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Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies

HIGHLIGHTS

- This report examines the processes that followed passage of abortion law reforms in Cambodia, Colombia, Ethiopia, Mexico City, Nepal and South Africa and identifies a framework of activities that are essential to successfully implement less restrictive abortion laws.
- Essential activities include strategic publicity of the change in the legal status of abortion; formulation and dissemination of detailed medical guidelines for the provision of legal procedures; introduction of legal abortion services; and development of data collection and monitoring systems to evaluate the level, quality and impact of these new services.
- Campaigns to publicize the new abortion laws were undertaken in most of the six settings, but the scale and success of the dissemination efforts varied considerably.
- The existence, scope and public availability of guidelines also vary across settings. The most comprehensive and widely available guidelines exist in Ethiopia and Colombia.
- Limited health service infrastructures in all setttings have challenged the rollout of abortion services. Rollout has been relatively successful in South Africa, Ethiopia and Nepal, partly due to the support of international nongovernmental organizations.
- The revised law in South Africa has been followed by a dramatic reduction in abortion-related maternal deaths. Some evidence suggests the incidence of abortion-related complications has declined in Ethiopia and Nepal. The narrow terms of the change in Colombia's law preclude a notable impact on the incidence of abortion or related outcomes. Impact in Mexico City and Cambodia cannot yet be reliably assessed.
- Other activities often required for successful implementation of new laws include establishing mechanisms for financing safe services and developing adequate responses to resistance to the new law.
- Successful implementation of abortion law reform can take years, and requires ongoing commitment from government, providers and advocates for women's health and rights.

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Introduction

Induced abortion* has been legal on broad grounds in most of the industrialized world† since the early 1970s or longer. However, the legal status of abortion in the developing world is mixed, and interpretation of existing laws varies. As of 2008, 47% of women of childbearing age in the developing world lived in countries that banned the procedure outright or allowed it only to save a woman's life or protect her health.[1] Excluding women living in China and India, where abortion laws are liberal, eight in 10 women in the rest of the developing world were living under highly restrictive laws in that year. Yet, the evidence is clear that such laws are associated with a high incidence of unsafe abortion and its health consequences, and abortions in these settings contribute substantially to maternal morbidity and death worldwide.[2–4]

In the face of international consensus that unsafe‡ and clandestine abortions (which are common in countries where abortion laws are restrictive) are an abuse of human rights[5] and of women's right to reproductive health,[6–10] and in light of evidence that the costly and harmful health consequences of unsafe abortion for women are more common in countries with repressive abortion laws,[3] some changes are emerging in Africa, Asia and Latin America.[11] In fact, 26 countries have removed legal restrictions on abortion in the last 17 years.[12,13]

Initiatives to Reform Abortion Laws

Reform of abortion laws has generally been spearheaded by country-based and international women's health and human rights organizations that have waged hard-fought legal and educational campaigns to bring about these changes.[14–21] A number of common processes and strategies have emerged. Components of successful reform campaigns include qualitative and quantitative studies of morbidity and mortality associated with unsafe clandestine abortion (often providing estimates of the heavy costs to public health systems incurred from having to treat women with severe abortion-related complications)[22,23]; the dissemination of these findings to key advocacy groups and political organizations; the presence of nationally influential figures championing for law reform[24]; exchanges of parliamentary groups and continent-wide meetings of reproductive rights activists; advocacy campaigns using mass communications to mobilize public opinion; coalition building; and the development of innovative, human rights–based litigation strategies.

Although successful campaigns to revise abortion laws or penal codes are well documented, somewhat less has been published about what happens in a country once a law has passed and the impact, if any, of implementation of the new law on the number and type of abortions performed and on women's reproductive lives. Few countries have conditions that make it possible to conduct before-and-after studies to determine the overall impact of liberalizing the abortion law.§ Ideally, measures of abortion incidence and abortion-related morbidity would be available for the years preceding and following changes to the law. In all but a handful of developing countries with restrictive abortion laws, however, there are no reliable estimates of the number and rate of clandestine procedures occurring each year. The experience in several countries has challenged the assumption that safe abortions will automatically replace unsafe ones after passage of a less restrictive law.[25,26] In India, for example, abortion has been legal on broad grounds since 1971, but fully 30 years later, fewer than half of the estimated 6.4 million procedures carried out annually were deemed safe. Similarly, although abortion was legalized in 1996 in South Africa, the major-

*Throughout this report, *abortion* refers to *induced abortion* unless otherwise specified.

†Ireland, Malta and Poland are the major exceptions.

‡The World Health Organization refers to unsafe abortion as a procedure for terminating an unwanted pregnancy that is performed by persons who may lack the necessary skills or that is conducted in an environment that lacks the minimal medical standards, or both (source: reference 2).

§A notable exception is Romania, where good-quality statistics on abortion and associated maternal mortality were collected before, during and after periods in which both the procedure and the use of modern contraceptive methods were banned under the repressive Ceausescu regime of the 1970s and 1980s. After the end of that regime in 1989, abortion was legalized and the maternal mortality ratio fell dramatically from 160 maternal deaths per 100,000 live births in 1993 to 40 by 1999 (source: Hord C et al., Reproductive health in Romania: reversing the Ceausescu legacy, *Studies in Family Planning,* 1991, 22(4):231–240).

ity of terminations performed in 2008 were still unsafe. These findings suggest that it may take a long time after legislative change to reach full coverage of safe abortion services, especially in rural or largely poor countries.[27] Indeed, successful implementation of abortion law reform is likely to be a long process in nearly any setting where abortion had been criminalized for a lengthy period of time, because social change will be a necessary part of this process.

Overview of Reform in Six Settings

Six of the settings that have undergone abortion law reform—South Africa, Ethiopia, Mexico City, Colombia, Nepal and Cambodia—share in common the facts that they undertook particularly substantial reforms of their laws, these reforms all occurred in the span of about a decade (between 1996 and 2007), and they took place in settings with relatively large populations. These settings collectively offer a prime opportunity to evaluate and learn from experiences in translating a new law to accessible abortion services.

There are some noteworthy differences between the settings, however. First, although all six undertook broad reforms, the scope of the new laws varied widely across the settings (see box). In three countries (Cambodia, Nepal and South Africa), the revised laws made abortion available without restriction in the first trimester (12 weeks) of pregnancy and on a more limited basis during the second trimester. The Mexico City law permits it on request during the first 12 weeks of pregnancy, but not later. Ethiopia allows abortion in cases of rape or incest and under a range of conditions pertaining to the well-being of the woman or the fetus, but only up to 28 weeks' gestation. The Colombian law allows abortion only in cases of rape, incest or fetal malformation, and to save the woman's life or health; no gestational age limit is specified.

The authorities that enacted abortion law reform also differed. In Cambodia, the law was changed by royal decree; in Colombia, by a decision of the country's Constitutional Court. In Ethiopia, the Criminal Code was amended through parliamentary action. In Nepal, the law changed as a result of parliamentary revisions of the Legal Code, but the king had to assent to the new articles before legal abortion services could be offered (the monarchy has since ended). In Mexico City, the legislative assembly passed the law decriminalizing abortion and requiring the Ministry of Health to fund all requests for the procedure. And in South Africa, the parliament of the new South African Republic passed a law repealing an earlier act, which was then signed by the president.

Also, although the law reforms in all six settings have been fairly recent, some countries have had more time than others to adopt and implement strategies for providing legal abortion services. The law was revised in 1996 in South Africa,* 1997 in Cambodia, 2004 in Nepal,† 2005 in Ethiopia,‡ 2006 in Colombia and 2007 in Mexico City. Finally, the settings contrast to the greatest extent in terms of measures of socioeconomic development (Table 1, page 7). Most striking are the large differences in per capita gross domestic product and, consequently, in levels of health care spending between the three middle-income settings (Colombia, Mexico City and South Africa) and the three low-income ones (Cambodia, Ethiopia and Nepal). These differences carry implications for the capacity to translate new laws into provision of safe and legal abortion services. Other important contrasts between the settings, including cultural factors and differences in the level and nature of religiosity, also influence the level and pace of receptivity to abortion law reforms.

About This Report

This report contains a collection of case studies we conducted to examine the passage, implementation and impact of revised, less restrictive abortion laws in the six country settings introduced above. The methods used, including information sources and the framework employed to assess the impact of the changed law, are decribed in the box (page 6). Each country is considered separately. To facilitate cross-country comparisons, the descriptions of the countries follow the same format: Each covers the country setting; legal grounds for abortion under the revised law; formal guidelines for implementing the new law, and their dissemination and efforts to inform the public about the changes; creation, availability and uptake of safe abortion services; and the impact of the revised law. Finally, we summarize our key findings and some additional insights, and offer recommendations that may provide guidance to policymakers, program planners, health providers and other stakeholders undertaking reform of abortion laws.

*The law was passed in 1996 and enacted in 1997.

†The law was revised in 2002 but was not approved until December 2003.

‡Revision of the penal code began in 2004 and went into effect in 2005.

Summary of the grounds for legal abortion, before and after revision of the law in six country settings

Country setting/ year of revision	Before revision	After revision
Cambodia, 1997	Abortion was permitted only to save a woman's life.	Abortion is permitted during the first 12 weeks of pregnancy without restriction as to reason. Abortion is subsequently permitted if (1) the pregnancy is abnormal, growing unusually or poses a risk to the woman's life, (2) the baby that is going to be born could have a serious incurable disease or (3) the pregnancy resulted from rape. The abortion request must come from the woman herself or, if she is a minor, from her parents or guardian.
Colombia, 2006	Abortion was not permitted on any grounds.	With the woman's consent, abortion is permitted (with no gestational limit specified) if (1) continuing a pregnancy threatens her life or health as certified by a medical doctor, (2) a doctor certifies that the fetus has grave malformations incompatible with life, or (3) the pregnancy resulted from the criminal acts, duly reported to the proper authorities, of incest, rape, sexual abuse or artificial insemination or implantation of a fertilized ovule without the woman's consent.
Ethiopia, 2005	Abortion was permitted only if continuing the pregnancy would threaten the woman's life as agreed on by two doctors, one a specialist in the alleged health-threatening condition.	Abortion is permitted (1) if the pregnancy is the result of rape or incest; (2) if the continuance of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; (3) where the child has an incurable and serious deformity; or (4) where the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child.
Mexico City, 2007	Abortion was permitted only to protect the woman's life or health; if the pregnancy was the result of involuntary artificial insemination or rape; and in cases of fetal impairment.	Abortion (or voluntary pregnancy termination) is permitted during the first 12 weeks of gestation without restriction as to reason. Penalties for women who self-induce or consent to an abortion performed after 12 weeks are reduced.
Nepal, 2004	Abortion was not permitted on any grounds.	Abortion is permitted during the first 12 weeks of pregnancy without restriction as to reason with the woman's consent; between 13 and 18 weeks with the woman's consent if the pregnancy resulted from rape or incest; and at any gestation, with the woman's consent and under an authorized medical practitioner's recommendation, if the woman's life or physical or mental health is at risk, or if there is a risk of fetal impairment.
South Africa, 1996	Abortion was permitted only to protect the woman's life or physical or mental health; in cases of rape (which had to be documented), incest or other unlawful intercourse; and in cases of fetal impairment that could result in the birth of a severely handicapped infant.	Abortion is permitted on request of a woman during the first 12 weeks of pregnancy. Abortion is permitted from the 13th up to and including the 20th week if a medical practitioner, after consultation with the pregnant woman, is of the opinion that (1) the continued pregnancy would pose a risk of injury to the woman's physical or mental health, (2) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality, (3) the pregnancy resulted from rape or incest or (4) the continued pregnancy would significantly affect the social or economic circumstances of the woman. Abortion is permitted after the 20th week of pregnancy if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy (1) would endanger the woman's life, (2) would result in a severe malformation of the fetus or (3) would pose a risk of injury to the fetus.

Sources: **Cambodia**—Population Division, United Nations Department for Economic and Social Development, *Abortion Policies: A Global Review, Volume I, Afghanistan to France,* New York: United Nations, 2002, p. 80. **Colombia**—Law 599, which issues the Penal Code with changes from Sentencia C-355/06, 2006; <http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=6388>, accessed Mar. 15, 2012. **Ethiopia**—reference 13. **Mexico City**—reference 105. **Nepal**—reference 177. **South Africa**—reference 36 and the Abortion and Sterilization Act No. 2, Section 3, *Government Gazette,* 478, 1975.

Case Study Methods

Information Sources

We gathered information from a wide range of reports on the situation that preceded and followed legal reform in six country settings that span three major world regions: South Africa and Ethiopia in Africa; Mexico City and Colombia in Latin America; and Cambodia and Nepal in Asia. As the peer-reviewed literature on this topic is quite limited, other types of published work and unpublished documents were key sources of information for this report. Grey literature* was obtained by searching Web sites of government agencies and of organizations that focus on law change and its impact, and through direct contact with individuals who are specialists on abortion law change and related matters for each of these countries.

To amplify and inform the findings of this broad literature review, we asked experts familiar with each of the six country cases to complete a questionnaire on the implementation of a revised law in that country. These experts included members of relevant government agencies, stakeholders in international nongovernmental organizations (NGOs) who have been participating in the implementation of the new laws, and social scientists with informed perspectives on this process. We identified the experts, referred to in the case studies as key informants, in the course of the literature review and through the professional networks of the researchers who contributed to this report.

The questionnaire was composed of open-ended and closed-ended questions in four topic areas: the existence, dissemination and availability of health service regulations and guidelines; the implementation of programs to provide services capable of offering safe abortions to all eligible women in need; the uptake, quality and accessibility of these new services; and the health and social impact, if any, of legal reform, including possible backlash on the part of opponents of legal abortion and challenges to the new law. The questionnaires were administered by e-mail in April and May of 2011 to more than 20 key informants. Follow-up was carried out through e-mail and telephone. In a few instances, experts were interviewed in person.

We synthesized and structured the information from all sources using the framework discussed below. With written reports serving as principal sources of information, the input from this survey of experts helped validate our interpretation of the literature, identify additional literature and provide insights beyond those that could be obtained in written reports.

A Framework to Assess the Impact of Law Change

On the basis of findings from an initial review of the literature, we identified a number of activities that ideally should begin after passage of a revised abortion law to achieve its successful implementation, and created a framework that identifies the key activities and used this to structure our assessment of the degree to which the necessary processes have taken place in each of the country examples since the law was reformed. We determined that this framework should cover the following essential activities:

- Strategic publicity, to workers in all government health agencies and private health facilities, as well as the general public, that the legal status of abortion has changed;
- The formulation, publication and dissemination of guidelines or regulations outlining the eligibility criteria for a legal abortion under the new law,† as well as types of facilities and providers legally allowed to perform abortions and the required (or recommended) methods of termination;
- The introduction of new abortion services capable of providing safe abortions to all eligible women in need, and programs to train health workers assigned to those services; and
- Data collection and monitoring systems to evaluate the level, quality and health impact of the new services.

We also examined significant activities on the part of opponents of legal abortion and in the form of legal challenges to the new law.

*Defined as "that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (source: New York Academy of Medicine, What is grey literature? no date, <http://www.nyam.org/library/online-resources/grey-literature-report/what-is-grey-literature.html>, accessed Feb. 18, 2012).

†The importance of easily accessible and understandable guidelines, or protocols, is emphasized in a recent publication of International Planned Parenthood that compares and evaluates abortion service guidelines in 13 countries in which the procedure is largely legal (source: International Planned Parenthood Federation (IPPF), *Legal Abortion: A Comparative Analysis of Health Regulation. A Review of Latin America and Selected Countries in Europe and Africa*, London: IPPF, 2009).

TABLE 1. Selected social, demographic and health care characteristics of six country settings, various years

Region and country setting	Population, 2010 (in 000s)	GDP per capita, US$		% GDP spent on health—public and private (2008)	% rural (2010)	% of women 15–49 with more than primary education		% of women >15 who are literate	
		In 2008	In 2010						
	1	2	3	4	5	6		7	
Africa									
South Africa	50,133	5,642	7,275	8.2	38	2003	79.3	2003	90.7
Ethiopia	82,950	335	358	4.3	83	2011	11.2	2003	35.1
Latin America									
Mexico	113,423	9,909	9,166	5.9	22	u	u	2005	85.7
Colombia	46,295	5,436	6,225	5.9	25	2010	76.1	2005	90.7
Asia									
Nepal	29,959	435	524	6.0	81	2011	42.8	2001	34.9
Cambodia	14,138	749	802	5.7	80	2010	34.7	2004	64.1

Region and country setting	Predominant religion, % of population		% of women 15–49 exposed to mass media* regularly		No. of health providers per 10,000 population (2000–2010)		% of deliveries having skilled attendant	
					Doctors	Nurses and midwives		
	8		9		10	11	12	
Africa								
South Africa	Protestant	72.6	1998	87.0	7.7	40.8	2003	91
Ethiopia	Ethiopian Orthodox	44.3	2005	20.1	0.2	2.4	2011	10
Latin America								
Mexico	Roman Catholic	76.5	u	u	28.9	39.8	na	94
Colombia	Roman Catholic	90.0	1995	96.5	13.5	5.5	2010	95
Asia								
Nepal	Hindu	80.6	2006	70.0	2.1	4.6	2011	36
Cambodia	Buddhist	96.4	2010	67.5	2.3	7.9	2010	71

*Newspaper, television or radio. *Notes:* u=unavailable. GDP=gross domestic product. *Sources:** **Column 1**—reference 70. **Columns 2 and 3**—World Bank, GDP per capita (current US$), no date, <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>, accessed Nov. 11, 2011. **Column 4**—World Health Organization, *World Health Statistics 2011,* 2011, <http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf>, accessed Nov. 11, 2011. **Column 5**—United Nations Statistics Division, Social Indicators, June 2011, <http://unstats.un.org/unsd/demographic/products/socind/hum-sets.htm>, accessed Nov. 11, 2011. **Column 6**—*South Africa:* reference 33; *Ethiopia:* reference 71; *Colombia:* reference 142; *Nepal:* reference 183; *Cambodia:* reference 202; *all other settings:* Measure DHS and USAID, STATcompiler, 2011, <http://statcompiler.com/>, accessed Nov. 11, 2011. **Columns 7 and 8**—Central Intelligence Agency, *World Factbook,* no date, <https://www.cia.gov/library/publications/the-world-factbook/index.html>, accessed Nov. 11, 2011. **Column 9**—Measure DHS and USAID, STATcompiler, 2011, <http://statcompiler.com/>, accessed Nov. 11, 2011. **Columns 10 and 11**—World Health Organization, *World Health Statistics 2011,* 2011, <http://www.who.int/whosis/whostat/EN_WHS2011_Full.pdf>, accessed Nov. 11, 2011. **Column 12**— *South Africa:* reference 33; *Ethiopia:* reference 71; *Colombia:* reference 142; *Nepal:* reference 183; *Cambodia:* reference 202; *Mexico:* United Nations Development Programme, *Human Development Report 2010: The Real Wealth of Nations: Pathways to Human Development,* Statistical Tables, 2010, <http://hdr.undp.org/en/media/HDR_2010_EN_Tables_reprint.pdf>, accessed Nov. 11, 2011.

TABLE 2. Legal abortion rates and maternal mortality ratios in six country settings, various years

Country setting (year of law's revision)	Legal abortions per 1,000 women 15–44	Maternal deaths per 100,000 live births*		
	2008	1990	2000	2008
	1	**2**	**3**	**4**
Africa				
South Africa (1996)	6	230	380	410
Ethiopia (2005)	6	990	750	470
Latin America				
Mexico City (2007)	6	na	na	na
Mexico†	na	93	90	85
Colombia (2006)	39	140	110	85
Asia				
Nepal (2004)	15‡	870	550	380
Cambodia (1997)	11§	690	470	290

*Maternal mortality ratios presented here are from the World Health Organization and do not necessarily match the estimates given in the body of this report, which are based on a variety of published sources. †Data are given for Mexico because most measures are not available for Mexico City alone. ‡For July 2007 to June 2008. §For 2005. *Note:* na=not available. *Sources:* **Column 1**—*Colombia:* reference 144; *all other settings:* reference 26. **Columns 2–4**—reference 135.

South Africa

A. The Country Setting

South Africa, a middle-income country, had 50.1 million inhabitants in 2010 (Table 1, page 7); 80% were black, 9% white, 9% colored (people of mixed-race descent as classified by the previous apartheid government) and 2% Indian/Asian.[28] About four in 10 South Africans live in rural areas. An estimated 17% of the adult population aged 15–49 years is HIV positive.[29]

A number of reports describe the harmful consequences of unsafe abortions for the health and survival of South African women before the abortion law was liberalized in 1996.[30] The goverment spent some 18.7 million South African rand in 1994 (equal to roughly US$5.3 million in that year) on treatment in public hospitals of complications arising from incomplete and other unsafe abortions, which usually presented in the form of sepsis (widespread infection) and hemorrhage.[22] The same year, an estimated 44,686 women sought care for incomplete abortions at public hospitals, and approximately 425 women died from unsafe procedures.[31] However, the total number of unsafe abortions performed annually around that time was likely much higher; public health experts estimated that by 1996, approximately 200,000 illegal procedures were taking place each year in South Africa.[32]

General health services are highly uneven in South Africa, as the country's overall health system still reflects the social and economic inequities imposed on its African communities by many decades of apartheid.[33] The black population, the group least likely to have full-time employment, depends heavily on the public health sector for health care, whereas the white population predominantly uses private health care facilities, covered through work-related health insurance or paid for out of pocket.[34,35] The quality and accessibility of health care are among the best in the world for those who can pay for private medical services (predominantly the affluent white population) but are insufficient to address the multiple interconnected economic and health issues of the poorest members of society (predominantly the black population in rural areas). Thus, two separate and highly unequal health systems reflect a continuation of the two-nations aspect of South Africa, despite the overthrow of apartheid.

B. Legal Grounds for Abortion Under the Revised Law

With revision of its abortion law, South Africa became one of only four countries in the Africa region* that permit abortion without restriction as to reason (but with gestational age and other limits). When its abortion law was made less restrictive, the country had just emerged from long years of apartheid rule, and there was strong momentum for reform incorporating a human rights perspective in all areas of social and political life. The 1996 Choice on Termination of Pregnancy (CTOP) act[36] replaced a 1975 law that severely curtailed access to abortion services by requiring permission of a physician, psychiatrist and hospital superintendent, and in some cases approval of a magistrate, before an abortion could be performed.

South Africa's abortion law is considered a model in that it recognizes women's right to have an abortion with no restrictions in the first trimester; allows midlevel providers to perform early terminations; gives women, not husbands or guardians, the sole right to consent; and addresses inequity by making services government funded. Under the revised law, a woman may request an abortion during the first 12 weeks of gestation without giving any reason. From 13 to 20 weeks, she may obtain an abortion if a medical practitioner affirms that there is a risk to her own or the fetus's physical or mental health, that the pregnancy is the result of rape or incest, or that the continued pregnancy would significantly affect the social or economic circumstances of the woman.[36] After 20 weeks' gestation, abortion is allowed if two health care providers (two doctors or a doctor and registered midwife) believe that continuing the pregnancy would endanger the woman's life or result in severe malformation of, or injury to, the fetus. Termination during the first trimester may be carried out by a trained nurse-midwife or a doctor; at later

*The other three are Cape Verde, Tunisia and Zambia.

gestations, only doctors are legally permitted to perform terminations.

Under the law, abortions may be performed only at facilities designated by the central Ministry of Health or by provincial health administrations. After parliamentary oversight hearings on the implementation of the new law, an Amendment Act was passed in 2004 to improve access.[37] This amendment permitted not just midwives but also registered nurses with appropriate training to perform abortions and required clinics conducting the procedures to maintain and submit service statistics. It also allowed the provincial health administration to designate clinics to provide abortion services. The qualifications to be licensed as a designated facility under the amended law are stringent. The amendment states:

> Termination of a pregnancy may take place only at a facility which: (a) gives access to medical and nursing staff; (b) gives access to an operating theatre; (c) has appropriate surgical equipment; (d) supplies drugs for intravenous and intramuscular injection; (e) has emergency resuscitation equipment and access to an emergency referral centre or facility; (f) gives access to appropriate transport should the need arise for emergency transfer; (g) has facilities and equipment for clinical observation and access to in-patient facilities; (h) has appropriate infection control measures; (i) gives access to safe waste disposal infrastructure; (j) has telephonic means of communication; and (k) has been approved by the Member of the Provincial Executive Council by notice in the *Gazette*.[37]

A key informant noted that as a result of these requirements, implementation of the law has occurred predominantly in busy urban hospitals, and decentralization to primary health facilities, especially in rural areas, has not been achieved.

There is a provision in the law for minors. Under the law, women younger than the age of 18 "shall be" advised to inform or consult with their parents, guardian, family members or friends about their decision to have an abortion, provided that they are not denied the procedure if they decide not to do so.[36]

Of note, the law does not contain any conscientious objection exemptions for health workers[38] and, moreover, states that any person who prevents the lawful termination of pregnancy shall be guilty of an offense and liable on conviction to a fine or imprisonment. In addition, it stipulates that during counseling, a woman should be informed of her rights and that the provider may not prevent access to termination services. However, the situation is more complex, as the country's Constitution upholds "freedom of conscience, religion, thought, belief and opinion."[39] The belief that health workers are under no obligation to perform or take active part in an abortion if they do not wish to is widespread and has a negative impact on the provision of abortion services in the public health sector in many districts in South Africa.[40,41] A national policy for conscientious objection in the implementation of the CTOP act has been drafted and is awaiting implementation by the National Department of Health.

C. Guidelines and Their Dissemination

After passage of the 1996 law, the Women's Health Directorate of the South African National Department of Health developed implementation guidelines for health workers.[42] They were assisted by a number of health activists working in the area of women's health policy and research. NGOs, including the Reproductive Rights Alliance (RRA), played a major role. The alliance comprised 30 organizations, all of which had played an important advocacy role before passage of the 1996 law, committed to promoting women's right to freedom of reproductive choice. The alliance was mainly funded by international donors such as the Henry J. Kaiser Family Foundation, according to a key informant. Local offices of international organizations such as Ipas and Ibis have also played an important role in supporting the new services. However, input from reproductive health activists has decreased over time for several reasons, including both a lack of funding and the institutionalization of services in public facilities. Key figures in the reform process have moved into other areas of research and activism. Another major reason has been the demands made on public services by the growth in the HIV epidemic.

There is no evidence of a large-scale information campaign to inform South Africans about the change in the country's abortion law.[43] The national guidelines developed in 1997 were circulated to all provincial health services but were not actively implemented in all provinces. Some hospitals did, however, issue clinical guidelines governing the provision of safe abortion for their participating staff.[44]

D. Creation, Availability and Uptake of Safe Abortion Services

Implementation of the revised abortion law, through the National Abortion Care Programme, has been spelled out in detail:

> The National Abortion Care Programme…was carried out through a partnership among the Maternal, Child and Women's Health (MCWH) Directorate of the Department of Health, the Reproductive Health Research Unit (RHRU), which coordinated the National Abortion Care Programme and provincial health departments and academic institutions. Ipas,

an international non-governmental organization with extensive experience in training and research on abortion care, collaborated in the design of the training content and process as well as in the evaluation of midwives' skills.

The main purpose of the National Abortion Care Programme was to develop the capacity to provide safe, high quality and accessible abortion care services in public sector hospitals and clinics. The Programme aimed to include abortion services as part of the array of services offered at primary and secondary level health care facilities, therefore bringing services closer to the communities where women live, particularly poor women and women living in rural areas whose access to services is often limited.

The key elements of the National Abortion Care Programme were: training physicians in the use of manual vacuum aspiration (MVA) for termination of pregnancy and treatment of incomplete abortions; and the Midwifery Abortion Care Training Programme, which focused on training midwives to provide comprehensive abortion care services. This included the use of manual vacuum aspiration for first trimester abortion and in the treatment of incomplete abortion, as well as training other midwives in post abortion contraceptive counselling.[44]

According to this program, legal abortions are provided for free, just like every other maternal health service delivered through the public health system.

Training specifically for nurses has been made available. The University of Witwatersrand and Ipas developed a short course to certify nurses in pregnancy termination, management of incomplete abortions and provision of reproductive health care. The Nursing Council of South Africa requires that nurses attend this course, and then obtain practical experience, to perform abortions in the first 12 weeks of gestation.[45]

Government service statistics are available for the program's first 12 years. The annual number of registered, legal abortions in public facilities increased from 26,000 in 1997 to 77,000 in 2009.[46] The increase is likely due in part to the reporting requirements enacted in 2002–2004.

It is clear that many abortions are still taking place outside of government health institutions and excluded from official counts. For example, in a 30-month period during the first three years after revision of the law, nearly 26,000 terminations were provided by one international NGO, indicating heavy reliance in the early years on the private health sector in achieving the overall numbers.[47] Government reports of the proportion of designated facilities that actually provide abortions have ranged widely since 2000, between a low of 25% in 2009 and a high of 62% in 2003,[48] perhaps as a result of incomplete information. There is no available breakdown of total terminations by public- versus private-sector providers.

The leading abortion method in public hospitals and clinics is manual vacuum aspiration (MVA), used in combination with misoprostol.[44,45] Medication abortions are now considered to be widely available in the private sector but are still rare in the public sector, despite recommendations noting that provision of this method would be effective, safe and convenient.[49] Studies have also demonstrated the effectiveness and the potential convenience and safety of this method in the context of South Africa's health system,[49] providing support for the argument that the National Departmemt of Health should include it as an additional method offered by government providers. Mifepristone was registered by the Medicines Control Council for this purpose in 2001, and guidelines for its use were submitted to the National Department of Health in 2008 but have not yet been put into wide practice. The combination of mifepristone and misoprostol for medication abortion in the early stages of pregnancy (at gestations of less than eight weeks) is accepted by the Western Cape Health Department and has been available in one subdistrict of the province since 2008.[49]

Government statistics for the period 1997–2004 indicate that more than two out of 10 reported abortions were of pregnancies later than 12 weeks of gestation.[50] Suggested reasons for this sizable proportion of later terminations include women's complex decision-making processes and delays in obtaining care resulting from structural inefficiencies in the public-sector abortion service.[51]

E. Impact of the Revised Law

The impact of South Africa's 1996 law has been closely monitored, and the National Committee of Confidential Enquires into Maternal Deaths reports that the law led to a dramatic 91% decline in abortion-related maternal mortality between 1994 and 1998–2001.[52] The researchers indicated that this reduction is "even greater than that reported in other countries, such as Romania," and "shows that this legislation has been extremely successful in advancing women's health and rights."

Understanding the contribution of unsafe abortion to maternal mortality in South Africa is complex. The proportion of maternal deaths in health facilities that were attributed to abortion fell from 5% in 1990–2001 to 3.4% in 2005–2007.[53] However, an increase in the burden of other causes of maternal death can reduce the relative contribution of abortion, and the HIV/AIDS epidemic in South Africa seems to have created this situation. Indeed, it has been noted that the dramatic 46% increase in adult mor-

tality nationally between 2001 and 2007 was due largely to the epidemic.[54] An additional consideration is that most maternal deaths occurring outside of health institutions are not reported, and in rural areas, 20–66% of maternal deaths fall into this category.[55]

With respect to the law's impact on maternal morbidity, one study found a significant decrease in the proportion of incomplete induced and spontaneous abortion cases with signs of infection, suggesting a decline in the severity of complications from unsafe induced abortions between 1994 and 2000.[56] The authors conclude that "legalisation of abortion had an immediate positive impact on morbidity, especially in younger women," and that "this is an important change as teenagers had the highest morbidity in 1994."

Similarly, a study of indigent women attending two public hospitals in western Pretoria over the period 1997–1998 to 2003–2005 found "a massive reduction in women presenting with incomplete abortions."[57] The prevalence of critical illness due to complications of abortion did not change, but the case-fatality rate* and the maternal mortality ratio (MMR)† both declined significantly, suggesting that although there was no reduction in serious complications, they were less often leading to death. The authors attribute these improvements to passage of the 1996 abortion law.

The combined rate of both legal and illegal abortion in South Africa is not known. However, the overall rate of abortion in the subregion of Southern Africa,‡ where nearly 90% of the female population consists of residents of South Africa, is estimated to have fallen from 19 to 15 per 1,000 women aged 15–44 between 1995 and 2008, after rising in the early part of this interval.[26] This decline is attributed entirely to a decrease in the unsafe abortion rate. According to official statistics reported to South Africa's Department of Health, the legal abortion rate remained unchanged between 2003 and 2008, at six per 1,000 (Table 2, page 8).

Unsafe abortion remains a problem because of persistent obstacles to the delivery of legal services. Whereas all abortions in the Southern Africa subregion were deemed unsafe in 1995, 58% were classified as unsafe in 2008.[26,58] Thus, despite a marked decrease, unsafe abortion has certainly not disappeared in the country. Indeed, it was recently ranked the fourth leading cause of maternal death nationally.[35] Many women—especially those living in rural areas with inadequate provision of public health care resources—still resort to use of unsafe, untrained providers and still go to emergency rooms for incomplete abortions and the treatment of abortion-related complications. Among the reasons offered for this situation are widespread lack of knowledge of the law among many women,[59] the poor quality or sheer lack of services in designated health facilities in many areas,[60–62] the frequent stigmatization of abortion among hospital and clinic staff[44,63,64] and delays in access to services.[65]

Key figures in public health and women's rights advocacy recognized early on that shortages of trained providers would impede the delivery of services, and various assessments at the time urged that training programs be established as soon as possible after passage of the 1996 law.[43] A particularly prescient report foretelling the problems that would result from provider shortages acknowledged that the "decentralisation of abortion services to the primary health care level was expected to be slow initially, as midwives needed to be trained in abortion provision."[44] Another obstacle to providing safe, legal abortion services, mentioned by a key informant, is the HIV epidemic, which has made major demands on health care resources, in terms of both finances and personnel. Many of these barriers are articulated in one report, as follows:

> Possible explanations for the lack of…services… are a shortage of trained staff, resources and beds; a lack of support for the process by hospital and district management personnel; unwillingness of certain staff to participate in TOP [termination of pregnancy] services; fear of victimisation from other members of staff with members of the community; lack of political commitment to the process from provinces; and difficulties in introducing a new service at a time of major reorganisation of the health care system…
>
> …Resistance on the part of health care providers to offer abortion services as well as negative attitudes toward service provision in general also posed major barriers to women's access to high quality services. Midwives complain about the hospital management not being supportive; victimisation from other members of staff; the overwhelming demand and severe staff shortages, as well as the inability to help women who are more than 12 weeks pregnant. There are no reliable, accessible second trimester services in many of the areas. Negative attitudes of management towards…service provision, intimida-

*The number of deaths per 100,000 abortions performed.

†A common measure of women's reproductive health, typically expressed as the number of maternal deaths per 100,000 live births. A maternal death is one occurring during pregnancy or in the 42 days afterward from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (source: WHO, Maternal mortality ratio (per 100 000 live births), undated, <http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html>, accessed Feb. 18, 2012).

‡The Southern Africa subregion, as defined by the United Nations, includes Botswana, Lesotho, Namibia, South Africa and Swaziland.

> tion of abortion care providers by both colleagues and communities, and service providers acting as gatekeepers, contribute to the non-functioning of designated facilities.[44]

A 2009 social sciences briefing, sponsored by the World Health Organization (WHO) and focusing on the quality of services in Cape Town, shows similar findings.[41] Clearly, a broad range of barriers to safe abortion provision persists, even though these barriers are fairly widely understood and acknowledged.

A number of formal challenges to the abortion law have found their way to the court system. In 1998, three antiabortion groups (United Christian Action Group, the Christian Lawyers' Association and Christians for Truth) asked that the law be overturned on the grounds that it denies the fetus the constitutional guarantee of a right to life.[66] Doctors for Life International also challenged the 2004 amendment to the law in the Constitutional Court, on the basis that there had not been sufficient public engagement on the issue before its passage. In August 2006, the court declared that the amendment was indeed unconstitutional on those grounds, but suspended the invalidation for 18 months during which time Parliament would have to ensure proper public involvement. Extensive workshops to inform the public of the Amendment Act, coordinated by Ipas, were held in communities throughout South Africa.[67] The amendment was reenacted in 2008,[68] shortly before its invalidation would have gone into effect.

South Africa is a conservative society, public opinion disapproving of the law is strong, and abortion remains a highly stigmatized issue. Challenges to the existing law are also evident in the public health sector, where health care workers often impede or undermine women's access to abortion services. But discomfort with legal abortion among nurses in government health facilities, a phenomenon highlighted in many assessments of the country's provision of safe and legal terminations, was widespread even before passage of the 1996 law. However, some sharpening of hostile attitudes may have occurred since then. And the absence of any conscientious objection clause in South Africa's abortion law leaves the issue of provider disapproval largely unresolved.[69]

As one key informant notes, few health centers (as distinct from hospitals) have obtained the designated service status needed to provide abortions; the government consistently refuses additional pay for medical workers performing them; booking procedures at health facilities is cumbersome, leading to delays in service; a high proportion of women seek abortions beyond the first trimester; and in urban areas, the mass media carry paid advertisements for private doctors and clinics performing low-cost (and unregulated) terminations. Overall, a conclusion reached 11 years ago about the future consequences of South Africa's changed abortion law appears still valid today:

> On one hand, the country has instituted model legislation and has begun building, with limited resources, a network of public-sector providers that will offer all women safe abortion services without charge. On the other, the obstacles these efforts have encountered—despite the active support of the government—pose a warning that, even in favorable circumstances, the process of moving from a situation in which abortion is illegal to one in which services are available and accessible to all women is unlikely to be short or smooth.[43]

Ethiopia

A. The Country Setting

Ethiopia is a large, very poor and predominantly rural African country. In 2010, it had an estimated 83 million inhabitants, its per capita income was $358 a year, and 83% of the population lived in rural areas (Table 1, page 7).[70]

If fertility were to remain constant at 2010 levels, an Ethiopian woman would bear an average of 4.8 children in her lifetime.[71] This represents a decrease in the five years since 2005, when the total fertility rate was 5.4 births per woman. Overall, only 29% of currently married women use some method of family planning. Although contraceptive prevalence is low in the country, it rose substantially since 2005, when 15% of women were contraceptive users. The induced abortion rate was estimated to be 23 per 1,000 women aged 15–44 in 2008, and the unintended pregnancy rate was 101 per 1,000.[72]

The contribution of unsafe abortion to the country's high maternal mortality ratio is not known. The overall level of maternal mortality, however, was declining even before the new abortion law took effect. The Demographic and Health Survey of 2000 estimated that the MMR in 1994–2000 was 871 maternal deaths per 100,000 live births.[73] By 2005, the year the law was revised, the ratio had dropped to an estimated 673 deaths per 100,000 live births.[74]

While these trends indicate improvements in the country's health care services, Ethiopia's health infrastructure remains frail. The country suffers from an acute shortage of health workers. A 2006 government plan to improve reproductive health services in the country states:

> Assessments…suggest that the role of health care professionals in program implementation is becoming increasingly undermined by their heavy burden of work, low motivation, and inadequate training. Staff shortages; low remuneration; the lack of incentives to improve skills; burdensome administrative procedures; and limited opportunities for professional growth are all cited as key factors contributing to high staff turnover and poor quality health care provision.[75]

A public health initiative introduced in 2005, the Health Sector Development Programme, aims to help address the lack of trained professionals with the addition of more than 24,571 new health extension workers (one for every 3,134 individuals in the population).[76] By the program's fourth stage in 2010, ambitious targets were being set, including a reduction in the MMR from 590 per 100,000 live births in 2010–2011 to 267 in 2014–2015.[77]

Still, in 2010–2011, there were merely 0.2 trained physicians and 2.4 nurses and midwives per 10,000 population (Table 1). Maternal health services in Ethiopia remain insufficient to meet the need, as is illustrated by a key statistic: In 2010–2011, only 10% of women were attended at delivery by a skilled health worker (Table 1).[71] (Cultural factors and the country's vast geography also play a role in the low use of maternal health services.) It is hardly surprising, therefore, that services for women who have had an abortion are also of low quality. A 2002 report assessing the quality of postabortion care (PAC) in public hospitals and health centers in three regions revealed that at that time, some 10 years ago, only 54% of the facilities had the capacity to perform uterine evacuation, and in those facilities, D&C was the procedure used 94% of the time,[78] even though WHO guidance clearly indicates that "the preferred surgical technique for abortion up to 12 completed weeks of pregnancy is vacuum aspiration."[79] Furthermore, the report determined, "[o]ver three-quarters of the health facilities that provide uterine evacuation services often take no measures to alleviate pain for patients being treated for abortion-related complications. The most frequently stated reason for not giving any pain control was an absence or shortage of analgesics."

In 2004, the government began amending Ethiopia's Penal Code to align it with the country's constitution, a process that revealed the stark public health need to expand the legal grounds for abortion. A number of hospital-based studies had documented the toll that unsafe abortion was taking on Ethiopian women's health.[78,80–85] And a study conducted in 1990 in five Addis Ababa hospitals among women admitted for abortion-related complications found that one-third of the procedures had been carried out by health assistants and nonmedical personnel working in hospitals, and more than one-fourth were self-induced.[86] A 1999 WHO assessment concluded:

> [S]tudies indicate that abortion is widespread and generally performed by untrained persons. Complications due to unsafe abortions constitute one of the main causes of maternal mortality in Addis Ababa and account for 54% of all direct obstetric deaths. In 1987, abortion was the most common reason for women's hospitalization, accounting for almost 16% of the recorded cases of hospitalization and almost 10% of hospital deaths.[87]

B. Legal Grounds for Abortion Under the Revised Law

In 2004, a working group of lawyers and doctors* succeeded in eliminating some of the most punitive provisions of the Penal Code of 1957 criminalizing abortion.[88] Under the revised law, which went into effect in 2005, abortions are permitted, with a gestational limit of 28 weeks, in several circumstances: when the pregnancy results from rape or incest; when the health or life of the woman or the fetus is in danger; in cases of fetal abnormalities; for women with physical or mental disabilities; and for minors (women younger than 18) who are physically or psychologically unprepared to raise a child. The law also notes that extreme poverty may be grounds for reducing the criminal penalty for abortion.† And in cases of rape or incest, no proof is required beyond the woman's statement that it has occurred.

C. Guidelines and Their Dissemination

Ethiopia produced a model set of guidelines for safe services. In the year after the revision to the Penal Code, the Ministry of Health issued guidelines to be observed in the safe practice of legal abortion.[89] The newly amended provisions of the Penal Code stipulate that these guidelines are, in fact, part of the law, which means that failure to observe them can be considered a punishable offense. A working group was created to advise the Ministry of Health in formulating the guidelines, which are largely based on the WHO technical document issued in 2003[79] but made specifically applicable and relevant to the legal and reproductive health situation in Ethiopia. According to the Center for Reproductive Rights, the guidelines "focus on two types of care related to pregnancy termination: woman-centered abortion care and postabortion care."[90] Woman-centered abortion care is defined as "a comprehensive approach to providing abortion services that takes into account the various factors that influence a woman's individual mental and physical health needs, her personal circumstances, and her ability to access services." In the guidelines, this care includes services "that support women in exercising their sexual and reproductive rights." The guidelines stipulate that abortions should be provided within three days of a woman's request. The second type of care, postabortion care, is described as a set of comprehensive services for women who seek care at health care facilities with complications after a spontaneous abortion or an attempted pregnancy termination.

The guidelines address such issues as standards for providers' skills and performance, essential equipment and supplies, the monitoring and evaluation of services, and counseling and informed decision making. They also set out procedures for both medication and surgical abortions. The guidelines explicitly allow midlevel providers, such as nurses and midwives, to provide comprehensive abortion services, including MVA and medication abortion. And they set forth regulations pertinent to each revised article of the Penal Code; for example, women seeking an abortion on the grounds of rape or incest are not required to submit evidence of the act or identify the offender; a woman does not have to show signs of ill health to request a termination of pregnancy; and a woman seeking an abortion on the grounds that she is a minor and unable to care for the child is not required to prove she is younger than 18.[91] Furthermore, the guidelines state that health care providers have an ethical obligation to direct women to a health facility that will provide suitable services.

Information is not readily available about how widely the 2005 revision of the law was publicized, or whether the guidelines were systematically distributed in government health facilities.

D. Creation, Availability and Uptake of Safe Abortion Services

Legal abortion services seem to have been established on a fairly broad scale in Ethiopia. A nationally representative study of abortion and postabortion services in Ethiopia's public and private health systems carried out in 2007–2008 showed that about half of all eligible health facilities were providing legal induced abortion services—76% of public hospitals, 63% of private or nongovernmental facilities and 41% of public health centers.[72] On the other hand, only one in 10 facilities of any type had a provider who could perform second-trimester procedures. Overall, 87,000 (or 84%) of the approximately 103,000 legal abortions performed in

*The group included representatives of the Ethiopian Women's Lawyers Association, the Ethiopian Society of Obstetricians and Gynecologists, grassroots community-based organizations and Ipas.

†"Article 550. – Extenuating Circumstances. Subject to the provision of Article 551 below, the Court shall mitigate the punishment under Article 180, where the pregnancy has been terminated on account of an extreme poverty" (source: reference 88).

that period were carried out in private or nongovernmental health facilities. In contrast, 43,000 (or 74%) of the approximately 58,000 women receiving treatment for complications from unsafe procedures (carried out elsewhere) were treated in government hospitals and clinics. Thus, Ethiopian women appear to depend heavily on private or NGO medical services to obtain safe abortion, but predominantly on government health services if they experience complications from unsafe abortions.

Another telling study, conducted in 2006 among 1,492 women of reproductive age in three large Ethiopian regions, asked women where they typically went for abortion or PAC.[92] Most said they would prefer government services to private health facilities in both cases, but that public facilities were often too far away (and transport was lacking) or too expensive.

As one stakeholder has articulated, "A number of factors may explain why access to safe abortion services is not yet a reality in many parts of the country. …These include the fact that many women and health care providers alike are unaware of the expanded criteria under which abortion is legal and that too few health care facilities outside of urban areas are equipped to offer the services."[93] The authors of the 2007–2008 study recommend that the Ethiopian government increase availability of safe abortion services and PAC in public hospitals and health centers, educate providers and women about the new law, and provide additional resources to improve access to safe procedures. They also note that introducting medication abortion could greatly expand access to services in a cost-efficient manner. The likelihood of such expanded access would be even greater if training in safe abortion techniques were expanded, especially among midlevel providers who are legally permitted to perform abortions.[72]

E. Impact of the Revised Law

In the absence of reliable estimates of the number of unsafe abortions carried out in Ethiopia annually before 2005, it is not possible to accurately assess the degree to which the new law has affected these practices. Nevertheless, in 2008, three years after the easing of restrictions, researchers estimated that 382,500 terminations were performed in Ethiopia, for an annual rate of 23 abortions per 1,000 women aged 15–44.[72] Just over one-quarter of these procedures—103,000, or 6 per 1,000 women this age—were legal and safe and performed in health facilities (Table 2, Page 8).

In terms of morbidity, there are some indications that women seeking care for pregnancy-related complications in Ethiopian hospitals are now less likely than in the past to be suffering from abortion-related problems.[94,95] A study in one major university hospital in Addis Ababa indicates that the ratio of abortion complications to live births declined after the law changed in 2005.[95] An assessment of the success of a model to improve the availability and quality of abortion and postabortion services in public health facilities in the Tigray region between 2006–2007 and 2008–2009 found that the proportion of obstetric complication cases treated in hospitals that stemmed from unsafe abortion fell—from 51% to 37%—but there was no comparable decline in health centers, where it remained at 29% during the same period.[96]

Unfortunately, problems in access to safe abortion services persist. Ethiopian health professionals knowledgeable about the practice of abortion estimate that almost six in 10 women who have an abortion experience serious complications, and that only about a quarter of them (or an average of 14% of all women having abortions) receive the treatment they need.[72] The 2005 Demographic and Health Survey provides some reasons as to why women with abortion-related complications might not receive the care they need.[74] These include lack of money for treatment (76%), concern that the health provider may not be a woman (72%), absence of a health facility nearby (68%) and inability to obtain permission to go to health facilities on their own (35%).

An analysis of Ethiopian hospitalization data found that in 2008, a total of 58,600 women were treated in hospitals for abortion-related complications.[97] Within this group, 100 women died from their complications, and many more suffered from related injuries or illnesses. Four out of 10 women showed signs of infection or invasive injuries when they arrived at hospitals or other health facilities for PAC. These statistics likely present only a partial picture, as many women with complications never reach health care facilities, because they live too far away, they avoid seeking help as a result of fear and stigma, or they die before getting to a facility.

Abortion law reform in Ethiopia, undertaken in the context of broad national efforts to improve maternal health, has only begun to contribute to national declines in maternal mortality and morbidity. With guidelines in place, the general shortage of trained health professionals and accessible public facilities are perhaps the greatest barriers to further implementation of the law. Until these obstacles are overcome, for-profit clinics in the private sector and NGOs from outside the country will likely continue to play a significant role in service provision.

Mexico City

A. The State Setting

Mexico is a federation of 31 states plus Mexico City,* the country's capital, which has a somewhat different, more independent status. Each Mexican state has its own government and formulates its own abortion law, and although the criteria under which abortion is permitted vary somewhat, with the notable exception of Mexico City—which reformed its abortion law in April 2007—the exceptions to illegality usually do not go beyond women's health or survival, rape and fetal malformation. As of September 2011, all 31 Mexican states and Mexico City permit abortion on the grounds of rape (incest is subsumed under this category); 29 of these entities also permit abortion if continuing a pregnancy threatens the woman's life, 14 in cases of a malformed fetus and 12 to protect the woman's health.[98] The outstanding exception to this general pattern, Mexico City, with a population well in excess of 11 million people (nearly 10% of the country's population; Table 1, page 7), is the most economically developed and probably most secular region of the country, and has the most extensive and well-resourced public health infrastructure.[99]

Before Mexico City reformed its abortion law, unsafe abortions were having harmful health consequences for women living there (as they were in the rest of the country).† A study conducted in 2006, a year before the new Mexico City law was enacted, estimated that in the city that year, 16,459 women were hospitalized for the treatment of complications from unsafe abortion. However, a much larger number of women—about 10 times as many—were estimated to be obtaining clandestine abortions (safe and unsafe) during that same period.[100]

The reform of Mexico City's abortion law was a joint effort of many stakeholders. A coalition‡ of lawyers, health care planners and women's rights advocates collaborated for many years to draw attention to the abuse of human rights and harmful effects on women's health represented by unsafe abortion. A major NGO responsible for directing the research, lobbying and public advocacy efforts, Group for Information on Reproductive Choice (*Grupo de Información en Reproducción Elegida*—GIRE),[101] directed its efforts to decision makers and politicians, as well as the mass media and opinion leaders. GIRE considered the city's specific political and social context to be the most important factor leading to its decriminalization of abortion. An analyst concurred that "a confluence of social, legal, and political conditions in Mexico City enabled passage of the bill."[14] And a 2009 report concluded:

> The factors that made this reform possible were the presence of a liberal political party governing at the state level, favorable public opinion and pressure from nongovernmental women's organizations that promote reproductive rights. In addition, there has been a gradual trend toward secularization and the growth of religious diversity in the city.[1]

The breadth of the 2007 law was perhaps not surprising, given the bold earlier phases of reform that preceded it. In 1989, four Mexico City hospitals were authorized to perform legal abortions for women pregnant as a result of rape.[102] In 2000, under the Robles Law (*Ley Robles*)—named after the District leader at the time who championed the legislation—Mexico City further expanded the grounds on which abortion was decriminalized to include fetal malformation incompatible with life, grave risk to the woman's health and forced insemination.[15,103] Opponents challenged this reform as unconstitutional, but the Supreme Court of Mexico City denied the suit, thereby creating a fundamental precedent for the development of the 2007 reform bill.

Additional reform of the law in 2004 allowed conscientious objection for individual physicians but stipulated that health institutions could not invoke this clause and had to ensure the presence of nonobjecting providers at all times.[104] It also ruled that the service had to be provided within five days of the request. This reform is also noteworthy in that it increased punishment for those who

*Mexico City is also known as the Federal District, the official name of this special political entity, or state.

†An analysis of hospital discharge data estimated that 106,500 Mexican women received treatment for abortion-related health complications in the country's hospitals in 1990 (source: Singh S and Wulf D, Estimated levels of induced abortion in six Latin American countries, *International Family Planning Perspectives,* 1994, 20(1):4–13).

‡The National Pro-Choice Alliance *(Alianza Nacional por el Derecho a Decidir).*

performed an abortion without the woman's consent, thus emphasizing women's autonomy in the decision-making process.

B. Legal Grounds for Abortion Under the Revised Law

Mexico City's legislative assembly passed the new law in April 2007, permitting abortion on request during the first 12 weeks of pregnancy. The new law revises four articles of the existing penal code and Health Law. The key article in the revised law is number 144, which states: "Abortion is the interruption of pregnancy after the 12th week of gestation. For the purpose of this Code, pregnancy is the part of human reproduction that begins with the implantation of the embryo into the endometrium."[105] Redefining abortion as the legal termination of a pregnancy of 13 weeks of gestation or more is considered by activists and reproductive health experts to be the most innovative aspect of the new law. During the first 12 weeks, the procedure is simply labeled the legal termination of pregnancy—*interrupción legal del embarazo,* or ILE.[106] The reform also reduced penalties for women who self-induce or consent to an abortion performed after 12 weeks of gestation.

Among other guidelines, only a medical doctor can perform ILE services, and facilities performing them must document the gestational age of the fetus. In response to this requirement, all health facilities that provide ILE services began conducting an ultrasound before the procedure. Two other provisions of the new abortion law are also important: One is a stipulation that the procedure be available to city residents without charge in public hospitals and for a small fee to women from other states or countries; the other mandates that sexual and reproductive health be made a priority of public health policies in Mexico City, specifically invoking the constitutional right of all persons to decide the number and spacing of their children freely, responsibly and in an informed manner.[107] Articles 144–148 lay out guidelines for these policies, calling for "permanent, intensive and integrated education and training campaigns promoting sexual health, reproductive rights, and responsible 'maternity and paternity,' family planning, and contraception services aimed at reducing the number of abortions through the prevention of unplanned and unwanted pregnancies, reducing reproductive risk, avoiding the propagation of sexually transmitted diseases, and helping in the full exercise of sexual rights taking into account a gender perspective, and respect for sexual diversity."[107] The Health Law charges the city health department with "providing medical and social counseling regarding sexual and reproductive health, permanently providing free services…, as well as the provision of all contraceptive methods of which the efficacy and security have been scientifically proven."[107]

A further important element of the new law is its approach to the issue of conscientious objection. As articulated by the Center for Reproductive Rights, "Health providers who oppose abortion on religious grounds or personal convictions may refuse to provide one, but they must refer the pregnant woman to a physician who is willing to perform the procedure. Providers may not refuse to perform abortions in emergency situations where the pregnancy threatens the health or life of the pregnant woman. Public health institutions are required to ensure that services are provided in a timely manner and that personnel who are not opposed to abortion are available to provide the procedure."[108]

One observer considers the changes in the content and language of the Health Law to define three important trends: the exclusion of public morality from the language and thrust of the law; the new emphasis on women's autonomy to make their own reproductive decisions; and the placing of sexual and reproductive health and rights at the center of both the criminal and the administrative law.[109] He emphasizes that the thrust of the new law "is not only decriminalization of abortion during the first trimester but also robust legislation enhancing family planning, respect for sexual and reproductive rights and, importantly, prevention of unwanted pregnancies."

More recently, in July 2009, the Mexico City government provided greater detail on the conditions that must apply to the provision of safe and legal ILEs in the public sector. The stipulations as published in the *Official Gazette* on July 7, 2011, constitute the regulations for the city's Health Law.[110] (In Mexico City and elsewhere in the country, such reforms must be formally published as regulations or directives to operationalize the contents of the new law.)

C. Guidelines and Their Dissemination

Mexico City has created its own set of medical protocols for the provision of safe and legal abortion services, but most of these are not publicly available. Two key documents in the set are the official norms published by the city government and a manual for legal abortion procedures, the *Procedure Manual of the Federal District Secretary of Health* (*Manual de Procedimientos de la Secretaría de Salud del Distrito Federal*). The official norms contain the basic criteria for legal abortion procedures and are public, while the manual is much longer and directed to health service providers, and explains in detail where and how services should be provided. The manual is a confi-

dential, internal document of the state Ministry of Health. Both documents are "very clearly written and thorough," according to a key informant.

In 2009, Mexico's national Ministry of Health itself issued a set of medical protocols for the proper and safe practice of legally permitted abortion in health facilities throughout the entire country.[111] These protocols apply equally to Mexico City and to states where abortion is broadly banned for all but limited reasons.

The state Ministry of Health runs a 24-hour hotline *(Interrupción Legal del Embarazo de la Secretaría de Salud del DF*—ILETEL) that provides information about the free legal abortion services available. In addition, in 2007, the National Pro-Choice Alliance launched the campaign *¿Embarazada?* (Pregnant?), which provides this same information. The campaign was disseminated on national and local radio, as well as in the Mexico City metro system, and through the distribution of flyers. After the launch, detailed information from the campaign was uploaded to both the alliance's Web site and the Web site of the group Catholics for the Right to Decide (*Católicas por el Derecho a Decidir*—CDD).[112] A public opinion survey conducted in 2010 shows that more than 85% of the Mexico City population knows about the ILE program,[113] and support for the program seems to have increased steadily among the general city population since the reform—from 38% in 2007 to 74% in 2009.[114] Another possible reason for the general familiarity with the changed law and the new program is the huge amount of well-publicized political debate and media attention directed at the issue.

D. Creation, Availability and Uptake of Safe Abortion Services

Almost overnight after passage of the new law, some safe and legal abortion services were up and running in Mexico City. This was made possible by the fact that the consortium of advocates supporting the new law before its passage included the Federal District's Ministry of Health and other high-level members of the health department, who had met regularly to plan for the new service.[115] In addition, immediately after the law was passed, a cadre of doctors began receiving clinical training in safe abortion services from a number of international NGOs.[116] However, those responsible for the program have been very open about the difficulties encountered in its early days, including the lack of personnel, space and resources; a large number of conscientious objectors; and the enormous influx of women seeking services, which resulted in a work overload for participating professionals.[117]

Official statistics for 2008, the first full year of the revised abortion law's implementation, indicate that 12,900 women obtained legal terminations in Mexico City's public hospitals in that year. Some 16,475 were reported in 2009, 16,945 in 2010 and 15,577 between January and September of 2011.[118] However, the annual number of Mexico City residents reported as obtaining legal pregnancy terminations in Ministry of Health facilities is nowhere near the total number of abortions estimated in a recent study for 2006, before law reform (140,000–160,000).[100,119(Note 12)] Still, the recent study also indicated that, according to key informants' opinions, the majority of these procedures were low risk and did not result in serious complications needing treatment; most of these clandestine abortions were likely done in the private sector. Assuming that these conditions of abortion service provision continued after the 2007 law reform, it is likely that substantial numbers of legal (first-trimester) abortions (formerly classified as clandestine low-risk procedures) are now being provided by private doctors, although there is no evidence on this, because data are not collected on these services. Mexico City's health secretary has acknowledged that large numbers of unreported legal pregnancy terminations were likely being carried out by private doctors.[120] In 2010, legislators were planning to introduce a bill to enforce public registration of abortions performed in private clinics,[121] but no action has yet been taken on that measure.

The 16,475 legal abortions reported in 2009 in Mexico City were carried out through the use of either MVA (71%) or misoprostol alone or combined with other drugs (29%).[122] Fourteen public health facilities provided ILEs in that year, but almost half of all these procedures were carried out in a single facility.

Sociodemographic data available for 20,000 of the women who obtained ILEs in Mexico City facilities between 2007 and 2010 show that 44% were in a union (married or cohabiting) and 53% had never married; 53% were younger than 25 (36% were 20–24), and 60% had had at least 10 years of schooling (including 21% who were educated beyond high school).[116] One in four identified themselves as students, and more than eight in 10 as Catholics; two-thirds had at least one child. By 2010, 64% of the procedures were medication abortions (using misoprostol only) and 32% were performed by MVA assisted with misoprostol. (The Ministry of Health of Mexico City has recently registered mifepristone for scientific study and will be offering women this option as well.) All women having ILEs received postabortion contraceptive counseling, and 88% selected a contraceptive method—predominantly an IUD (42%) or a hormonal method (19%).

Mexico City is home to a large number of federal and state employees, all of whom are entitled to health coverage for themselves and their families through

the Institute for Social Security and Services for State Workers (*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*—ISSSTE). In addition, salaried employees working in private companies and their families are covered by the Mexican Social Security Institute *(Instituto Mexicano del Seguro Social*—IMSS). Both health insurance systems oversee an extensive network of clinics and hospitals to serve their insured populations. However, neither system provides abortion services in their health facilities located in Mexico City. Women covered under these plans who wish to terminate a pregnancy must either avail themselves of the city's separate network of public clinics and hospitals, or pay for services in the private sector. Thus, a paradox inherent in the wide discrepancy in terms of abortion legality between Mexico City and the rest of the country can be seen in the fact that hospitals and clinics run by federal health programs rather than the state's own health program, but located within Mexico City, do not offer legal services[116]—even though they may continue to treat women for complications of unsafe abortions. In fact, federal health statistics indicate that in 2009, about 14,800 women were treated for abortion-related complications in the city.[123] Additionally, the city's own hospital data collection system shows that in 2010, complications from unsafe abortion was the fourth leading cause of hospitalization among women, a ranking this diagnosis has held since 2001.[124(Table 3.4)]

Some additional obstacles to access exist. The network of public health facilities in Mexico City providing legal and safe pregnancy terminations is limited in size. It comprised 17 facilities (one teaching hospital, six general hospitals, eight maternity hospitals and two health centers) immediately after the abortion law was reformed, but by 2010 consisted of 12 facilities (one teaching hospital, three general hospitals, six maternity hospitals and two health centers).* The bulk of the 16,945 ILEs carried out in 2010 took place in one health center (7,371) and one maternity hospital (2,152).[124(Table 5.25)] A recent assessment found that even though ILEs are available at no cost in the city's public health facilities, arranging transportation, getting an appointment and receiving services are sometimes difficult for unmarried women and those having little education, possibly due to a combination of lack of knowledge of where to go and stigma, especially for the unmarried women.[125]

NGOs have also opened clinics offering abortions, but the service is not free and the quality of care varies, according to a key informant. In addition, many women are still accessing services privately, despite the availability of free or low-cost services at public facilities. A survey of 135 doctors performing legal abortion in private clinics in Mexico City found that more than 70% still used D&C and fewer than a third offered MVA or medication abortion.[126] On average, each facility performed only three terminations per month; few reported more than 10 monthly. More than 90% of the physicians said they had been offering abortion services for less than 20 months. In addition to highlighting the continuing use of D&C, these findings pointed to high fees for abortions (a mean of US$157–505), poor pain management practices and the unnecessary use of ultrasound, general anesthesia and overnight hospital stays among this group of private practitioners. However, as a key informant pointed out, there are also high-quality private services in Mexico City that use state-of-the-art technology. And a small-scale qualitative study of women's experiences of abortion services in one public and two private clinic settings in 2008 found a high degree of satisfaction with services at both public and private sites, although some women had to go to more than one site before receiving services.[113] All the participants felt that they were treated with respect.

Conscientious objection and the stigmatization of legal abortion are ongoing obstacles. Well before the 2007 revision to Mexico City's law, there was evidence of some discomfort with abortion among members of the medical profession. A 2001 survey of medical students specializing in obstetrics and gynecology in Mexico City found that even if abortion were legal, the majority said they personally would not provide the service.[127] A 2002 national survey of doctors who were asked whether they would terminate a pregnancy for a woman who had been raped (a legal ground throughout most Mexican states at the time) found that, on average, seven in 10 said they would do so.[128] However, half considered women seeking an abortion for this reason to be irresponsible. Inadequate medical preparation may explain part of this reluctance. A review found that medical schools in Mexico do not offer medical students the option of clinical training in integrated models of abortion care, including the use of safe and effective methods.[129]

Even though pregnancy termination in Mexico City is now legal in the first trimester, many health professionals working there remain opposed to the provisions of the 2007 law and choose to opt out of performing the service. Immediately after passage of the law, fully 85% of the gynecologists working in the city's public hospitals declared themselves conscientious objectors and refused to provide abortion services.[130(Footnote 75, p. 156)]

*As of this writing, two health centers *(Beatriz Velasco de Alemán* and *Santa Catarina)*, both in marginalized areas of Mexico City, offer ILEs.

E. Impact of the Revised Law

It is too soon, and empirical evidence is too sparse, to measure the reproductive health consequences for women of the new Mexico City abortion law. Yet, even in the absence of empirical data allowing measurement of the anticipated positive health impact that could be attributed to the change in the law, there is evidence of another indirect, beneficial social impact. The massive amount of attention the issue of unwanted pregnancy and unsafe versus safe abortion has received in the academic literature and in the mass media has undoubtedly contributed to a widening and deepening of the debate—both throughout Latin America and internationally—over the human rights and moral and public health issues that underlie the growing worldwide movement for abortion law reform.

There has been substantial political backlash to the 2007 Mexico City Health Law. Instead of encouraging other states to undertake reforms of their own constitutions, the law's passage appears to have had quite the opposite effect. Since that time, 16 Mexican states have amended their constitutions to incorporate a clause declaring that life begins at conception. In these states, where abortion was already allowed only under very limited circumstances, it is not yet clear if the new amendments overrule those few exceptions and result in a blanket ban.[131,132] Furthermore, a challenge also remains in Mexico City, in the sense that if the 2012 elections result in a less liberal party governing the city, the 2007 law could be rescinded or heavily amended.

In summary, implementation of Mexico City's landmark ruling in a region of the world generally characterized by restrictive abortion laws has been impressive for the seriousness and strength of the political commitment at the highest levels of the state government, for the high quality of safe and legal abortion services provided and for the state Ministry of Health's readiness to open its legal abortion program to rigorous evaluation. Given the strong political support for high-quality, legal, free and accessible first-trimester abortion services at the highest levels within the Mexico City government and health department and the intense degree of scrutiny to which the program is being subjected (through both quantitative and qualitative operations research), it is highly likely that gradual increases in services (especially if the law is amended to allow nurse-midwives to carry out medication abortions) will eventually result in larger declines in the number of unsafe abortions among Mexico City residents.

Colombia

A. The Country Setting

Colombia is a middle-income Latin American country with evidence of a central reproductive health and demographic paradox. Fertility is at a replacement level, contraceptive use is very high (in 2010, nearly 80% of Colombian women who were married or cohabiting were using a contraceptive method, 73% a modern one*, and induced abortion was banned on any and all grounds until 2006—yet two-thirds of all pregnancies are unintended and 44% of this large subset end in clandestine abortion.[133] According to some key indicators of social development, conditions for the average Colombian woman are favorable: Three-quarters have attained schooling beyond the primary level, and 95% of deliveries are attended by a skilled health professional (Table 1, page 7).

Colombia's MMR was estimated to be between 75 and 85 maternal deaths per 100,000 live births for the year 2008.[134,135] This means that as many as 780 maternal deaths occurred nationally that year. Approximately 9% of maternal deaths in 2007 were attributable to unsafe abortion,[136] down from 16% in 2004.[137] These data suggest that about 70 Colombian women still die each year from abortion-related causes and that there is continued use of increasingly safe but clandestine methods to end unwanted pregnancies.

B. Legal Grounds for Abortion Under the Revised Law

Until fairly recently, Colombia was one of only three countries in the world (along with Chile and El Salvador) to ban abortion on any and all grounds. In 2006, the ban, articulated in Article 122 of Colombia's Penal Code, was successfully challenged and declared unconstitutional by the country's Constitutional Court. The court's ruling in decision C-355/06 listed as exempt from criminal prosecution abortions performed on any of several grounds: when continuation of a pregnancy would jeopardize the mother's health or survival, as certified by a doctor; when, as a result of serious impairment, the fetus is declared nonviable by a doctor; and when the pregnancy is the result of rape, incest or involuntary artificial insemination.[138]

The gist of the successful argument made to the Constitutional Court was that denying women access to abortion in these cases violated not only women's right to equality, life, health, dignity and reproductive autonomy, but also the country's obligations under international treaties to protect women's right to life and health. On December 13, 2006, the president of the country signed into law Decree 4444 (*Decreto 4444*), which spelled out how the Court's decision was to be implemented.[139] The document is impressive in its detail. Article 1 provides a comprehensive list of all types of health facilities—public and private—that must respect the law. Article 2 states that legal abortion services must be provided at all levels of health care serving pregnant women. Article 3 notes that the Ministry of Social Protection (*Ministerio de la Protección Social*) will draw up technical regulations regarding the provision of abortion. Article 4 specifies that the public health system will cover the cost of legal abortion services. Article 5 stipulates that in order to guarantee the provision of this essential public health service, to avoid barriers to access and so as not to undermine the basic rights protected in accordance with the court's decision, conscientious objection is an individual not an institutional decision, which applies exclusively to health providers directly involved with the procedure but not to administrative staff. Article 6 specifies that health professionals cannot be discriminated against on the basis of their decision to apply or not apply for conscientious objection, or their performance of abortions on grounds permitted under the new law.

C. Guidelines and Their Dissemination

Soon after Decree 4444 went into effect, the government published technical regulations (called *norma*) for the practice of abortion, heavily based on the WHO guidelines, in the form of a 35-page manual. The manual spells out conditions and regulations for implementing abortion services compliant with the new law.[140] It defines what constitutes safe terminations (both surgical and medication) and unsafe ones, characterizing the latter as a major

*Male or female sterilization, the pill, IUD, injection, implant, condom, gel/spermicide or emergency contraception.

threat to women's health and survival and a huge public health problem. The manual also points out that the gains achieved by the ruling do not in and of themselves guarantee women access to integrated, timely and safe services. The document reproduces a chart developed by the WHO showing which methods are advisable at which gestational ages, and laying out step by step mandatory clinical care (including pain management) and intake and discharge procedures (including contraceptive counseling and referral).

The government formally attempted to inform the general public of the law's passage and its content, although some observers believe this promotional initiative had very limited success. In November 2006, the finance director of the Ministry of Social Protection declared in Resolution 4192 that it was "necessary to adopt measures to strengthen health promotion and citizens' sexual and reproductive rights and to develop programs that would guarantee the respect, protection and observance of women's right to reproductive health care…," which would include eliminating obstacles that impede access to voluntary and legal abortion services, and to safe, timely and effective sexual and reproductive health education and information—both of which are rights asserted by the Constitutional Court ruling.[141] The resolution announced the availability of four billion Colombian pesos (approximately US$1.8 million) to fund a mass media campaign alerting the Colombian public of their reproductive health rights. A single television campaign designed by a private advertising company ran for only a few weeks in December, when most Colombians are on holiday. This was the only promotional initiative carried out, and it was seen by very few people.

Nevertheless, knowledge of the new law appears to be widespread, as suggested by results of a 2010 survey in which Colombian women were asked whether they knew about the conditions under which abortion was legal.[142] Fully 76% knew that the procedure was legally permitted to save a woman's life or protect her health, 79% if the fetus was malformed and 78% in cases of rape.

There is need for greater outreach and public education especially among younger and rural women. Although there appears to be broad awareness of the law change among women of reproductive age, it is not known if they are aware of where the procedure can be obtained, or if providers and other professionals are sufficiently informed to carry out the law. A recent report concluded as follows: "The specifics of the ruling need to be widely disseminated to the professionals who are responsible for implementing and enforcing it, such as medical and paramedical workers, members of the judiciary, and staff at agencies that assist victims of rape and domestic violence."[133] The need for greater efforts to disseminate information about the law is seen in the May 2009 ruling of the Constitutional Court that ordered a national education campaign to inform the public, including students, about the partial decriminalization of abortion.[143]

D. Creation, Availability and Uptake of Safe Abortion Services

As noted above, the revised law stipulates that legal abortions for eligible women must be provided in nearly all public and private health facilities having the necessary resources. Despite this requirement, only an estimated 11% of health facilities with the capacity to provide legal services were doing so in 2008.[133] There was little difference between public- and private-sector facilities in the proportion offering legal abortions (10% and 12%, respectively). But it was 2–3 times higher in the Bogota region, home of the capital city, than in the country's other four regions (23% vs. 8–12%).

A survey of government and private hospitals and clinics in Colombia found that just 322 legal procedures were performed nationwide in 2008.[133] Two-fifths were done using the surgical method of D&C, one-fifth using MVA and the remainder using misoprostol alone or with D&C. This small number of legal procedures represents less than one-tenth of 1% of the more than 400,000 clandestine abortions carried out in that same year.[144] Of 657 legal abortions officially reported to the Ministry of Social Protection for the period 2008–2010, 57% were performed on the grounds of grave fetal abnormality, 27% because of rape or incest and 16% to preserve the woman's life or health.[133(pp. 24–25)]

Further evidence of the widespread prevalence of unsafe abortion in Colombia comes from the 2010 national Demographic and Health Survey, which found that among women who had ever been pregnant, almost 8% said that they had terminated a pregnancy in the previous six years, and another 16% reported a miscarriage;[142] the estimated prevalence of miscarriage is so high that it suggests that many of these losses were induced abortions wrongly reported. (Demographic and Health Survey findings in every country are undermined by high levels of underreporting by women of their actual behavior when it comes to abortion.) Most women who did report having had an induced abortion or a miscarriage said they received hospital or clinic treatment (82% and 92%, respectively), and in the vast majority of cases, the cost of medical care was partly or fully paid for through the country's public health system.

E. Impact of the Revised Law

Colombia's annual abortion rate is estimated to have risen slightly between 1989 and 2008, from 36 to 39 per 1,000 women of childbearing age—both high levels. The leading method used to induce clandestine procedures in 2008 was misoprostol (or Cytotec, as it is commonly known in the country).[133] In light of the small number of reported, legal abortions performed in 2008 and the short time elapsed between implementation of the 2006 law and the 2008 study of abortion in Colombia, no impact of the law on the country's overall abortion rate or on women's reproductive health can be expected. In any case, the effect of a narrowly based law such as Colombia's is likely to be limited.

Implementation of the law has been slowed by strong political backlash. In 2009, Alejandro Ordóñez Maldonado, Colombia's newly appointed *Procurador General* (the closest English translation is Attorney General, but there is no exact equivalent)—the government official whose main function, ironically, is to ensure that human rights are respected and that the country's laws and judicial decisions are observed—began to pursue a political (and, some would say, religiously motivated* agenda that included overturning decision C-355/06. During his first year in office, he tried unsuccessfully to rescind[145] a Constitutional Court ruling that requires inclusion of information about women's right to legal abortions, as spelled out under the terms of the decision, in all publicly supported campaigns designed to educate the public about their sexual and reproductive rights.[143] An antiabortion coalition—former colleagues of the Procurador General's appointee to defend women's rights (see below)—petitioned the Council of State (a division of the judicial branch), which issued an injunction temporarily suspending presidential Decree 4444 in October 2009.†[146] The injunction questioned the legal authority of the national government, through a ministry, to regulate a Constitutional Court ruling.

However, according to the Constitutional Court itself, its decision—not Decree 4444—is the source of the country's obligation to provide legal abortion services; therefore, suspension of the decree does not in theory affect the country's continuing obligation to make these services available to women who need them.‡ Unfortunately, as a key informant noted, many health providers in small clinics across the country do not have a good understanding of that distinction, and much confusion exists on this point.

Other decisions by various branches of the judiciary have had the effect of denying eligible women their right to a legal abortion. Many of these decisions subsequently required countermanding by the Constitutional Court. For example, in 2006, a pregnant woman whose fetus was ancephalic (meaning that it lacked a large part of the brain and skull) requested and was denied a termination by a private health clinic.[147,148] The woman appealed the decision to an administrative judge, who declined to authorize a legal abortion on the grounds that her strong Christian faith required her to claim conscientious objection in the case. The woman was forced to take the pregnancy to term, and the infant died five minutes after birth. And in 2010, a woman had to make an expedited appeal to the Constitutional Court to contest a public hospital's decision not to perform an abortion when her life was in danger from a pregnancy with complications. She had already lost three pregnancies from preeclampsia. The woman had appealed the hospital's refusal to higher judicial review, resulting in a ruling that although her pregnancy was high risk, her life was not in danger. When handing down the decision, the judge reproached the woman on moral grounds. The woman then obtained a clandestine

*There is well-documented evidence of the Procurador General's ultraconservative Catholic beliefs (source: Alejandro Ordóñez/El Procurador, *Gente y la Actualidad,* Oct. 12, 2011, <http://revistagentecolombia.com/2011/10/12/alejandro-ordonez-el-procurador/>, accessed Nov. 17, 2011).

†Ilva Myriam Hoyos was appointed as the attorney in charge of women's rights in March 2009. Previously, she was the founder and president of Red Futuro Colombia *(La Red Futuro Colombia),* an antichoice organization. As its president, she led the opposition to several issues related to sexual and reproductive rights, including the constitutional challenge against the absolute criminalization of abortion, during which she made public and vehement statements in several conferences, interviews and forums, and filed 47 amici against any liberalization of abortion (see list of amici filed in court rulings C-1299/05 and C-355/06 and interviews at <http://www.aciprensa.com/noticia.php?n=12606> and <http://beatrizcampillo.blogspot.com/2009/07/entrevista-la-dra-ilva-hoyos-lider-pro.html>). Luís Rueda Gómez, who filed for the unconstitutionality of Decree 4444, was a member of the board of directors of Red Futuro Colombia (see reference 146, a Constitutional Court bulletin <http://www.corteconstitucional.gov.co/comunicados/noticias/NOTICIAS%2015%20DE%20ABRIL%20DE%202011.php> and a related notice <http://www.cec.org.co/?apc=I1-;;;-&x=35135>).

‡According to the court's ruling, C-355/06, it is not necessary to establish explicit regulations for one to access a voluntary abortion in any of the three enumerated circumstances: "However, the decision to decriminalize abortion in the three enumerated circumstances doesn't prevent the legislature or regulators in the field of health insurance, when complying with their duties or acting within their respective legal competencies, from adopting regulations regarding women's constitutional rights. For example, they may adopt regulations aimed at promoting the effective enjoyment of women's rights in conditions of equality and safety within the general health insurance system" (source: Constitutional Court, Decision C-355/06, no date, <http://www.corteconstitucional.gov.co/relatoria/2006/C-355-06.htm>, accessed Nov. 17, 2011). It was reinstated in 2010, after the decree had been suspended on Auto 327/10 (source: Auto 327/10, no date, <http://www.corteconstitucional.gov.co/relatoria/autos/2010/a327-10.htm>, accessed Nov. 17, 2011).

abortion. In strong dissenting language, the Constitutional Court magistrate ordered the Superintendent of Health (*Superintendencia de Salud*) to require hospitals and the government health service to adopt rapid diagnosis protocols in cases such as these.[149] The court concluded:

> It is inconceivable to this court that a pregnant woman in a poor state of health, deserving of special constitutional protection but abandoned by the health system, should be forced to seek a legal remedy for her condition only to be subjected to renewed abuse in a moralistic judicial opinion that seeks to deprive her of her basic right to reproductive autonomy.*[150]

The Procurador General rejected the Constitutional Court's rulings in the above case and another like it.[151–154] Additionally, he has used a variety of other strategies to limit legal abortion and wider reproductive health rights, including banning the inclusion of misoprostol on the list of medications approved for use in government health programs,[155,156] publicly stating that the "morning-after pill" is an abortifacient,[157] and issuing a memorandum allowing workers in all health and educational institutions to claim the right to conscientious objection.[158,159]

In addition, the Procurador General appointed a well-known antiabortion activist, Ilva Myriam Hoyos†, as *Procuradora Delegada*, Assistant Attorney for Infancy, Adolescence and Family (*Procuradora Delegada para la Infancia, la Adolescencia y la Familia*) and gave her responsibility for enforcing a monitoring system designed, ostensibly, to ensure that women, adolescents and children are not deprived of their human rights.[154] Using this mandate as her cover, she has zealously promoted conscientious objection and the closing of abortion clinics.[160] She also wrote a letter to the Superintendent of Health, who is responsible for ensuring the fairness, equity and proper practice of the government's health services, requesting that he cease investigations into complaints lodged against hospitals for failing to deliver safe abortion services for eligible women.[161]

Another example of the successful obstructionist strategies used by abortion opponents supported by the Procuradora Delegada was the prevention of construction of a public clinic in Medellin that would focus on providing health services to women, including legal abortions.[162] The local mayor initially welcomed and endorsed the clinic, which was planned by a group of women's rights activists. Before the clinic even opened, members of two antiabortion groups flooded the mayor's office with e-mails claiming that the clinic would provide a service of death; as a result, the clinic was ordered not to perform legal abortions.[160]

A suit against the Procurador General for appointing Ilva Myriam Hoyos as Procuradora Delegada has been filed in Colombia's Supreme Court. It claims that he should be subjected to disciplinary action "for having incurred the following infractions that merit disciplinary actions: i) failure to fulfill the functions as assigned by the Political Consitution, and abuse of power in assuming the role of supreme director of a public Ministry, ii) naming and keeping in the post of Procuradora Delegada…someone with multiple conflicts of interest for that position."‡[154] The brief claims that "The behavior of the Procurador General, in both his actions and omissions, has concrete negative consequences that will be fully detailed later in this complaint. However, his behavior has also produced effects that are much more difficult to show, ones that would clearly persuade government officials who look to the Procurador General of the Nation for guidelines on how to do their jobs. These effects, despite being by their nature highly difficult to prove, are easily noticable."§

Sustained political attacks against the abortion law continue. In an even more recent case, the Procurador General attempted to launch an investigation of two court magistrates who failed to denounce a woman who sought a clandestine abortion after being refused a legal procedure by the health and judiciary system (the woman with

*Translated from Spanish: "Para la Sala es inconcebible que una mujer embarazada que padece un lamentable estado de salud, sujeto de especial protección constitucional, acuda al aparato judicial después de haber sido ignorada por la institución de salud y resulte nuevamente violentada al ser víctima de juicios de reproche de tipo moral, que buscan coartarle su derecho fundamental a la autodeterminación reproductiva."

†Many newspaper articles have reported on the background of this politician. These do, indeed, show her to be extremely conservative and to have made her antiabortion positions the center of her political philosophy and activities. (See articles at <http://www.lasillavacia.com> and <http://www.labmedios.pagina.gr/265345_Entrevista-Procuradora.html>).

‡Translated from Spanish: "…por incurrir en las faltas disciplinarias consistentes en i) el incumplimiento de las funciones asignadas por la Constitución Política y abuso de poder en el cumplimiento de su papel como supremo director del Ministerio Público, ii) nombrar y mantener como Procuradora Delegada para la Infancia, la Adolescencia y la Familia a una persona incursa en conflicto de intereses."

§Translated from Spanish: "El comportamiento del Procurador tanto en sus acciones como en sus omisiones, tiene consecuencias negativas concretas que se describirán en el desarrollo de esta queja. Sin embargo, también tiene efectos a un nivel mucho más difícil de probar, pero igualmente persuasivo para los funcionarios que buscan en el Procurador General de la Nación guías sobre cómo cumplir con sus funciones. Estos efectos, si bien por su naturaleza imponen grandes límites probatorios, son en efecto fácilmente perceptibles."

pregnancy complications described above).[163,164]

In October 2011, a member of Colombia's Conservative Party proposed a revision of the country's constitution to declare that human life begins at conception, a change that would make abortion on any grounds a criminal offense punishable by imprisonment of a woman ending a pregnancy, even if the procedure was justifiable on the grounds set forth in in the 2006 law. The legislation was rejected by a senate committee after a close vote.[165]

A new case has been filed in the Consitutional Court against the Procurador General for violating women's right to information, maintaining that as a public servant, he must separate his opinions from the information he provides in the context of his public duties.[166] Even if the court decides in favor of the claim, at most, the Procurador General will be required to admit he gave unreliable information and then correct it; he will neither be removed from his position nor sanctioned in any way.

The unending series of erroneous public announcements concerning reproductive health services and rights coming out of the Procurador General's office (including his pronouncement that there are no human rights, only divine rights)[167] and the persistence of political actions hostile to any implementation of the 2006 abortion law have left Colombian health providers in a state of confusion and uncertainty. Currently, two large not-for-profit agencies still provide legal services in their private clinics, as do a few urban hospitals. However, it is clear that most of the estimated 400,400 abortions occurring in Colombia each year continue to be clandestine, and many remain unsafe.[168]

In summary, a fierce ideological battle is being waged in Colombia between women's rights groups and human rights groups (aided by some supportive elements of the judiciary) on the one hand, and the country's Procurador General on the other. It will likely take many years for the suspension of Decree 4444 to be confirmed or denied. The effect will be to leave the legal status of reproductive health providers and the fate of the 2006 abortion law reform in a state of deep uncertainty for many years to come.

Nepal

A. The Country Setting

Nepal is a small country with a population of about 30 million (Table 1, page 7). It is predominantly rural (81% of people live in rural areas) and one of the poorest countries in the world, having a per capita income in 2010 of US$524. About 70% of women have not received education beyond primary school, and only 35% are literate.

Before its most recent amendment, the abortion law in Nepal was extremely restrictive. It was first introduced in 1854, amended several times and then extensively revised in 1963. Yet even then, the *Muluki Ain* (Criminal Code) did not permit the termination of pregnancies that resulted from rape or incest, or threatened a woman's life. In effect, it equated abortion with infanticide, and infanticide with other kinds of murder or homicide, and did not recognize any mitigating factors or exceptional circumstances under which abortion was not a crime of murder. Physicians and other medical practitioners were prohibited from recommending or performing abortion without exception.

The harsh provisions of the old law contributed to a recurring situation in which induced abortions, and sometimes even spontaneous ones, were deliberately misclassified as a crime of infanticide, willful killing or murder, in order to convict and incarcerate women so that they would lose their rights to any family property. Many women prosecuted under the old law were still behind bars in November 2004, when the king of Nepal granted the first amnesty.[169–171] Studies of women in prison had strengthened arguments for reforming the law, thus attracting the attention of legal professionals, women's groups, human rights activists and social justice groups.

In the mid-1990s, the Ministry of Health issued a paper outlining a safe motherhood policy and work plan.[172] An important recommendation in the policy was a revision of the existing abortion law to help reduce that part of the country's high level of maternal mortality and morbidity that was attributable to unsafe abortion. Support to end the old abortion law came from a number of civil organizations and professional groups.*[18] The 1994 International Conference on Population and Development and the 1995 Beijing Conference on Women provided international impetus and additional legitimacy to the women's rights movement that was gaining momentum in Nepal. Availability of and access to safe abortion services increasingly began to be understood in the context of women's rights, in addition to their public health impact.[18]

In a study of five urban hospitals during the prelegalization period, deaths from abortion-related complications were deemed to account for more than half of all maternal deaths.[173] Advocates extrapolated these hospital-based estimates to the whole country, citing the estimate that more than 50% of maternal deaths were attributable to abortion as evidence of the profound need to legalize abortion.[174]

B. Legal Grounds for Abortion Under the Revised Law

The 2002 revision of the Nepal Legal Code granted all women the right to terminate a pregnancy up to 12 weeks' gestation on demand, up to 18 weeks if the pregnancy is due to rape or incest, and at any gestational age if the woman is advised that the pregnancy poses a danger to her life or physical or mental health, or in cases of fetal abnormality or impairment.[175] The code prohibits abortion on the basis of sex selection, and amniocentesis for the purpose of sex determination.[175] Changes in the government delayed approval of the revision until December 2003, creating a frustrating period during which abortion was technically no longer illegal, but public services could not be provided.[176]

There was little apparent organized opposition to these efforts to revise the law, either from the public or the private sector. One reason suggested is that a large segment of the population of Nepal is Hindu. Abortion had already been legal for many years in neighboring India, and that country's culture substantially influences Nepalese life because of the shared religion.[18]

*These included the Family Planning Association of Nepal; the Population and Social Committee of the National Parliament; the Nepal Medical Association; the Nepal Society of Obstetricians and Gynaecologists; the Nepal Women's Organization; and the Law Reform Commission represented by justices, judicial administrators, legal and administrative authorities, and lawyers.

C. Guidelines and Their Dissemination

Reports of the consultative process that preceded and followed passage of the revised law state that guidelines governing the practice of safe and legal abortions were issued in 2003. However, the guidelines could not be found in the course of research for this report.

In 2002, the Ministry of Health, assisted by consultants from the German and UK overseas development ministries, issued a document that provides details about various aspects of services under the revised law. It stipulates that services comprising comprehensive abortion care will be accessible and affordable and provided through service providers listed in the Safe Pregnancy Termination Order; that these services will be expanded through government health facilities, autonmous institutions, NGOs and the private sector; and that the services will make an effort to offer women a choice of available abortion methods.[177] The document also sets forth a plan for publicly disseminating word of the revised law: "All available media will be used to raise public awareness on the new abortion policy, unwanted pregnancy and safe abortion, emergency contraceptive and unsafe abortion. Information on Comprehensive Abortion Care services and referral procedures will be disseminated in local languages." The Center for Research on Environment Health and Population Activites (CREHPA) in Nepal does in fact engage in many activities to expand awareness of the country's abortion law and to investigate how well it is being implemented.[178]

D. Creation, Availability and Uptake of Safe Abortion Services

Several policy and program strategies for implementing Nepal's new law have been developed.[179,180] The initiative was led by the government, in collaboration with NGOs, donors and other stakeholders.[176] A task force charged with looking at other countries' experiences in implementing abortion laws identified three cross-cutting principles that they believed should inform the implementation of Nepal's new law:

- Advocacy does not end with the passage of a liberal law. In other countries, continued advocacy has been necessary to insure that anti-abortion forces do not overturn or curtail hard-won legal reforms, that health care providers are on board and willing to provide safe services, and that women are aware of their rights and able to access services.

- A progressive law that cannot be fully implemented is not enough of an improvement, although it may prevent women being harassed and imprisoned. In addition, policies and procedural guidelines must be sufficiently flexible to allow rapid implementation of services with limited resources, without compromising safety or standards.

- Strengthened family planning services must become an integral part of comprehensive abortion care, in order to reduce unwanted pregnancy and achieve a significant reduction in maternal mortality.[176]

On the basis of these three principles, the task force made 35 detailed recommendations, covering issues such as changing social attitudes toward abortion; meeting women's needs; setting service policies and standards; removing health system barriers; making funding decisions; creating a clear health policy framework; and establishing cross-sector linkages, partnerships and systems for monitoring and evaluation.[176]

The task force was the basis for the eventual formation of the Technical Committee for the Implementation of Comprehensive Abortion Care—a quasi-governmental group within the Ministry of Health, under the overall guidance of Ipas, charged with designing and implementing health service protocols to be observed in the practice of safe abortion in Nepal. Two multipartner working groups within the committee—one for information dissemination and the other for clinical services and training—provide technical advice. An advisory board* chaired by the Director General of Nepal's Department of Health Services is responsible for major strategic decisions and recommendations.[181] The group's work includes drafting manuals; establishing and managing a training program and public-sector services; setting standards and monitoring procedures for both public and private services; and initiating information and behavior change activities, including the development of printed materials and radio/television spots.

The process followed to establish safe abortion services throughout Nepal has been well documented.[179] A large Kathmandu maternity teaching hospital (Paropakar Maternity and Women's Hospital) became the first model demonstration site for publicly supported abortion services and doctor training[182]; smaller regional and zonal hospitals were later added and supplied with basic starter kits. The rollout of services was designed to move from urban to rural areas. Services were introduced in a

*Other international partners included the Program for Appropriate Technology in Health (PATH) and the German Technical Assistance (GTZ) Health Sector Support Programme. Key national partners included the Forum for Women, Law and Development (FWLD), the Center for Research on Environment Health and Population Activities (CREHPA), the Family Planning Association of Nepal (FPAN), the Safe Motherhood Network Federation (SMNF) and Marie Stopes International (MSI).

"structured and systematic" way, with government taking the lead in piloting, evaluation and systematic scale-up, as a key informant explained:

> The training of doctors in first-trimester procedures began in 2004. To increase coverage, a subsequent decision was made to shift this practice to nurses, a pilot project was implemented and subsequently scaled up in 2008. Second-trimester procedures were piloted by the Nepal Society of Obstetricians and Gynaecologists in five major tertiary hospitals. These hospitals have now gained full approval to establish these services permanently. Medication abortion services were initially provided only by doctors, but nurses and other mid-level providers were then trained and found to be equally effective.

However, training takes place only in Kathmandu, and many remote mountainous areas of the country still lack abortion facilities. Travel to communities that do have such facilities is often prohibitive for poor women without any means of transportation.

By June 2011, the Nepalese government listed 245 certified abortion service sites in both the public and private health sectors, according to a key informant. Among public-sector facilities, abortion services are available in all district hospitals, in about half of primary health care facilities and in 81 health posts. In addition, 800 physicians and 300 staff nurses have been trained to provide first-trimester terminations.

Second-trimester abortion services began in 2008, and 24 obstetrician-gynecologists working in five private and seven government hospitals have been trained in these services. Another 81 midlevel workers in community health facilities have been trained in medication abortion (use of misoprostol with or without mifepristone). At present, 70 out of 75 districts have at least one approved site offering abortion services.

The private sector was involved from the start in plans to make services widely available throughout the country. Staff doctors in NGOs (both for profit and not for profit) could partake in training at the Paropakar Maternity and Women's Hospital in the very earliest days of the program for a small fee. Both providers and facilities must be approved and placed on the government's accredited list to offer abortion services. Providers are added to the list when they receive their certificate of competency at the end of the training.

Government policy right from the beginning was to charge a small fee for abortion services. However, this has created some problems:

> The fees charged are set by the individual hospitals and clinics, and among the government sites range from Rs.800 to Rs.1,500.* These do not include the cost of drugs, such as painkillers and antibiotics (if needed) and equipment such as gloves and syringes, which averages around Rs.300 extra. Since these additional costs are "hidden", women do not know in advance exactly what the total cost of the service will be, which may cause problems for those struggling to afford the fee.[179]

A more recent report is even stronger in its criticism of the fee structure:

> Universal access to safe and affordable abortion services is a fundamental right for all Nepalese women guaranteed by the abortion law. Unfortunately, existing government policy of charging a high fee even at government CAC [comprehensive abortion care] facilities for both surgical and medical abortion services has deprived many poor women from availing this right. Abortion fees at government CAC facilities range from Rs 800 to Rs 1000 (US$11 to $14) and [are] even higher at NGO managed facilities (ranges from Rs 1150 to Rs 1500).[184]

One key informant indicates that "in terms of quality of care, NGO sites generally provide straightforward abortion and family planning services; however, they have less capacity to manage complications from abortion and prefer to refer such cases to government facilities, which, in addition to legal abortion services, also provide comprehensive emergency obstetric care, and have facilities for major surgery and blood transfusion." The same respondent suggests that NGO services have the advantages of greater confidentiality and overall better quality of services, including the greater likelihood of providing postabortion family planning services.

Government reports do not contain information about the methods being used in public health facilities, but MVA is probably the primary and major technique. However, since 2004, efforts have been made to train providers in the use of medication abortion. A pilot program was started in six districts, and by the end of 2009, 245 listed comprehensive abortion care sites, covering all 75 districts in Nepal, were included; 260 physicians had been trained to use this method; and more than 5,900 women had received medication abortions through these sites.[185] According to a key informant, this method is currently available in most public- and private-sector facilities that offer abortion care, and it can be provided by both doctors and midlevel providers.

Official statistics show a disproportionate reliance on NGOs for service provision. In 2007, 38% of all accredited abortion facilities were government facilities and 45% were NGO facilities, predominantly those of Marie Stopes

*The currency is the Nepalese rupee (R).

International (the remainder were private clinics).[186] Some 87% of all reported abortions were performed by NGOs, 9% by the government sector and 4% in private clinics. According to the DHS, reliance on nongovernmental sources is even greater: only 19% of women who reported their abortions in the survey went to a government health facility, while 34% turned to an NGO facility and most of the remaining women went to a private facility.[183]

There are no reliable estimates of abortion incidence in Nepal before the law was changed in 2002. Some 720 legal abortions were reported by the Family Health Division of the Department of Health Services in 2003–2004, 10,560 in 2004–2005 and 47,450 in 2005–2006.[187(Table 3.2)] Between July 2007 and June 2008, a reported 97,400 legal abortions were performed in public and private facilities, for an abortion rate of 15 per 1,000 women 15–44 (Table 2, page 8).[26] However, these rates are based only on legal procedures taking place in accredited facilities. There is no estimate of the annual incidence of other, often unsafe abortions in Nepal, but the number is likely substantial. It has been speculated that the true number of abortions obtained is nearly twice the reported level.[26]

E. Impact of the Revised Law

The estimated MMR in Nepal declined dramatically between 1996 and 2006, from 539 to 281 maternal deaths per 100,000 live births, according to findings from two successive Demographic and Health Surveys. (The latter estimate differs, however, from that published by the WHO for 2008, which was 380 per 100,000 live births.[135]) In September 2010, Nepal received a United Nations Award for the significant reduction in MMR and subsequent progress toward achieving United Nations Millennium Development Goal 5, which aims to improve maternal health by reducing the MMR by three-quarters and achieving universal access to reproductive health care by 2015.[188]

It is unclear how much of Nepal's maternal mortality decline can be attributed to the legalization of abortion. A cautious assessment of the magnitude of the reduction confirms that it is large, but finds that a reliable assessment of the factors contributing to this trend is still elusive.[189] And a Demographic and Health Survey analysis concludes that "[t]he 2006 [MMR] estimate…is likely to have captured little if any of the impact of the introduction of safe abortion services."[187] Whatever the reasons for Nepal's decline in maternal deaths, the MMR is still high, according to the United Nations Children's Fund (UNICEF), and "many…deaths are direct consequences of under utilization of maternal health services and low quality of care, especially in remote areas."[190]

Despite these encouraging signs, problems still remain. A 2006 assessment of the quality of legal abortion services in a nationally representative sample of authorized abortion facilities yielded mixed findings:

> Only…64% [of clients] actually received services on the same day as their initial visit; the remaining 36% were either asked to return another day or were refused services because they were beyond the gestational limit….[Some] women with 9–12 weeks gestation were also turned away at several facilities because providers were reluctant to use MVA beyond eight weeks. Over half the clients (54%) visiting the [Kathmandu] Maternity Hospital on any given day were asked to return for services on another day. On the other hand, at the Family Planning Association of Nepal (FPAN) clinics and Marie Stopes International (MSI) centers, over 95% of clients received services on the same day.[191]

The results of a recent poll in Nepal illustrate some of the reasons why urban men and women believe women still resort to unsafe abortion, despite the new law: society's negative attitudes toward abortion (cited by 81% of respondents), the high cost of services (73%) and long distance to the services (69%).[192] Some have suggested a link between the inadequacy of safe abortion services and the second-rate status of women, hypothesizing that the "extent to which abortion...services are safe, legal, and women-friendly is a strong proxy of gender equity."[193] Additional reasons that have been identified for the slow uptake of safe abortion services include lack of awareness about the 2002 law and the availability of safe abortion services; women's lack of choice of abortion techniques; limited male support; and the slowness of social change, including prejudice and stigma against the procedure.[174]

Evidence of changes in the incidence of abortion complications is mixed. A 2009 facility-based study in eight districts (comprising 12% of the country's population) points to a complex set of relevant findings:

> The percentage of facility deaths due to abortion… increased, from 10% to 14%, but the percentage of abortion complications at facilities has dropped significantly, to 28%, from 54% of all complications in 1998. This is a significant finding, suggesting that, although fewer abortion complications are presenting at facilities, they are more serious and/or their management is not adequate.[194]

Although the study above indicates that the incidence of abortion-related morbidity declined substantially since law reform was enacted, a separate report indicates that some of this decline might have begun before the safe services were comprehensively rolled out.[187]

In summary, abortion law reform in Nepal resulted in a well-coordinated series of activities to expand provider

training and the opening of facilities from the capital outward to less densely populated areas of the country. Remaining challenges include extending training beyond Kathmandu, ensuring that rural areas are equipped to provide safe abortion services (especially MVA), and helping women overcome cost barriers to obtaining safe services. Currently, the majority of safe abortions are performed in clinics associated with an international NGO or in private clinics.

Cambodia

A. The Country Setting

Cambodia is a largely rural Southeast Asian country. The United Nations put Cambodia's population in 2010 at 14.1 million, 80% of whom live in rural areas (Table 1, page 7). Per capita income was estimated at US$802, and just one in four women had more than a primary school education. The MMR was estimated by the WHO to be 290 deaths per 100,000 live births in 2008 (Table 2, page 8).

From 1975 to 1979, Cambodia was completely devastated by the genocidal policies of the Khmer Rouge, under its leader, Pol Pot. During his regime, 1.5–2.0 million people (a fifth of the population)—mostly well-educated individuals, men and professionals—lost their lives, leaving a large number of poor, rural and uneducated women heading families and raising children. The country was also left without an educational or health structure of any kind.

The People's Republic of Kampuchea, which was established in the wake of the total destruction of the country's institutions, infrastructure and intelligentsia, ruled Cambodia from 1979 to 1991. After interim control by the United Nations Transitional Authority, the monarchy was restored in 1993. The kingdom is a constitutional monarchy with Norodom Sihamoni as head of state. The head of government, Hun Sen, is the longest-serving leader in Southeast Asia and has ruled Cambodia for more than 25 years.

With a high level of support from international donors and heavy reliance on the private health sector, Cambodia has slowly tried to rebuild its devastated health system. According to a recent WHO estimate, there were only two doctors and eight nurses or midwives for every 10,000 population in the first decade of this century (Table 1). Many women in rural communities were using the services of traditional birth attendants and traditional healers, or *Kruu Khmer*.[202] However, by 2010, 71% of deliveries were attended by a skilled attendant.

B. Legal Grounds for Abortion Under the Revised Law

Until 1997, abortion was legally permitted in Cambodia only to save a woman's life. In that year, the king at that time, Norodom Sihanouk, signed a law permitting the procedure on broad grounds.[195] Now, abortion during the first 12 weeks of pregnancy is legal on request. At later gestations, it is allowed under three circumstances: the pregnancy is abnormal, growing unusually or poses a risk to the woman's life; the baby that would be born could have a serious incurable disease; or the pregnancy resulted from rape. The abortion request must come from the woman herself or, if she is a minor, from her parents or guardian. Health professionals are required to counsel women about possible complications of abortion and about the importance of birth-spacing services.

According to the 1997 law, abortions may be performed only by medical doctors, other medical practitioners or midwives authorized by the Ministry of Health, and only in a hospital, health center, health clinic or maternity ward having the technical capability for emergency management of complications, or the means to refer women to a sufficiently equipped hospital, if necessary. Facilities must send monthly reports to the ministry stating the number of abortions and the method used for each.

If representatives of the medical profession, the judiciary, women's groups or civil organizations were consulted about the law reform while it was being undertaken, these processes were not documented. Nor is there any evidence that the rationale for the new law was supported by any hospital-based or community-based epidemiologic studies of the prevalence and consequences of unsafe abortion at the time.

C. Guidelines and Their Dissemination

No official government guidelines regulating the provision of safe abortions under the 1997 Cambodia law are available, and text of the new law was never disseminated in any systematic way, either to health care providers or the public at large. The law stipulated that regulations governing the proper practice of safe abortions would be forthcoming. However, if they do exist, it appears that such regulations (*kram*) were never officially approved, published or disseminated.

D. Creation, Availability and Uptake of Safe Abortion Services

The first nine years after legalization of abortion in 1997 were characterized by a lack of technical guidance from the Ministry of Health, funding to train safe abortion providers and political will to implement the new law.[196] No service statistics covering those years are available. Some urban hospitals were performing abortions, but services were largely available through an ad hoc group of midwives and traditional birth attendants with sparse or checkered abortion-training histories, who charged high fees for procedures carried out predominantly in their private clinics or homes.[197] MVA and D&C were the major methods used.

In an attempt to compensate for the clear shortcomings in government legal abortion services, the international donor and NGO communities designed a large-scale intervention, the Reduction in Maternal Mortality Project (RMMP). This project was carried out by a consortium of national institutions and international NGOs, including Ipas and Marie Stopes International, with funding from the UK Department for International Development. Its aim was to support the Ministry of Health's efforts to increase access to and quality of safe abortion services nationally.[196]

Between 2006 and 2011, the RMMP pilot project—which covered 113 of Cambodia's 829 health centers and 33 of its 80 hospitals—produced and disseminated national guidelines for safe induced abortion, trained more that 350 providers in safe techniques, introduced medication abortion into the public health sector, renovated more than 50 health facilities, and distributed thousands of MVA kits. Over the course of the project, about 43,000 women obtained safe abortions.[196] If the project had had national rather than partial coverage, these results suggest that the demand for services could have been two or even three times greater. However, the RMMP closed down in 2011, when the British government stopped providing international aid to Cambodia. As a key informant notes, this loss of support has left uncertain the continuation of both training activities and the provision of safe abortion services in areas of the country in which services had been upgraded through the project.

E. Impact of the Revised Law

Given the tragic political conditions in Cambodia that preceded the 1997 reform of the country's abortion law, any attempt to assess the law's impact on abortion prevalence is out of the question. Moreover, as the government still has not collected statistics on the number of abortions performed in its health centers and hospitals, private clinics are not required to report procedures and women themselves underreport terminations, reliable estimates cannot be made of the number of procedures, safe and unsafe, performed annually in Cambodia, or of the country's abortion rate. However, a study carried out in 2005 estimated that 35,200 pregnancy terminations occurred in private and public health facilities that year and another 38,700 terminations outside of formal facilities, for an estimated annual abortion rate of 22 per 1,000 Cambodian women of childbearing age.[198] In the same year, approximately 31,500 women nationally were treated in government health facilities for complications arising from unsafe abortions.[199]

Data suggest some temporal trends related to abortion. Three years after the enactment of the new abortion law, the 2000 Demographic and Health Survey (DHS) of Cambodia estimated that the MMR in the country was 437 maternal deaths per 100,000 live births for the period 1994–2000.[200] The survey also offered a look into the practice of abortion in Cambodia during that period. The findings on prevalence are compromised by the fact that even in countries where the procedure is broadly legal, underreporting is common. Notwithstanding this severe limitation, among the Cambodian women aged 15–49 who responded, 1.9% said they had had at least one abortion in the past five years. Two-thirds of the procedures took place in a public or private health facility, and the remainder in the woman's home or with consultation of a traditional provider.[200]

Five years later, findings from the 2005 DHS suggested that the MMR for the period 1999–2005 was still high in Cambodia—472 deaths per 100,000 live births.[201] The incidence of abortion had increased, with 3.5% of women of childbearing age now reporting that they had terminated at least one pregnancy in the past five years. The rate rose most among urban women and among those with 3–4 children. According to the 2010 DHS, maternal mortality has fallen precipitiously to 206 for everly 100,000 live births, while a greater proportion of women (5%) reported that they had had an abortion in the previous five years.[202]

As of 2010, only 14% of abortions were taking place in public facilities (down from 27% in 2000). More than four in ten abortions took place in private facilities in both 2000 and 2010, and home-based abortions continue to make up a large share of all abortions—38% in 2010, down a bit from 45% in 2000. Doctors, nurses or midwives assisted in the majority (67%) of terminations in 2010. These findings suggest that a considerable number of trained health professionals were carrying out abortions in their own homes. In both years, D&C and vacuum aspiration were by far the most common methods.

The more recent DHS also offers data that help explain

the role of abortion in the reproductive lives of Cambodian women, suggesting that some may use this practice to regulate their fertility. The total fertility rate in Cambodia dropped from 4.0 births per woman in 2000 to 3.4 in 2005[200,201] and further decreased to 3.0 in 2010[202]—evidence of a substantial decline in family size within a short period. By 2010, about 51% of currently married women were using contraceptives (35% a modern method,* an increase from 2000, when the proportion was 24%). But a sizable proportion of currently married women (about one in six) have an unmet need for family planning, and it is especially high among the poorest women and those having less than secondary school education.[201] On the other hand, it is not obvious how much of the increase in reported abortions is the result of an increase in terminations and how much is due to a greater willingness of women to report them in the years after the abortion law was liberalized.

Persistent problems in Cambodia's overall health system also affect its abortion services. Severe shortcomings in these services were identified very early on after signing of the 1997 law, particularly the absence of training for nurse-midwives, the group bearing the largest responsibility for health care in rural areas.[203] However, the problems identified differed little from the many problems with Cambodia's overall public health services. The authors of one assessment report:

> The health situation in Cambodia is among the worst in the world and the health care system faces immense problems. Quality health care is scarce, and public confidence in the system is low. In 1995 Government per capita spending on health was $2. In 1997 only 5.7 percent of public spending was for health. Limited access to quality health care is worsened by poor living conditions, poor hygiene, large families and food shortages. Illiteracy and poor knowledge of health and hygiene prevent people from coping with illness.[203]

The 2005 survey of health facilities found that only 47% of hospitals, 10% of high-level (tertiary care) health centers and 5% of low-level (primary care) health centers provided abortion services.[198] Among the facilities that did, nearly half refused to provide services to adolescents, and 40% of providers in hospitals believed that the Ministry of Health did not permit abortion. Although all hospitals were providing PAC services, fewer than half of the health centers did. One out of five health centers reported that lack of a competent abortion provider was a primary reason for referral. Health centers indicated that referrals for PAC services were most often due to a lack of skilled providers or necessary equipment, or restrictions by the ministry on the types of care they were allowed to provide. Two-thirds of all facilities (67%) were forced to refer women trying to terminate an unwanted pregnancy. Lack of training and lack of supplies were the most common reasons for not providing abortion services.[204]

Examining the quality of PAC available, the study found that D&C was the most commonly used method for uterine evacuation in both hospitals and health centers, and that a high proportion of patients underwent uterine evacuation procedures without receiving appropriate pain management. One-third of hospitals did not provide contraceptive counseling or services to PAC clients, and 39% did not provide them to clients having induced abortions. In hospitals, 30% of PAC patients and 20% of patients terminating pregnancies were referred to another facility for contraceptive services.

A 2006 qualitative study carried out in the capital, Phnom Penh, and in one rural province provides a glimpse of women's perspectives on abortion and abortion services. The study found that many younger women seeking abortions were doing so to end unintended pregnancies resulting from unprotected sex before marriage, while many older married women were terminating their pregnancies to try to regulate their family size, space their children, avoid ill health or avert marital disharmony.[196,205] And even though abortions are legal, many pregnant women did not know where to obtain one, lived far from a clinic offering termination services or did not like or viewed as unavailable the services offered in clinics and hospitals. The reasons for the dislike or perceived unavailability included the cost, the lack of privacy in large public hospitals, a belief that private clinics treat only the well-to-do, the poor quality of care and punitive provider attitudes. Some women mentioned that at that time, medication abortion, a method that many preferred, was not offered in public facilities. A recent study suggests that women continue to resort to unsafe abortion.[199] The analysis was based on all of Cambodia's 71 hospitals, 14% of eligible high-level health centers and 22% of eligible low-level health centers. It found that in 2005, an estimated 31,579 women with complications of miscarriage or terminations were treated in Cambodian government facilities (80% in health centers); 40% of these women either reported or had strong clinical evidence of prior attempted terminations. Nearly 17% of these women had been in the second trimester of pregnancy and 42% of them had severe complications. The annual incidence of complications from induced or sponataneous abortion was 867 per 100,000 women of reproductive age. The projected ratio of compli-

*Male or female sterilization, the pill, IUD, injection, implant, condom, gel/spermicide or emergency contraception.

cations was 93 per 1,000 live births.

Although Cambodia has had several years to translate its reformed abortion law into the provision of safe services, progress was compromised by the devastated health care infrastructure at the start of this window of time and the lapse of several years before guidelines and training programs were put in place. International donors and NGOs have been instrumental in efforts to develop guidelines, train providers and establish services in recent years, and the country is now vulnerable to setbacks in the face of the withdrawal of these sources of support.

Conclusions

This collection of case studies provides an overview of the diversity of experiences in countries following their adoption of new laws expanding the legal grounds for abortion. This review has the value of synthesizing experiences over a recent period of time and spanning a wide range of contexts. Despite the limitations of inadequate documentation of processes following abortion law reform, the report provides some perspective on the extent to which countries have progressed in implementing access to legal abortion services after the landmark achievement of reforming their abortion laws. Efforts to relax legal restrictions on abortion are under way in a number of countries, and if this trend continues, such efforts are likely to take hold in many others. These countries have much to gain from increased understanding of the experiences where the abortion law was reformed. Although more thorough assessments, based on longer-term and more in-depth research and evaluation, are needed in all six cases, we offer some tentative conclusions from our findings.

Key Findings

Public Awareness of Changes in the Law

Public awareness campaigns are critical to de facto implementation of a change in the law. Nearly all the countries reviewed here undertook dissemination activities of some scope, but government-sponsored, comprehensive and effective campaigns to reach all segments of the population were not realized in any of them. It is sometimes unclear whether this omission was intentional or inadvertent. The lack of broad information campaigns might reflect a fear that drawing attention to the new law could attract further opprobrium, and governments may choose not to promote such information in order to draw as little attention as possible to an issue often viewed as a political liability. Other possibilities include limited resources and the persistent widespread stigma surrounding abortion.

Despite the lack of comprehensive public awareness campaigns, knowledge of changes in the abortion law appear high in the two most economically developed of our six country settings: Mexico City and Colombia. Both have a strong national newspaper culture and large television audiences, and these media offer daily and intensive coverage of and debate over the outstanding political issues of the day—which abortion certainly became leading up to and following legal change.

Guidelines and Their Dissemination

Clinical and administrative guidelines are important for formalizing and standardizing the delivery of services and medical care. The existence and scope of such guidelines varies across the six settings studied, and comprehensive guidelines are widely available in two (Ethiopia and Colombia.) The Ethiopian guidelines were doubtless an important factor contributing to the country's ability to make progress in improving access to legal abortion services. Colombia's service guidelines are accessible and complete (based, as they are, on a WHO manual), but because of unrelenting political opposition to actual service provision, there has been hardly any opportunity to demonstrate their utility. Guidelines appear to exist in Mexico City and Nepal, but their elusiveness strongly suggests they have had limited chance to be used in practice, and this is likely to represent a missed opportunity. NGOs, relevant international agencies and other stakeholders have participated to varying degrees in the development and dissemination of guidelines where they do exist. Such entitites could bring to bear their knowledge and experience, including experiences from other settings, and thereby facilitate the process of making guidelines widely available in settings with newly revised laws.

Creation and Uptake of Safe Abortion Services

The experiences of the six country settings highlight some pragmatic issues in moving from advocacy and passage of a law to actual implementation. A carefully planned transition can be identified in Nepal, where the same international NGO helped oversee the process of legal change and the process of implementation, and in Mexico City, where high-level Ministry of Health officials started planning for the kind of abortion services that would be made available well before the new law actually passed. Given that Ethiopia faces huge deficiencies in its overall health infrastructure, particularly an acute shortage of trained doctors and nurses, and given the recent trauma inflicted on

all of Cambodia's social and health networks, the shortfalls in implementation of safe abortion services in these two countries is hardly surprising. The recent large-scale efforts to train and deploy additional health extension workers in Ethiopia represents an alternative approach to dealing with a shortage of more highly trained health care providers.

In most country settings, it appears that different sets of actors came on the scene once the law had passed. Government health planners and medical professionals responsible for introducing safe and legal abortion services are unlikely to show the same passion and political will that often characterized the groups originally campaigning for legal reform. This suggests the need for continued involvement of a broad range of advocates to monitor implementation in a public and visible manner, to ensure that the necessary steps by the public and private health sectors are in fact happening at a steady if not rapid pace.

The findings in the six settings also show that when the practical issues of implementation replace the abstract issues entailed in drafting of a law, the political context can change dramatically. Agitation for a new law may appear far less threatening to opponents than the actual introduction of safe and legal abortion services. That could well be the case in Colombia, where the Catholic Church assumed a largely hands-off role in the days before the 2006 law was passed, but opposition intensified dramatically thereafter.

Creating a service to provide safe abortions as part of a public health system may be particularly challenging for countries with underfinanced, weak and already overstretched health infrastructures. Notably, the professional training (in D&C, vacuum aspiration and medication abortion), the technologies (anesthesia, manual and electric vacuum equipment) and the drugs (anesthetics, antibiotics and, more recently, misoprostol and mifepristone) needed for first- and second-trimester abortion are exactly the same as those that should be on hand in any adequately resourced health facility that offers treatment for complications from unsafe abortion and routine or emergency obstetric care. Consequently, any training given in such abortion techniques would benefit and enhance the skills of health professionals engaged in both postabortion and emergency obstetric care services to improve standards of safe motherhood and reduce maternal mortality and morbidity.

Impact of the Revised Law

Given the tremendous diversity across country settings in sociodemographic features, and in the extent to which the abortion law was reformed and the time that has elapsed since, it is not suprising that the measurable impact has varied. In South Africa, where the new law has been in place the longest, the legal abortion rate increased between 1997 and 2003 and then remained stable through 2008,[26,206] while estimates of the unsafe and largely illegal abortion rate available for the subregion that includes South Africa have continued to decline since the new law was enacted, up to 2008 (the latest year for which data are available).[58] There is some empirical evidence that the revised law in South Africa has been associated with a dramatic reduction in abortion-related maternal deaths. It is important to note, however, that thousands of clandestine procedures still take place in the country each year, and unrecorded deaths likely also persist.

In Ethiopia, where baseline measures of unsafe abortion before revision of the law are unavailable, safe legal procedures made up slightly more than a quarter of all abortions in the country in 2008.[72] The effect of law reform on overall maternal mortality has not been measured. A subnational study indicates that the incidence of complications has declined,[95] either as a result of abortion law reform or as a part of other national measures to improve maternal health in this country, of which law reform was a part.

In Mexico City, the very large gap between the number of reported, legal abortions and the estimated overall level of abortion derived from independent research suggests that most abortions are still obtained outside of officially sanctioned facilities. A number of possible factors could explain this gap, including inadequate availability and accessibility of legal services in the public sector, or women's preference for the confidentiality of a private-sector procedure or the privacy and low cost of a misoprostol-induced abortion at home to a procedure performed in a public health clinic. For these reasons, and because very little time has passed since legal reform, measures of improvements in maternal mortality or morbidity from unsafe abortion in this setting are not yet available for Mexico City.

Other consequences, though largely unanticipated, have followed the legal change in Mexico City, one negative and one positive, and neither measurable in standard public health terms. There is little doubt that abortion opponents in the rest of the country, fearful of the positive example set by the country's capital, have responded by further toughening their already restrictive state laws. On the other hand, intense debate over the revised law in the media has created an invaluable educational opportunity to advance the human rights– and health-based rationale for abortion law reform, which is being closely watched by policymakers, program planners, women's groups and reproductive health advocates throughout the Latin American region.[207]

Official counts of abortions legally performed in Nepal indicate an increase in the rate of legal procedures since 2005. It is not possible, however, to ascertain how much of this has been accompanied by a decline in clandestine abortions. There is suggestive evidence that the law reform has contributed to a decline in the incidence of complications from unsafe abortion. Evidence as to whether the abortion law has contributed to Nepal's rapidly declining maternal deaths is being closely examined. The narrow terms of the change in Colombia's law preclude any notable impact on the incidence of safe and unsafe abortions or on related maternal mortality or morbidity.

Generally speaking, a high standard of service monitoring is necessary for any meaningful attempt to evaluate the impact of a new abortion law on the incidence of safe abortion. Where health data collection systems are inadequate and the private sector provides the majority of legal abortions but is not required to report them, the incidence of legal procedures cannot be accurately measured. Public health advocates, international donors and researchers around the world should continue striving to improve the completeness of reporting of legal abortions, the recording and accurate classification of abortion-related maternal deaths, and the attainment of robust estimates of overall maternal mortality and both legal and safe terminations and unsafe terminations.

Additional Insights

A number of important issues emerged in the research for this report, beyond those addressed in the framework of processes that must follow law reform. In some cases, sufficient information was not available to address the issue, and in others, it is not clear that the concerns will apply to all settings. Three critical issues that emerged are the financing of safe abortion services, the role of international stakeholders in country efforts to implement laws and the importance of countering resistance to reform.

Safe Abortion Service Costs

Once an abortion law is liberalized, planners and policymakes must address the cost of providing safe abortion services in the public sector. One can intuit that safe procedures directly save money by reducing the cost of PAC for women who previously would have experienced complications from unsafe abortions. More importantly, safe procedures yield further benefits by saving lives, reducing morbidity and protecting women's reproductive health. However, in practical terms, if the financial and human savings from preventing unsafe abortions are to be realized, certain investments have to be made in training and equipment for new services, especially in already underserved rural areas. The questions then become how great these costs will be and who will bear them. The initial policy decision that abortions should be provided on a fee-for-service basis in Nepal, even in government hospitals, seems to have posed cost barriers that deterred many women from obtaining safe services.

Little information has emerged in this review about the actual costs of implementing services in different sectors (public vs. private) and health care settings (hospitals vs. clinics) and by type of provider and method. It is clear, though, that cost considerations hinge largely on the abortion methods offered and the level of training required. The advantages gained from involving midlevel health professionals rather than doctors in providing routine PAC services have been well demonstrated,[208,209] as they have been to some extent in the case of provision of legal abortion services.[210,211] International studies also demonstrate that misoprostol and MVA are more cost-effective than D&C,[212–215] which is still widely used in some developing countries despite its higher costs and greater risk. Provision of medication abortion and MVA pose different challenges. Government approval of medication abortion is a prerequisite to its widespread use, and this could be a lengthy process. Additionally, funding is still likely to be a challenge to using MVA, as most of the countries reviewed here seem to continue to depend on international NGOs to pay for the simple equipment needed.

Role of International Stakeholders in Implementation Efforts

A number of key international donor, research and reproductive health advocacy groups have contributed in important ways to the processes countries develop to implement legal reform.* The efforts of these organizations have undoubtedly been useful and, in some cases, essential. But their presence serves to underline the difficulties government health systems and domestic NGOs often face in confronting the health and human rights issues related to unwanted pregnancy in their own countries.

In addition, the engagement of the private health sector and of international and domestic NGOs can help to

*These include Ipas, which has played a large role in guiding and supporting the introduction of legal abortion services in at least three of the case study settings, as well as in carrying out educational efforts to counter the cultural and social stigma that often surrounds abortion; Marie Stopes International, which has built, stocked and staffed safe abortion clinics; the Center for Reproductive Rights, which has supported local groups in bringing legal cases and making constitutional challenges to defend the new laws; the Guttmacher Institute, which provides research evidence to support advocacy and to defend against court challenges; and the Population Council, which has supported field-based operational research in the area of legal abortion services.

fill gaps in training and service provision. But where these services are largely funded for only a limited period, attention is needed to how to transition to the public sector or alternative sources of support—a challenge currently being faced in Cambodia.

Countering Resistance to Reform

Opposition to abortion law reform itself usually does not end once a new law has been passed: Indeed, it may even intensify, and ongoing administrative and legislative obstacles set up by organized antiabortion groups may continue to impede its full implementation. As the case studies have shown, conscientious objection claims, political backlash and continuing stigma are common reactions to abortion law reform. In certain settings, health planners may have to anticipate staffing shortages stemming from reluctance on the part of some health professionals both to confront the stigma surrounding sexuality, unplanned pregnancy and abortion, and to participate in providing the service. Many laws contain conscientious objection provisions that allow hospital and clinic workers to opt out of the service for religious or ethical reasons, and several country examples have demonstrated that antiabortion legislators often capitalize on such provisions.

Once law reform has taken place, educating women and men about the new right to abortion, helping them fight for this right and overcoming the stigma often attached to the practice of abortion may all be difficult. And establishing a public health service to provide a procedure that up until passage of the law was often stigmatized, clandestine and outlawed is no simple task. It requires recognition that societal and cultural disapproval of abortion is often widespread and the development of educational strategies to counteract these deep-seated attitudes. In some settings, despite law reform, powerful social and religious groups may influence public opinion about the practice of voluntary pregnancy termination in a negative direction. This is not likely to change overnight. There are few precedents in any other area of medicine for this particularly complex challenge. Aware of the enormity of this issue, an abortion reform lawyer in Colombia notes:

> We knew that implementation wasn't going to take place from one day to the next. [The new law] was simply a judicial tool to aid the pursuit of social change. For example, doctors are told on one day that abortion is a crime; the next day, it becomes mandatory. The change is not an easy one.*[216]

Similarly, women who for decades have been accustomed to seeking abortions clandestinely, out of fear of social stigmatization or criminal prosecution, with the stroke of a pen are expected to throw off their old fears and acquire the courage to seek care openly at a public or private health facility used by their peers for other reproductive health purposes.

Recommendations

Insights on the transition from abortion law reform to implementation gained from the case studies in the six settings highlighted in this report allow us to make some recommendations for improving the process. These include the following:

- Countries should use strategic approaches to inform the public (and health providers, in particular) not just that restrictions on abortion have been eased but also who is eligible, where legal services can be obtained and which health professionals provide them. Targeted use of the Internet and of new social media in countries where access to digital tools is growing might help achieve these aims.
- Stakeholders should have modest expectations regarding the pace of impact of abortion law reform in predominantly poor and rural settings with weak health service systems. The shift to safe providers and methods will require concerted efforts in these environments. Useful measures might include providing low-cost procedures, including medication abortion, and increasing use of midlevel providers. Backup facility-based services for any complications that arise would still be needed.
- Countries anticipating revisions to restrictive abortion laws should be aware of possible problems in service availability that can arise when regulations defining who can legally provide services are crafted narrowly to exclude the role of midlevel providers. Advocates need to press for midlevel providers to be specifically included in the list of those who are permitted to perform legal abortions.
- The long-term sustainability of legal abortion services is highly dependent on the increased availability of skilled providers. Partnerships should be encouraged between ministries of health, medical schools and nurse-training colleges to promote training and recruitment in all reproductive health skills areas (including safe abortion).
- The weakness of public-sector services in some countries can lead to the greater involvement of the private sector. Private-sector services might be provided by

*Translated from Spanish: "Sabíamos que no se iba a implementar de un día para otro, era solamente una herramienta jurídica para seguir buscando el cambio social; que a los médicos, por ejemplo, un día les dicen que practicar un aborto es un delito y al otro día se vuelve obligatorio, y este cambio no es fácil."

NGOs and funded by external sources; as a result, these services are vulnerable to cuts in funding. Other providers in the private sector must charge fees for services, and these fees are sometimes but not always reasonable. Public-sector provision is ultimately needed to ensure that services are accessible to poor women who may not be able to pay the fees charged by private providers, and to prepare for the eventual exit of external support.

- Broad support for a liberal law in the populace may not be a prerequisite to a change in abortion law, but lack of such support can slow down the implementation of the law needed to ensure that women truly have access to safe and legal abortion services. Health planners should prepare for the possibility of organized political backlash to abortion law reform by continuing public education efforts to build and maintain public understanding and support for women should they choose to legally terminate a pregnancy. In addition, attention needs to be given to clearly addressing conscientious objection in the formulation of laws and official guidelines, and explicitly spelling out what actions facilities must take to ensure that women are able to access safe abortion services (e.g., if needed, by referral to other staff in a facility or in other facilities who will provide the services).
- It is hard to assess the impact of a revised abortion law on the incidence and safety of abortion, because it is difficult to measure the true incidence of a stigmatized procedure while it is still illegal and difficult to measure the incidence after liberalization as data collection systems tend to be inadequate and procedures performed in the private sector tend to go unreported. Nevertheless, attempts must be made to obtain baseline and follow-up estimates of a range of indicators that help to assess the law's impact: abortion incidence (differentiating legal and illegal procedures); related morbidity and its severity; mortality due to unsafe procedures; the circumstances under which women terminate pregnancies; and the characteristics of women using legal and safe services. The last two indicators help to identify the extent to which a change in the law reduces inequalities in access for poor and otherwise disadvantaged women. Serial surveys that document provision of legal abortion services according to type of facility and area of the country are needed to monitor the adequacy of provision among the various entities permitted to provide legal terminations. They also may indicate large differentials across regions and districts, pointing to inadequate service provision in particular areas.

Just as there is no single formula regarding the factors and processes that are most effective at changing the law, no one set of prereform conditions or actions seems to predispose a given country setting to more or less successful implementation of law reform. The postreform activities described in the framework presented here appear to be essential components of successful promotion and provision of safe abortion. However, the extent and timing of such success will depend on contextual factors, many of which are country specific.

Perhaps a key lesson to take from the six case studies presented here is that the process of translating law reform into practice is invariably characterized by interim successes, both large and small, as well as a number of hurdles. It is clear that the pragmatic tasks of establishing safe abortion services requires investments in training, equipment and service provision, and will be complicated by the slower process of educating the public and transforming attitudes of providers and the population at large. The evidence from countries with newly reformed laws and those with a long history of liberal abortion laws indicates that this process will ultimately result in much improved health and survival of women who live under them.

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