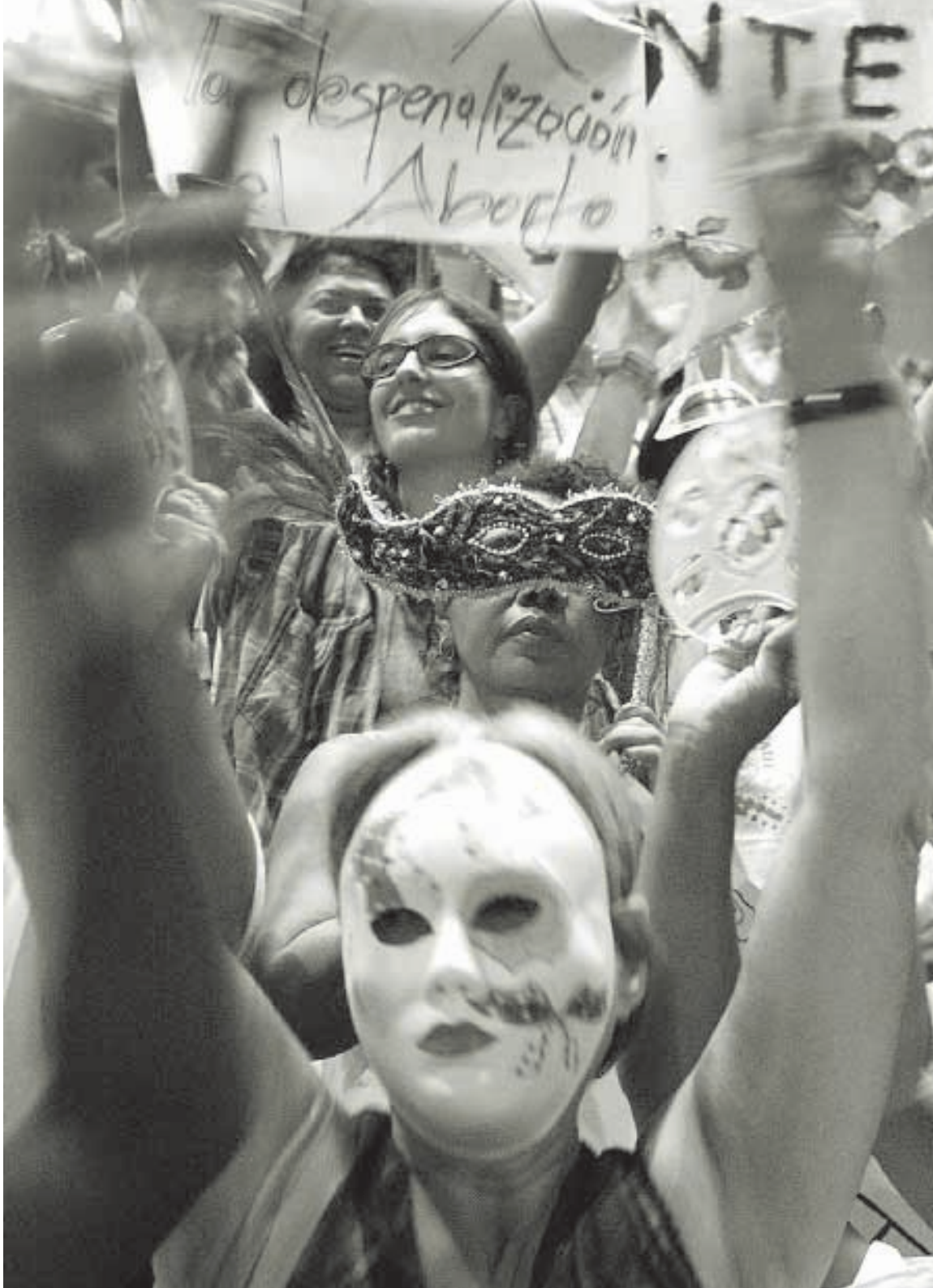
"Even if having an abortion caused pain, the women we studied felt mostly relieved," says Anneli Kero who has researched how women and men feel after an abortion.

Ninety-three per cent of the women studied said they felt well and experienced positive feelings in relation to their abortion twelve months afterwards. Only two women said they had some problems which they put down to their abortion. In the course of their follow-up consultations, the majority said they did not experience any emotional distress; several said that, to the contrary, there had been many positive effects of the abortion process including greater maturity. Several pointed out that they had been surprised by their own reaction. They had felt much better than they had expected. Some even asked themselves whether it was human not to experience some guilt and remorse after an abortion.

"What does this say about the expectations and myths surrounding abortion? The myth is that abortion is something traumatic for women. They are expected to feel bad and can be stricken with guilt if they don't," Anneli Kero points out.

The study is part of Anneli Kero's doctoral thesis,[1] presented at Umeå University in Sweden in 2002. A total of 211 women, who had previously applied to

1 Kero, Anneli, *Paradoxes in Legal Abortion, A longitudinal study of motives, attitudes and experiences in women and me.* From the Department of Clinical Sciences, Obstetrics & Gynecology, Umeå University, Umeå 2002.



Defeat the myths. Anti-choice groups often claim that women get depressed after an abortion. But studies show that most women feel relief after having had an abortion.

Pro-choice activists from around the world gathered in February 2002 at the World Social Forum in Porto Alegre, Brazil.

have an abortion, took part in the study and were asked to answer questions.[2] Every third woman participating in the study was then asked if she would like to take part in an interview study immediately afterwards, and then four and twelve months after the abortion respectively.[3] The results of this follow-up study confirm both Swedish and international research indicating that few women actually experience any problems after an abortion.[4] A relatively new American study that monitored women for two years after their abortion also reached the same conclusion as Anneli Kero's research group, namely that the dominant post-abortion emotion felt by the women was relief.[5] How then is the myth about abortion being something damaging and traumatic perpetuated? Why don't these conflicting results receive more attention?

"As I see it, abortion is still a taboo right. A woman not wishing to complete her pregnancy and even experiencing abortion with a sense of relief can be difficult to accept since it flies in the face of the traditional image of women, which strongly links womanhood with the role of carer and life-giver," says Anneli Kero.

The Swedish National Board of Health and Welfare's abortion expert, Viveca Odlind, a professor at the Department of Women's and Children's Health at Uppsala University, believes the myth has been cultivated by organized anti-choice groups:

"If you do an on-line search on the word 'abort' or 'abortion', you will find an abundance of incorrect statements and assertions. When the pill was launched, for example, its opponents put up fierce resistance to the claim that medical abortion was easier than surgical abortion; in other words, they objected to giving women access to a more humane method of abortion. I interpret this as wanting to maximize the suffering of women who have an abortion," says Viveca Odlind. "But a woman does not choose to have an abortion because there is a humane method, but because her pregnancy is unwanted," she adds.

Two out of three of the women did not feel the slightest inconvenience. The common denominator for these women was that the decision was relatively conflict-free and in most cases a foregone conclusion from the start. Almost half said that they had considered abortion as a possible solution to an unwanted pregnancy even before they became pregnant.

"Some may no doubt feel that this is controversial, but it provides proof of the fact that women are aware of their options in our country. Nothing in our studies points to abortion being used or seen as a form of contraception," Anneli Kero points out.

Despite the decision itself not being difficult to

2 Kero, Anneli et al., *Legal abortion: a painful necessity*, Social Science & Medicine 53, 1481–1490, 2001.

3 Kero Anneli, et al., *Wellbeing and mental growth long-term effects of legal abortion*, Social Science & Medicine 58, 2259–2569, 2004.

4 Adler NE, et al., *"Psychological responses after abortion"*, Science, 6 (248) 41-44, 1990; Trost, Anne-Christine, *Abort och psykiska besvär (Abortion and emotional disturbances)*, (pp.108-109), Thesis, Uppsala Universitet, 1982, In Swedish; Holmgren, Kristina, *Time of decision to undergo a legal abortion.* Gynecologic and Obstetric Investigation 26 (4), 289-295, 1988.

5 Major B et al., *Psychological responses of women after first-trimester abortion*. Archives of General Psychiatry, 57 (8), 777-784, 2002.

make, the abortion still provoked many deep thoughts in many of the women studied. Thoughts such as: Who am I? What do I want to do with my life? What would this mean for me and my family? Or for the potential child? Is it right or wrong?

Well-founded decision

Twelve women described their emotions after the abortion in terms of sorrow, quandary or depression. Three of them put their problems down to the way they were taken care of at the hospital. Three clearly expressed that they actually wanted to give birth and five more were ambivalent. Nine had a bad conscience and said that the decision was in conflict with their ethical or religious values. Extenuating circumstances, however, led these women nevertheless to have an abortion. And despite conflicting emotions, only two of the women were ambivalent towards the actual decision to terminate their pregnancy. The others stressed that they felt their decision was their own and well-founded despite conflicting emotions. When asked as part of the twelve-month follow-up, all but two felt their decision had been a responsible one – the abortion was seen as a necessity. It was noticeable that five of the women who grieved, valued the feeling of sorrow they had experienced. They felt that their grief was an important and appropriate response. These multifarious and seemingly paradoxical experiences of abortion have not been especially well captured in previous research, according to Anneli Kero. She is critical of this:

"It is the result of grading emotions as either positive or negative. A grieving process then risks being seen as a negative effect instead of a normal, relevant reaction when the woman takes the decision to have an abortion despite wanting to give birth. In other words, I feel it is important for a woman to be allowed to grieve over an abortion despite not regretting her decision," says Anneli Kero.

These ambivalent emotions can make it difficult for women to talk about the abortion. It may be hard for a woman to talk about her relief for fear of people thinking she has taken her abortion too casually. She may also find it difficult to talk about her pain and distress. Someone who has experienced distress does not wish to perpetuate the myth of abortion being traumatic or to lend support to the anti-choice groups.

"The effect will be that women lack anecdotes and experiences to which they can relate, with which they can draw comparison and thereby deal with their own emotions concerning their abortion," Anneli Kero adds.

No regrets

Anneli Kero feels that the silence surrounding these conflicting emotions creates a vacuum that benefits the anti-choice groups. It is obvious how anti-choice groups take advantage of women's ambivalence as an argument if you visit the 'Ja till livet' (Yes to life) website. There, for example, you will find an article about Joanna Rytel's virtual graveyard for aborted foetuses.[6]

6 www.abortkyrkogard.com

Joanna Rytel is a feminist and hit the headlines when she and Fia Sandlund rushed on stage at the 2001 Miss Sweden beauty contest with a large banner displaying the word 'gubbslem' (which roughly translates as 'lecherous slime'). In its article, 'Ja till livet' writes that Joanna Rytel has opened her virtual graveyard because there is a need for a place to say goodbye. According to the article, it is "clear that the website fulfils a need and many touching farewells have already been written there."[7] The article comments on the fact that the messages often finish with a 'sincere apology to the child who never got the chance to be born'. Anneli Kero expresses surprise when I tell her about the 'Ja till livet' article on the virtual graveyard.

"Do the anti-choice groups really use the website as one of their arguments?" she asks. "I think it supports our results, namely that women may want to express their grief and their compassion without actually regretting their decision to have an abortion. But it is important that the anti-choice groups are not allowed to claim exclusive rights to the ethical discussion, because even if you are pro-abortion, you may well experience a concurrent ethical dilemma."

One of the common misconceptions in the debate is that having an abortion is often the act of single, young or socially disadvantaged women. Abortion is described as a last resort, both by opponents and proponents alike. But the fact is that almost every second women in Sweden has had an abortion. Every fourth pregnancy in Sweden today is legally terminated. According to Anneli Kero's study, women have abortions even if they feel well and are in a steady, well-functioning relationship. In Sweden, 40 per cent of all abortions are performed on women over 30 years of age. Many co-habit with a steady partner and many already have children.

"It is not just women in vulnerable situations who make up the abortion statistics," Anneli Kero points out.

Several perspectives are weighed up

Why then do women have abortions? The standard answer given by the women themselves was that they felt they were being responsible – the abortion felt rational and emotionally correct. They had weighed up all the perspectives, not only their own, their partner's and that of any children they already had, but also that of the potential child. They felt that all children have the right to be wanted by both of their parents and a right to a high standard of care. In reality, the justification for having an abortion can be seen as a mirror-image of the explanation usually given by women and men when they feel the time is right for them to have children. They choose to prioritize their studies, work or the children they already have. Another common reason was that they didn't have the right partner. The men's incentives for their partner having an abortion basically tallied with those of the women.[8]

"This isn't particularly strange. Planned parenthood

7 www.jatilllivet.se/artikel.php?artikelid=396

8 Kero Anneli et al., *The male partner involved in abortion,* Human Reproduction 14, 2669-2675, 1999.

is after all the norm in our society," says Anneli Kero.

Many feel that the abortion figures in Sweden are too high, at 35,000 per year, or 0.6 abortions per woman per lifetime.

"But if you consider that the sexual debut of women and men occurs around the age of 16, that a woman has her first baby around the age of 30 and that she is likely to have less than two children, a great deal of sexual intercourse does not lead to abortion, taking the woman's life as a whole," Anneli Kero argues. "Seen from this perspective, women are very good at protecting themselves. We want to cut down abortion figures further, so it is important for preventive measures not only to focus on women but also on the reproductive responsibility of men," she adds. "Perhaps we should also subsidize male contraception?"

Nothing could change their mind

There is also a myth that it is not the woman herself who wants to have an abortion, but that she is forced into it by prevailing circumstances and the world around her. If she could, the woman would keep the baby, or so the story goes. This is linked to the idea that only socially disadvantaged women have abortions. This is why there are organizations such as 'Livlinan' (Lifeline), the aim of which is to explore the options facing women with an unwanted pregnancy:

"The aim is to help women and make them aware of the options so that they don't feel they are forced to have an abortion, to save them the potential pain and grief an abortion may cause. We must then ask ourselves how we can achieve this," says Ingrid Karlsson, the Director of 'Livlinan', in an interview on the 'Ja till livet' website.[9]

But Anneli Kero's study contradicts this theory that women have difficulty taking the decision to have an abortion, since all but two of those asked said they had taken the decision completely autonomously and that they were satisfied with their decision twelve months after the event. Over three-quarters, 76 per cent, also said there were no circumstances that could have altered their decision. The study performed prior to the women having an abortion showed the same result. Of the 211 women asked, 70 per cent said nothing could happen that would change their decision.

"This shows that most women already know whether they want to have an abortion or not from an early stage," says Anneli Kero.

Furthermore, the interviews indicated that women did not give in to external pressures but put their own interests first, having nonetheless considered the perspectives and opinions of those around them. The women often possessed great conviction as to what they wanted and they were content with their decision.

Bearing this in mind, it would be interesting to turn the notion on its head. How would women feel if they were forced to go through an involuntary pregnancy and give birth to an unwanted child? Such a modern-day study has yet to be carried out, but all the women

9 www.jatilllivet.se/artikel.php?artikelid=367

in Kero's study said they felt distress when faced with their unwanted pregnancy. This distress took the form of panic, grief, despair, a sense of unreality and depression.

Unwanted pregnancies might lead to suicide

History provides plenty of proof of how much distress an unwanted pregnancy can cause a woman. Romania is a case in point, where abortion was banned in about 1965 and pregnancy-related mortality increased dramatically (illegal abortions), and where we could also see the consequences for many children born to women who could not take care of them. In Sweden in the 1930s, radical doctors and public debaters brought attention to the number of young women committing suicide because of an unwanted pregnancy, which led to a debate about abortion and some relaxation in the law. A Karolinska Institutet thesis in 1901 examined women who had died as a result of 'foetal expulsion'. The study found that about five per cent of the women who had taken poison to induce an abortion were not even pregnant. They had probably not had their period out of sheer anxiety that they might be pregnant and in desperation had tried to redress the situation, proof of how desperately shameful it must have been to be an unmarried mother. Otherwise, they were referred to so-called baby farmers. Viveca Odlind has met some women who have been refused a late abortion.

"I can remember one particular case where the woman had probably resorted to violence to try and induce labour at a very early stage. But most came to terms with the situation and were able to feel joy at the prospect of the previously unwanted baby. But it is never possible to find out how a woman actually feels when forced to give birth to an unwanted child, since disclaiming one's own child is unthinkable," says Viveca Odlind.

But it is still very likely that women are distressed by unwanted pregnancy. Otherwise, why do so many women around the world subject themselves to the dangers of illegal abortion? According to WHO, 67,000 women die as a result of unsafe abortion every year.[10] An estimated 14 per cent of the world's maternal mortality is attributable to unsafe abortion.[11] This figure is as high as 50 per cent in some parts of the world.[12]

There will always be unwanted pregnancies. Estimates put the number of unwanted pregnancies at 75 million out of a total of 200 million pregnancies

10 WHO, *Safe abortion, Technical and Policy Guidance for Health Systems,* 2003.

11 UNFPA, *Fast Facts on Maternal Mortality and Morbidity.* www.unfpa.org

12 Oguttu Monica and Peter Odongo, *Midlevel Providers' Role in Abortion Care, Kenya Country Report.* A Paper for the Conference "Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care", South Africa, 2-6 December 2001.

altogether.[13] And wherever there are unwanted pregnancies, there will also be abortions – legal or otherwise. Women will continue to risk their lives to have unsafe abortions.

Denying women safe abortion is a serious threat to their health. The Programme of Action (PoA) adopted during the UN International Conference on Population and Development in Cairo in 1994 (ICPD) established that in countries where it was not against the law, abortion should be safe. Unfortunately, there are still several countries that cannot offer women safe abortion and where the procedure is still prohibited. Women continue to be injured and die as a result of unsafe abortion in these countries.

"Access to safe abortion is one of the most important world-wide women's health issues and must also include access to safe contraception," says Viveca Odlind.

Anneli Kero shows that women are perfectly capable of deciding whether or not to have an abortion, and that a woman's well-being is secured if she takes this decision herself. If women are not to decide over their own bodies, who should? Men? Society? The church?

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13 UNFPA, *State of the World Population,* 1997.

Face the truth and the rest will follow

Anna Musonda Phiri, filmmaker and cultural event planner based in Lusaka, Zambia, on the law that was intended to save women's lives

Lately I've had to come out of my comfort zone to tackle an issue that is shrouded in secrecy, shame and stigma despite its commonplace occurrence and that it is supported within my country's legal framework. That issue is abortion.

At the main public hospital in Lusaka, the University Teaching Hospital (UTH), they see 400 clients a month with complications due to unsafe abortion. Zambia has one of the highest maternal mortality rates in the world, at 752 per 100,000 births, and 30 per cent of these deaths are due to unsafe abortion. Therefore it is sad to hear that the hospital administration doesn't feel that it has the responsibility to inform the public, especially women, that they perform legal, safe and affordable abortions for just two U.S. dollars. "We cannot advertise our services, it is not ethical," says Dr Kafula, Deputy Director of UTH.

Most Zambians regard all abortions as categorically illegal. Why should this be so when it is widely and internationally acknowledged that Zambia has one of the most liberal abortion laws in sub-Saharan Africa? On October 13, 1972, the Termination of Pregnancy Act was passed, allowing abortions to be carried out on broad health as well as socio-economic grounds. Three physicians should approve of the procedure, which must be performed at a clinic or hospital. In rural areas, each clinic has one health practitioner who may perform abortions. The law was put in place to curb the rise of maternal deaths due to unsafe abortions.

Despite this, there are obstacles to obtaining a legal abortion, and therefore there is a continued reliance on illegal abortion. The environment simply does not promote access to safe and legal abortions. Few people know about the law, and furthermore, many women do not know where they can get affordable, safe termination of pregnancy services while, ironically, knowledge of illegal and unsafe services is widespread.

The stigma, a result of religious beliefs and culture, which surrounds abortion also means that women and girls are often faced with negative attitudes from families, peers, health workers and their communities. So that even if they are aware it exists, they are reluctant to request the service. This stigma is not limited to women and girls but also to the medical personnel who

provide or assist in providing this service. Because of this, it is not easy to find a doctor who is willing to perform abortions. Dr. Francis Chanda at UTH tells me that there are maybe three or four out of a possible 30 doctors who carry out legal termination of pregnancies. I dread to think what might be the scenario in the rest of the country.

Partly due to the declaration of Zambia as a 'Christian' nation, there is a lack of public discourse around abortion. This compounds all the other problems, and has serious and far-reaching consequences where women's rights and choices are being denied and limited unfairly.

Young people are bombarded with information that abortion is wrong. Yet there is just as much stigma attached to an unmarried (young) mother; such girls are 'branded for life'. Young men also have a very low opinion of young girls who have abortions: Yet, they are the same ones to insist that their girlfriends get abortions. There are community sanction arrangements between secondary schools and health centres in some areas for the systematic screening of sexual transmitted infections (STIs) and pregnancy. When found out, pregnant girls may be forced to leave. Fear and shame put pressure on girls to induce abortions despite the re-entry policy that allows pregnant teenagers back into school. Eighty per cent of girls at a school in Lusaka (the capital) said that, if they got pregnant, they would resort to abortion.

The fact that there is insufficient and poor quality of reproductive health education especially for young women does not help. Many of the providers of this education are organizations that are either faith-based or recipients of funding from the US Agency for International Development (USAID), whose global gag rule policy limits discussions on abortion to post-abortion care. In practice it is safer to stay away from the topic all together.

The continued reliance on unsafe abortion costs the health system a lot; post-abortion care is more expensive, more time may be spent in the hospital by patients, and more medicine is required and more human lives are lost. The ineffective implementation of the law and negative attitudes are not seen in the light of limiting women's choice. Even though Zambia is one of the 130 countries worldwide that ratified the convention on women's right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right, this promise has not been fulfilled.

For now, it seems women in Zambia will continue to choose abortion as the more viable option to deal with unwanted pregnancy. If only this truth could be faced, we might see the advantages of removing the obstacles so that safe abortions become more accessible. Until then the abortion issue will remain an unmet challenge, if only because maternal deaths are so high. It would be nice if we could remind ourselves why the Termination of Pregnancy Act was enacted in the first place. It was to save lives.

Anna Musonda Phiri

HIV may make unsafe abortions more dangerous

Unsafe abortions, prejudice and a lack of healthcare resources can be a deadly combination for women. Little attention has been paid to the fact that this situation may be even worse for those with HIV. "Women are caught between two public health disasters, HIV and unsafe abortions," says Maria de Bruyn, medical anthropologist at Ipas.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has established that women should be able to find out whether they are HIV-positive by taking a test. They should also have access to contraception in order to avoid becoming pregnant. Furthermore, they should be able to choose between having access to the appropriate medical drugs to eliminate the risk of transferring the infection during pregnancy or having a safe, legal abortion in the case of an unwanted pregnancy.[1]

But this is not the reality for more than just a fraction of the world's 2.5 million HIV-positive women who become pregnant every year. Few have access to drugs that reduce the risk of transferring the infection to the foetus or to the kind of tests that are routine in Sweden and other industrialized countries. As a result, many HIV-positive and pregnant women are totally unaware of the fact that they are infected.

Nor do many of them have the option of even considering an abortion, performed at a hospital by qualified personnel, due to restrictive national laws. Almost half of the 19 million women in the world who undergo unsafe abortion every year are forced to rely on

1 UN/WHO, *Aids epidemic update 2002,* December 2002.

untrained people to perform the procedure in environments that are far from basic requirements for sterility. Unsafe abortions are estimated to lead to almost 70,000 deaths annually, a quarter of which occur in Africa.[2]

Abortion – a sensitive issue

The road to safe abortion is long and littered with mostly legal, but also social, cultural and religious obstacles. Just how charged the issue is becomes apparent when I call a representative of an international aid organization in a central African city. She has a wide overview of the situation and should have been able to contribute valuable experience. But, instead she was very guarded and gave evasive answers to my questions.

"You must understand that abortion is a sensitive subject. What I say, expressing my personal opinion, might damage the organization for which I work. I follow the organization's policy, which is to respect national legislation, because I realize it is the only realistic way of working, but my personal opinion is more radical. I can speak freely with you if this conversation can be off-the-record, if I can remain anonymous."

One reason for her caution is not least the global gag rule, first introduced in the 1980s by the then American president Ronald Reagan, later abolished by President Clinton, only to be reintroduced by George W Bush. Under the Gag Rule, non-governmental organizations (NGOs) that receive money earmarked for family planning from the U.S. Agency for International Development (USAID) may not use it to perform abortions – other than when the woman's life is in danger or when she has been the victim of rape or incest. Nor may subsidy recipients refer women for legal abortions or promote the legalization of abortion.[3]

There could well be considerable financial consequences for the organization the anonymous respondent worked for, if she went on the record as saying:

"The abhorrent circumstances under which these women are prepared to have an abortion are in themselves a sign of how desperately they need the help we can offer them – regardless of their HIV status. For them, it is a question of what the future holds; if they become pregnant and have children, they will not be allowed to continue school, jeopardizing their entire future."

Young women are most vulnerable

Despite massive efforts over the last twenty or thirty years, Africa is still the continent showing the lowest rate of contraceptive use. Fifteen per cent of married women use some form of protection against unwanted pregnancy (the global average is 57 per cent), whilst 24 per cent of them say they would like to protect themselves, which means Africa also has the highest indicator of unmet need for contraception. [4] The same continent is also the hardest-hit by the HIV pandemic. About 26.6 million people in sub-Saharan Africa live

2 Ipas, *Lives worth saving: Abortion care in sub-Saharan Africa since ICPD – A progress report,* 2004.
3 The Global Gag Rule Impact Project, 2003. 64.224.182.238/globalgagrule
4 Ipas, *Lives worth saving: Abortion care in sub-Saharan Africa since ICPD – A progress report*, 2004.

HIV positive people have the same rights as everybody else. Every year 2.5 million HIV-positive women get pregnant. They need access to their sexual and reproductive rights.

with the infection, including the 3.2 million people infected in 2003. The most vulnerable group is girls and young women in the 15-24 year-age group, who run two and a half times the risk of infection than boys of the same age.

In a number of southern African countries – Botswana, Swaziland, Malawi, Zambia, Mozambique and parts of South Africa – more than one in five pregnant women is HIV-positive. [5]

Caught between two disasters

Many HIV-positive women in developing countries also wish to bear children and are advocating for access to antiretroviral (ARV) drugs to prevent perinatal HIV transmission. However, some women living with HIV want to avoid (another) pregnancy.

"The figures speak for themselves: young African women are caught between two public health disasters, HIV and unsafe abortion – phenomena which individual governments and organizations the world over are committed to combating, but which in combination attract seemingly little attention."

This is pointed out by Maria de Bruyn, medical anthropologist and active in the international NGO Ipas, which has remained committed to women's sexual and reproductive rights and health for the last thirty years.

"This is due to several factors. To a great extent, the main focus of attention regarding HIV and pregnancy has been on the right of HIV-positive women to have children, a right that has and still is brought into

5 UN/WHO, *Aids epidemic update 2003,* 2003.

question by community members and even some healthcare workers in many countries. In addition, abortion is a sensitive subject, which may deter researchers from studying unsafe abortion in relation to HIV/AIDS. Many countries also have restrictive legislation and abortion leads to stigmatization and discrimination, which in turn means that many women are unwilling to talk about it," she says.

Uninformed of their options

Maria de Bruyn has been studying research on HIV-positive women and abortion for several years. Her findings include:

• HIV-positive women may run a somewhat greater risk of developing complications after an abortion than those who have tested negative as a result of their immune deficiency, according to a study performed in Germany. Therefore, it is not unreasonable to assume that unsafe abortions may pose a greater danger for HIV-positive women than for women who do not carry the infection.

• Even in countries with more liberal abortion laws, it is common for women to be uninformed of the option of terminating an unwanted pregnancy. This might be the result of ambiguous information, or even no information at all, in information materials (e.g. the U.S.), or of negative attitudes to abortion on the part of healthcare personnel (e.g. in Thailand), or of the high cost of the procedure that must be met by the woman herself (e.g. some U.S. states).

• There are some programme implementers and policymakers who question whether HIV should be included under the conditions that entitle women to have an abortion in those countries whose legislation allows the procedure if the woman's physical or mental health is endangered. The reason for calling this into question is due to the risk of women being pressured into terminating their pregnancies. Others maintain that a woman's positive HIV status should be included among the reasons entitling her to an abortion. For example, some women may not want to take medicines that might affect the foetus; some women may be ill and not want to go through a pregnancy; and, other women may want to conserve their resources to take care of themselves and the children they already have. And it is well known that in some places, HIV-positive women run an increased risk of domestic and sexual violence, and may not want to carry a resulting pregnancy to term.

"Contraceptives, access to medical drugs for HIV infection and opportunistic infections during pregnancy and, in cases of unwanted pregnancy, safe, legal abortion are the basic pre-conditions for HIV-positive pregnant women throughout the world to be able to enjoy their full reproductive rights," says Maria de Bruyn.[6]

Thord Eriksson
Freelance journalist based in Stockholm, Sweden

6 de Bruyn, Maria, *Safe Abortion for HIV-Positive Women with Unwanted Pregnancy: A Reproductive Right,* Reproductive Health Matters, nr 22, 2003.

Women's rights are human rights

The Swedish Minister for Democracy, Integration and Gender Equality Issues, Mona Sahlin, on every woman´s right to decide over her own body

Imagine two jumbo jets crashing every day killing everyone on board. Approximately the same number of women, between 400 and 500, die every day as the result of illegal or unsafe abortions. The World Health Organization (WHO) estimates that 19 million unsafe abortions are carried out each year.

Anti-choice groups, employing more aggressive tactics than they have done for some time, are waging a struggle of life and death. But life is not their mission. They prefer to let hundreds of thousands of women die every year rather than agree to free and safe abortions. They often argue in terms of women either giving birth or having an abortion, when in reality the issue is about freedom of choice. I am one of the many women who could choose. I have had an abortion, miscarried and given birth to four children.

The UN Conference on Population and Development in Cairo in 1994 was an important milestone for a woman's right to her own body. The 179 participating countries pledged to focus on people's sexual and reproductive health and rights for the next 20 years

Ten years on and the backlash has begun. In Sweden, it is often said that the abortion issue is 'dead'. But I don't agree. In an internationalized world, Sweden is also influenced by international currents. Swedish politicians and popular movements must continue to argue for free abortion in the international arena.

The American Bush administration, supported and cheered on by the Christian right-wing, reintroduced the global Gag Rule in January 2001. Since 2002, Bush has frozen payments to the UN Population Fund (UNFPA) after incorrect information was circulated (naturally by the Christian right) saying that the fund was involved in forced abortions in China. At the UN Children's Summit last year, American diplomats led a coalition consisting of the U.S., the Vatican and Islamic regimes that successfully prevented a final declaration containing the words 'reproductive health services' from being adopted – wording, they said, that could pave the way for abortion counselling.

Anti-choice groups are also gaining ground within the EU. In Ireland, and also in the new member states of Poland and Malta, abortion is banned. In Portugal, midwives are charged with and found guilty of perfor-

ming illegal abortions. The Vatican has opened offices in Brussels and is lobbying intensively against free abortion. In March 2004, the conservative group in the European Parliament (including members of the Swedish Moderate and Christian Democratic parties) voted against a statement giving a woman the right to a legal and safe abortion in an emergency.

We indeed face an uphill struggle. While the United States has cut off its support to UNFPA, Sweden has increased it by 80 per cent, from EUR 17 million to 28 million a year between 2002 and 2004. In December 2003, the Swedish parliament adopted a new global development policy, affording particular attention to a woman's right to her own body and sexuality and to free abortion. Sweden is also promoting free abortion in developing countries on the practical level.

The Swedish International Development Cooperation Agency (Sida) has a key role to play in this respect. Sida is applying direct pressure to lift the abortion issue high up the political agenda in developing countries. By helping to supply equipment and training and disseminate information, Sida is supporting free and safe abortions.

The argument for free abortion must be put forward by many different governments. Not just myself, as the Swedish minister responsible for gender equality, but all ministers and governments who share Sweden's point of view must constantly stand up for free abortion in international contexts, both in the UN, to defend the results of the Cairo conference, and within the EU. Right-wing moralism must never be allowed to gain the upper hand.

Abortion and access to reproductive health services are matters for national legislators. But the EU has the responsibility, in its international contacts and as a development assistance donor to international organizations, to fight for free abortion and a woman's right to her own body. There must never be talk of a Gag Rule within the EU. The European Parliament is an important opinion-moulder and lobbyist in this context. Not least through its annual report on the state of human rights in the world can the European Parliament, with the right majority, take a stand on free abortion.

National measures can also send important international signals. The Swedish government is currently looking into the possibility of giving foreign women the right to have an abortion in Sweden. This is currently prohibited. As the Swedish minister responsible for gender equality, I see the welcoming of foreign women who wish to have an abortion as an important solidarity issue. It would also be a way of repaying the hospitality shown by other countries – Poland in particular – to Swedish women in the 1960s, when abortion was still outlawed in Sweden and many women travelled overseas to have one.

I cannot repeat it often enough; the abortion issue is about who has control of women's bodies. Prohibiting abortion, and thereby forcing women into undergoing dangerous and illegal operations, is ultimately an expression of gender-related violence. In a world where women's rights are human rights, abortion must be free. Every woman must have the power to decide over her own body.

Mona Sahlin

Medical abortion meets resistance

Medical abortion could play an important role in the efforts to make abortions safer, especially in developing countries. But to those who are anti-choice, this very safe method which involves no surgical procedure, represents a threat.

In several countries where medical abortion is used, the number of early and hence safer abortions has increased.[1] Medical abortion combines anti-progesterone (mifepristone) and prostaglandin to interrupt a pregnancy and induce miscarriage. France was the first country in the world to approve mifepristone for medical abortions in 1988, but it took pressure from the French government before the pharmaceuticals company, Russel-Uclaff, took the decision. The company's indecision was founded on the fear of boycott by anti-choice groups, but the French government's threat to revoke their rights tipped the balance.

Experiences from the U.S. also highlight the difficulties involved in making mifepristone available on the market. The American Food and Drug Administration (FDA) only approved the drug in 2000.[2] Similar to the Russel-Uclaff case, this was about a potential commercial threat that was deterring pharmaceutical companies from producing the drug. American anti-choice political powers opposing the right to free abortion also contributed to the twelve-year gap in approval between France and the U.S. [3]

1 Jones, Rachel K. and Stanley K. Henshaw, *Mifepristone for Early Medical Abortion: Experience in France, Great Britain and Sweden,* Perspectives on Sexual and Reproductive Health, Volume 43, Number 3, May/June 2002.

2 FDA, *FDA Approves Mifepristone for the Termination of Early Pregnancy,* 2000, www.fda.gov.bbs/topics/news/NEW00737.html

3 S. Marie Harvey, et al., *Understanding Medical Abortion: Policy, Politics and Women's Health,* Center for the Study of Women in Society, University of Oregon, Eugene, Oregon, 2002.

In Cuba medical abortion is available, but why is it so controversial in many other countries? It is a safe method and complications are rare. Governments must act now to save women's lives.

"The primary strategy of abortion opponents in the United States has been and still is to claim that mifepristone is dangerous," says Carol Joffe, Professor of Sociology at the University of California in Davis, who has researched the acceptance of medical abortion in the U.S.

This can be confirmed by carrying out a search on American anti-choice organization websites. Several of these describe mifepristone as a dangerous drug approved on shaky grounds.

Complications are rare

To the contrary, however, the method is adjudged by experts around the world to be extremely safe. Complications are rare.[4] No surgical procedure is necessary, avoiding any potential complications caused by anaesthesia. There is less risk of infection than in a surgical abortion, even though the surgical method is also considered to be very safe. In principle, abortion can also be performed as soon as pregnancy has begun, when the chances of avoiding complications are at their highest.

American anti-choice groups did not succeed in preventing mifepristone from being approved, but Carol Joffe says that they are now trying to push through laws restricting the drug's use:

"Among their demands is that only those who are entitled to perform surgical abortion should be able to carry out medical abortion."

Such restrictions represent a serious threat to what is considered one of the method's greatest benefits – namely that midwives, nurses and general practitioners, after receiving the appropriate training and with the support of gynaecologists, can perform the procedure whilst maintaining the same level of safety.[5] In many developing countries, where the problem of unsafe abortion is most prevalent, medical abortion could mean the difference between life and death for exactly that reason. In many of these countries, there is a lack of doctors capable of performing surgical abortions and the distances that women have to travel for treatment can be very long:

"Many more women in the world have access to midwives and nurses," says Dr. Kristina Gemzell-Danielsson, a member of the WHO expert group for safe abortions. She is also one of the pioneers of medical abortion at Karolinska Institutet in Stockholm, Sweden.

Some abortion doctors are critical

Kristina Gemzell-Danielsson speaks of how the opposition to medical abortion not only comes from well-known anti-choice groups in America and from the Vatican. When the method was introduced in the Netherlands, for example, many abortion doctors reacted negatively.

"It is a question of power and money. Medical abortion lessens the standing of doctors since midwives and

4 Ipas, *Medical abortions – Implications for Africa*, Chapel Hill, NC, 2003.

5 S. Marie Harvey, et al., *Understanding Medical Abortion: Policy, Politics and Women's Health,* 2002.

other healthcare personnel can also perform this relatively simple procedure. Some doctors running private clinics feel threatened by it," she says.

Today, mainly western European countries allow medical abortion although it is also permitted in countries such as Russia, China, India, South Africa and the U.S. – a total of 27 countries in all.[6]

"It has been an unusually long process," says Christian Fiala, who is a specialist in obstetrics and gynaecology and introduced medical abortion into Austria, "compared to the rapid spread of Viagra, which is quite a dangerous drug that has reportedly caused a number of deaths."

Christian Fiala has examined how different western European countries have regulated medical abortion. He is critical of what he calls 'the artificial restrictions' he feels most of these countries have introduced and gives some examples of several countries that only permit medical abortion to be performed in a hospital.[7]

Two African countries allow the method

Two countries that currently allow medical abortion to be carried out in the home are South Africa and Tunisia.[8] These are the only countries that allow medical abortion in Africa – a part of the world where the method could save countless lives.

The organization Ipas writes in its report 'Medical Abortion – Implications for Africa' that the proliferation of medical abortion in Africa would mean a lot to African women.[9] Nadine Gasman, who is responsible for Ipas activities in Mexico, agrees:

"Disseminating the method would definitely make abortions safer and more accessible for women in developing countries. It would also give women more control of the situation themselves," says Ms Gasman.

There are several obvious benefits of medical abortion if one considers the prevailing conditions in many developing countries. First of all, there is a lack of doctors and equipment to be able to perform safe surgical abortions. Medical abortion reduces the risk of infection, especially through the blood – something which can be ever so important in countries hard-hit by HIV.

"In circumstances in which abortion is not against the law such abortion should be safe." Such is the wording of the International Conference on Population and Development (ICPD) Plan of Action (PoA) from 1994.[10] The wording was a compromise so that parties who did not allow abortion could approve the plan.

The fact that abortion is banned in most African and Latin American countries obviously reduces the scope for disseminating the medical abortion method in these countries. But the method has become significant nevertheless. Experiences from countries like Brazil

6 Ipas, *Medical Abortions – Implications for Africa*, 2003.
7 Fiala, Christian, *Medical Abortion – Where We Are in Europe*, 2000.
8 Ipas, *Medical Abortion – Implications for Africa*, 2003.
9 Ibid.
10 UNFPA, *Programme of Action of the International Conference on Population and Development*. www.unfpa.org

show that women do perform medical abortions if they can obtain the drugs and despite the ban.[11]

"As long as abortion is banned, women will find alternative ways of having one," Marge Berer, editor of the periodical Reproductive Health Matters, points out. "Using the Internet is one such way. As long as the woman receives correct information about dosage, pregnancy term limits, etc., and then gets medical help in case of a problem, obtaining drugs over the Internet to perform a medical abortion is fairly low-risk."

But Marge Berer is quick to point out that she does not think people should have to go to such lengths to get help. And one problem with such informal use is the risk of the drugs (mainly prostaglandin used without mifepristone) being administered in incorrect doses.[12]

"In Mexico, we have seen examples of women having overdosed and developing serious side-effects. There are also women who perform medical abortion far too late," Nadine Gasman from Ipas in Mexico points out.

This problem would disappear if abortion was legalized. Other problems would remain, however.

"Up to now, at least, medical abortion has been expensive," says Kristina Gemzell-Danielsson. "The tablets cost too much, but WHO is trying to encourage pharmaceutical companies to produce them more cheaply."

Protracted bleeding is also common after a medical abortion and can last on average for 14 days, compared to just 9 days after a surgical procedure. Many women are satisfied nonetheless. According to a WHO survey, 84 per cent of those who have had the medical procedure would choose the same method again if they had to have another abortion.[13]

Anna Dahlqvist
Freelance journalist based in Stockholm, Sweden

11 Ipas, *Medical Abortion – Implications for Africa*, 2003.

12 The Alan Guttmacher Institute, *Unwanted pregnancy and Abortion: Public Health Challenges in Latin America and the Caribbean – Meeting report*, New York, 2001.

13 WHO, *Highlights of 2003*. www. who.int/reproductive-health/hrp/highlights.en.html

Key facts

Methods of abortion

Abortions are performed in many different ways in various parts of the world. In western Europe, both surgical and medical abortion are performed, with the latter requiring no surgical procedure. In the developing countries where it is legal, surgical abortion is the norm.

Also, a large number of unsafe surgical abortions are also performed in these countries. Such abortions, involving a surgical procedure via the cervix, are unsafe when performed by people with insufficient training and incorrect equipment. Furthermore, an unhygienic, poorly sterilized environment can also make the abortion unsafe. Only a few medicine abortions are performed in developing countries.

Surgical abortion

Vacuum aspiration

The preferred surgical technique for abortion up to twelve completed weeks of pregnancy is vacuum aspiration. Vacuum aspiration involves the evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration employs an electric pump, and with manual vacuum aspiration, the vacuum is created using a hand-activated aspirator. Vacuum aspiration is a very safe procedure and, depending on the duration of the pregnancy, the abortion takes from three to ten minutes to complete.

Most women who have first-trimester abortions with local anaesthesia feel well enough to leave the healthcare facility after observation for about 30 minutes in a recovery room. Longer recovery periods are generally needed for abortions performed later in pregnancy and when sedation or general anaesthesia has been used. Depending on their training and experience, some providers are able to use vacuum aspiration up to 15 completed weeks.[1]

1 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2003.

Dilatation and evacuation

Dilatation and evacuation (D & E) is used from about 12 completed weeks of pregnancy. It is the safest and most effective surgical technique for later abortion, where skilled, experienced providers are available. D & E requires preparing the cervix with an agent, dilating it, and then evacuating the uterus using electric vacuum aspiration with cannulae and forceps. Adequate dilatation requires anything from two hours to a full day, depending on the duration of the pregnancy. A D & E procedure usually takes no more than 30 minutes to perform, and general anaesthesia is not required. Clinic staff and women undergoing the procedure should expect more post-operative discharge, including bleeding, than that which follows a first-trimester abortion.

Dilatation and curettage

Dilatation and curettage (D & C) is less safe than vacuum aspiration and considerably more painful for the woman. The rates of major complications of D & C are two to three times higher than those of vacuum aspiration. Vacuum aspiration has replaced dilatation and curettage in routine use in most industrialized countries, and also in many others. D & C is used in the first trimester and the procedure involves dilating the cervix with mechanical dilators and pharmacological agents, and using sharp metal curettes to scrape the walls of the uterus.

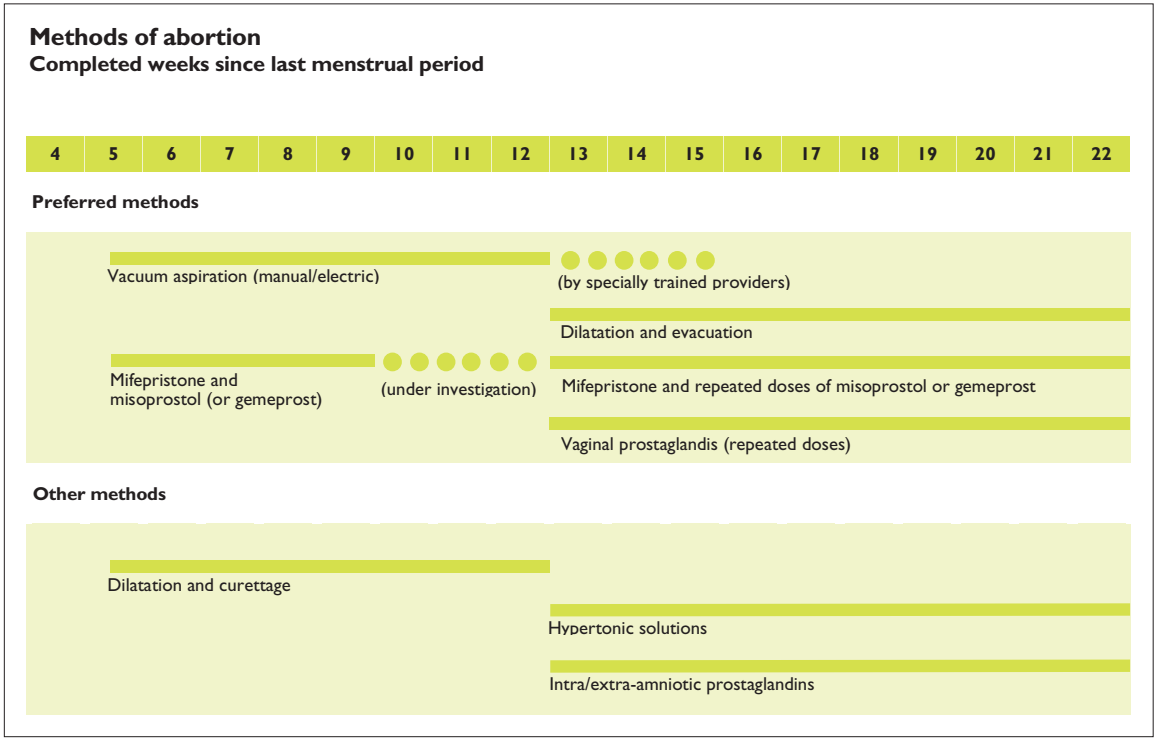
Medical methods of abortion

Medical methods of abortion have been proved to be safe and effective. The most widely used methods rely on the antiprogestogen, mifepristone, which binds to progesterone receptors, inhibiting the action of progesterone and hence interfering with the continuation of pregnancy. Treatment regimens entail an initial dose of mifepristone followed by administration of a synthetic prostaglandin analogue, which enhances uterine contractions and helps expel the products of conception. The effects of medical methods of abortion are similar to those associated with spontaneous abortion, and include cramping and prolonged menstrual-like bleeding. Bleeding occurs for nine days on average but can also last longer. Medical methods of abortion have proved acceptable in several low-resource settings. However, the drugs, mifepristone in particular, are currently available in only a few developing countries.

Mifepristone and prostaglandin

Mifepristone with misoprostol or gemeprost has proved to be highly effective – safe and acceptable for early first-trimester abortions. Approximately two to five per cent of women treated with this method will require surgical intervention to resolve an incomplete abortion. An oral dose of mifepristone is followed by a dose of prostaglandin (misoprostol or gemeprost), administered vaginally or orally. Most protocols require that women take both the mifepristone and prostaglandin under clinical supervision, involving a second visit to the healthcare facility two days after receiving mifepristone to take the prostaglandin.

Following administration of prostaglandin at the second visit, the standard observation period is between four and six hours, during which up to 90 per cent of the women will expel the products of conception. The women who do not abort during the



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

observation period should return about two weeks later to confirm that the abortion has been completed. In the case of an incomplete abortion, a surgical procedure is required.

Mifepristone and misoprostol are being investigated for use between nine and thirteen weeks of pregnancy. After twelve completed weeks since the woman's last menstrual period, a regimen of oral mifepristone followed by repeated doses (four doses maximum) of misoprostol or gemeprost is safe and highly effective.

Misoprostol or gemeprost alone

Although no comparative studies have been conducted, available data suggest that the effectiveness of misoprostol alone in the first trimester is lower and the procedure more painful than the combined regimen with mifepristone. The development of an optimal treatment regimen using misoprostol alone is under investigation because of the drug's availability and low costs. In some settings, its broader use has been reported to contribute to a decrease in complications from unsafe abortion.

After twelve weeks since the last menstrual period, misoprostol has been found to be up to 84 per cent effective in inducing abortion within 24 hours with a variety of doses administered orally or vaginally, although it is not as rapid as when used in combination with mifepristone. Vaginal administration of gemeprost alone is registered for termination of second-trimester pregnancy in several countries. One dose is given three to five times the first day and repeated the second day if necessary.

Other medical abortion agents

Most of these methods and routes of administration are invasive and less safe than the newer medical methods. Methotrexate, which is a cytotoxic drug used to treat cancer and some other conditions, has been used in combination with misoprostol as a medical method for early abortion in some countries where mifepristone has not been available. Although a success rate of 92 per cent has been reported, a WHO Toxicology Panel recommended against the use of methotrexate. Although the actual risks are yet unknown, limb defects and skull and face abnormalities in pregnancies that continued after failed attempts to induce abortion with methotrexate have been reported.

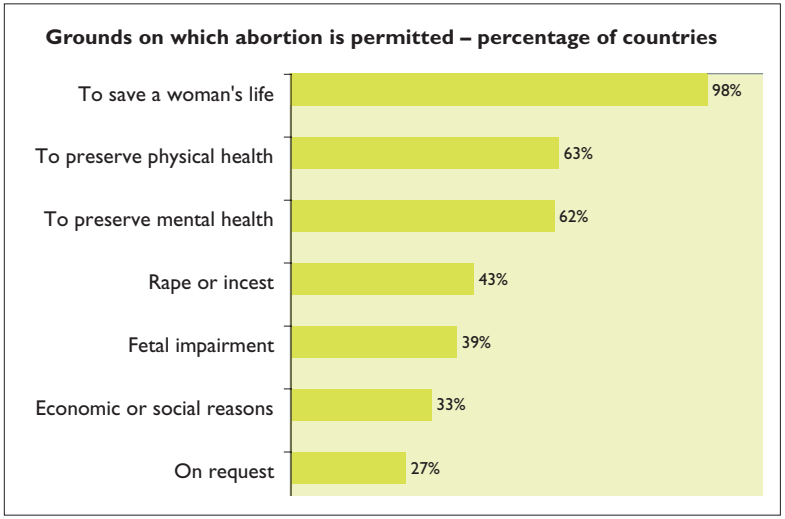
Other agents are used to stimulate uterine contractions and induce abortion from twelve completed weeks after the last menstrual period. They include, among others, intra-amniotic injection of hypertonic saline and parenteral, intra-amniotic or extra-amniotic administration of prostaglandin analogues.[2]

Carolina Ehrnrooth
Swedish Association for Sexuality Education (RFSU)

Fast facts

• Of the 210 million pregnancies that occur each year about 46 million (22 per cent) end in induced abortion.
• Globally, the vast majority of women are likely to have at least one abortion by the time they are 45.
• About 20 million, or nearly half, of the induced abortions annually are estimated to be unsafe. Ninety-five per cent of these occur in developing countries.
• Globally, approximately 13 per cent of all maternal deaths are due to complications of unsafe abortion.
• In addition to some 70,000 women who die each year, tens of thousands suffer long-term health consequences, including infertility.
• In countries where women have access to safe services, their likelihood of dying as a result of an abortion performed with modern methods is no more than one per 100,000 procedures.
• In developing regions (excluding China), 330 deaths occur per 100,000 abortions. The rate is highest, an estimated 680 deaths per 100,000 procedures – in Africa.[3]

2 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2003.
3 WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems,* Geneva, 2003. www.who.int



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

• In some low and medium-income countries, 50 per cent of the hospital budget is spent on complications resulting from unsafe abortions.[4]

• The link between unsafe abortion and maternal mortality is clear. For example, in some parts of Kenya, 50 per cent of maternal mortality is due to unsafe abortions,[5] and the corresponding figure in Latin America is 21 per cent.[6] The figure for Bolivia is 25–30 per cent.[7]

• Currently, over two thirds of all women live in countries where abortion is highly restricted by law.[8]

• In almost all countries, the law permits abortion to save the woman's life. In more than three-fifths of countries, abortion is also allowed to preserve the physical and mental health of the woman and, in about 40 per cent, abortion is permitted in cases of rape or incest or foetal impairment.[9]

• Medical abortion and vacuum aspiration (surgical abortion) are the two preferred methods of abortion during the first nine and twelve weeks of pregnancy, respectively. [10] Medical abortion terminates a pregnancy through the use of mifepristone and prostaglandin. Mifepristone and misoprostol have been introduced in 29 and 87 countries respectively.[11]

4 WHO, *Unsafe abortion: Global and regional estimates of incidence of a mortality due to unsafe abortion with a listing of available country data 1995-2000 –3rd ed.*

5 Oguttu Monica, Peter Odongo, *Midlevel Providers' Role in Abortion Care, Kenya Country Report*, A Paper for the Conference "Expanding Access: Midlevel Providers in Menstrual Regulation and Elective Abortion Care" South Africa, 2-6 December 2001. www.ipasihcar.net/expacc/reports/KenyaCR.PDF, 2004.

6 AGI, *Sharing Responsibility: Women, Society and Abortion Worldwide,* Special report, 1999. www.guttmacher.org/pubs/sharing.pdf

7 UNFPA, *Proposed Projects and Proposals, Bolivia 1998–2002.* www.unfpa.org/latinamerica/bolivia/2bol9802.pdf

8 Center for reproductive Rights (CRR), *The world's abortion laws 2003:* Wallchart, New York, 2003.

9 WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems,* Geneva, 2003. www.who.int

10 Ibid.

11 Ipas, *Medication Abortion: Frequently Asked Questions,* 2004. www.ipas.org

Abortion laws

Approximately 26 per cent of the world's people live in countries where abortion is generally prohibited, but the laws are not always an expression of the opinion of the local population. The table below illustrates the varying degrees to which countries worldwide permit access to abortion. Depending on such factors as public opinion, the views of government officials and providers, and individual circumstances, laws in each category may be interpreted more broadly or restrictively than indicated by their classifications.

I. Prohibited Altogether or Permitted Only to Save the Woman's Life (countries printed in bold make an explicit exception to save a woman's life.)

Afghanistan
Andorra
Angola
Antigua & Barbuda
Bangladesh
Bhutan – U
Brazil – R
Brunei Darussalam
Central African Rep.
Chile – x
Colombia
Congo (Brazzaville)
Côte d'Ivoire
Dem. Rep. of Congo
Dominica
Dominican Republic
Egypt
El Salvador – x
Gabon
Guatemala
Guinea-Bissau
Haiti
Honduras
Indonesia
Iran
Iraq
Ireland
Kenya
Kiribati
Laos
Lebanon
Lesotho
Libya – PA
Madagascar
Malawi – SA
Mali – R/I
Malta
Marshall Islands – U
Mauritania
Mauritius
Mexico – FE/R
Micronesia – U
Monaco
Myanmar
Nicaragua – SA/PA
Niger
Nigeria
Oman
Palau – U
Panama – PA/R/F
Papua New Guinea
Paraguay
Philippines
San Marino
Sao Tome & Principe
Senegal
Soloman Islands
Somalia
Sri Lanka
Sudan – R
Suriname
Swaziland
Syria – SA/PA
Tanzania
Togo
Tonga
Tuvalu
Uganda
United Arab
Emirates – SA/PA
Venezuela
West Ban & Gaza Strip
Yemen

72 Countries, 26.1% of World's Population

II. To Preserve Physical Health (also to save the woman's life)

Argentina – R I
Bahamas
Benin – R/I/F
Bolivia – R/I
Burkina Faso – R/I/F
Burundi
Cameroon – R
Chad – R/I/F
Comoros
Costa Rica
Djibouti
Ecuador – R I
Equatorial Guinea – SA/PA
Eritrea
Ethiopia
Grenada
Guinea – R/I/F
Jordan
Kuwait – SA/PA/F
Liechtenstein
Maldives – SA
Morocco – SA
Mozambique
Pakistan
Peru
Poland – PA/R/I/F
Qatar – F
Rep. of Korea – SA/R/I/F
Rwanda
Saudi Arabia – SA/PA
Saint Lucia
Thailand – R
Uruguay – R
Vanuatu
Zimbabwe – R/I/F

35 Countries, 9.9% of World's Population

III. To Preserve Mental Health
(also to save the woman's life and physical health)

Algeria
Botswana – R/I/F
Gambia
Ghana – R/I/F
Hong Kong – R/I/F
Israel – R/I/F
Jamaica – PA
Liberia – R/I/F
Malaysia
Namibia – R/I/F
Nauru
New Zealand – I/F
Northern Ireland
Portugal – PA/R/F
Saint Kitts & Nevis
Samoa
Seychelles – R/I/F
Sierra Leone
Spain – R/F
Trinidad & Tobago

20 Countries, 2.7% of World's Population

IV. Socioeconomic Grounds
(also to save the woman's life, physical health and mental health)

Australia – FE
Barbados – PA/R/I/F
Belize – F
Cyprus – R/F
Fiji
Finland – R/F
Great Britain – F
Iceland – R/I/F
India – PA/R/F
Japan – SA
Luxembourg – PA/R/F
Saint Vincent & Grenadines – R/I/F
Taiwan – SA/PA/I/F
Zambia – F

14 Countries, 20.7% of World's Population

V. Without Restriction as to Reason

Albania
Armenia
Austria
Azerbaijan
Bahrain
Belarus
Belgium
Bosnia
Herzegovina – PA
Bulgaria
Cambodia
Canada
Cape Verde
China – S
Croatia – PA
Cuba – PA
Czech Rep. – PA
Dem. People's Rep. of Korea
Denmark – PA
Estonia
France
Fmr. Yugoslav Rep. Macedonia – PA
Georgia
Germany
Greece – PA
Guyana
Hungary
Italy – PA
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Moldova
Mongolia
Nepal–S
Netherlands
Norway–PA
Romania
Russian Fed.
Serbia
& Montenegro – PA
Singapore
Slovak Rep. – PA
Slovenia – PA
South Africa
Sweden
Switzerland
Tajikistan
Tunisia
Turkey – SA/PA
Turkmenistan
Ukraine
United States – FE/PA
Uzbekistan
Vietnam

54 Countries, 40.5% of World's Population

Key for Additional Grounds, Restrictions and Other Indications:

R – Abortion permitted in cases of rape
RI – Abortion permitted in the case of rape of a woman with a mental disability
I – Abortion permitted in cases of incest
F– Abortion permitted in cases of foetal impairment
SA – Spousal authorization required
PA – Parental authorization/ notification required
FE – Federal system in which abortion law is determined at state level; classification reflects legal status of abortion for largest number of people
x – Recent legislation eliminated all exceptions to prohibition on abortion; availability of defence of necessity highly unlikely
S – Sex selective abortion prohibited
U – Law unclear

A note on terminology: 'Countries' listed on the table include independent states and, where populations exceed one million, semi-autonomous regions, territories and jurisdictions of special status.

Population statistics provided by the Alan Guttmacher Institute.

All facts from the Center for Reproductive Rights, www.crlp.org

Abbreviations

ABC Abstinence, Be faithful, use Condoms
AIDS Acquired Immune Deficiency Syndrome
CEDAW Convention on the Elimination of All Forms of Discrimination against Women
CESCR International Covenant on Economic, Social and Cultural Rights
COBAC Community-Based Abortion Care (Kenya)
COMECE Catholic bishops' organization
CRC Convention on the Rights of the Child
D & C Dilatation and Curettage
D & E Dilatation and Evacuation
FDA American Food and Drug Administration
FGM Female Genital Mutilation
FWLD Forum on Women Law and Development (Nepal)
GOPA Group of Policy Advisers
HIV Human Immunodeficiency Virus
IACHR Inter-American Commission on Human Rights
ICCPR International Covenant on Civil and Political Rights
IHCAR Division of International Health, Karolinska Institutet in Stockholm
ICOMP International Council on Management of Population Programmes
ICPD International Conference for Population Development
IPPF International Planned Parenthood Federation
KDH Christian Democrats (Slovakia)
KMET Kenya Medical and Education Trust
MVA Manual Vacuum Aspiration
MTP Medical Termination of Pregnancy
NGO Non-Governmental Organization
NPP The National Population Policy (India)
PAC Post-abortion care
PoA Programme of Action (ICPD)
Sida Swedish International Development Cooperation Agency
UDHR Universal Declaration of Human Rights
UNFPA UN Population Fund
WHO World Health Organization
SRHR Sexual and reproductive health and rights
SSPRVR The Slovak Family Planning Association
STI Sexually Transmitted Infection
RFSU Swedish Association for Sexuality Education
UNFPA The United Nations Population Fund
USAID United States Agency for International Development
UTH University Teaching Hospital (Lusaka)

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RESPECT CHOICE

The coming together of the international community in Cairo in 1994 at the International Conference on Population and Development (ICPD) signalled a radical change in approach to population issues. Sexual and reproductive health and rights (SRHR) replaced the then-prevailing narrower, demographically oriented perspective. The right of individuals to information and reproductive health services that would enable them to take control of their own sexuality was brought into focus, as was gender equality at all levels in society. Objectives and an action plan to achieve them were adopted by 179 countries in the ICPD Programme of Action (PoA). Five years later, the countries met again at a follow-up conference called ICPD+5.

This book is the fourth in a series of publications presented by the Swedish Association for Sexuality Education (RFSU) in conjunction with the 10th anniversary of the ICPD.

This book consists of a collection of articles about the issue of safe abortion. We connect what was adopted at the ICPD in this respect to the UN Millennium Development Goal to improve maternal health, and show that it is essential to make sure that women have access to safe abortion for its achievement. We also point out that access to safe abortion is a human right. The book mixes reflections and accounts of personal experiences with political analysis of the debate surrounding abortion.

rfsu