GUTTMACHER INSTITUTE

In Brief

Series 2012, No.1

Making Abortion Services Accessible In the Wake of Legal Reforms

The passage of a liberalized abortion law is one of many changes that must take place if women are to gain access to safe and legal services. A study of the process following legal reforms in six settings in Asia, Africa and Latin America confirms that the practical work of establishing safe abortion services can take years and requires resources and commitment. Where these efforts have been undertaken and information on trends in abortion-related illness and death is available, evidence is beginning to demonstrate that liberalized laws are followed by improved health outcomes for women.

Induced abortion has been legal on broad grounds in most of the industrialized world since the 1970s or earlier. However, the legal status of abortion in the developing world is mixed, and interpretation of the laws varies. Nearly one-half of women of childbearing age in the developing world live in countries that have banned the procedure entirely or allow it only to save a woman's life or protect her health. Outside of India and China, where abortion laws are liberal, eight in 10 women in the developing world live under highly restrictive laws.

Yet, there is clear evidence that restrictive abortion laws are associated with a high incidence of unsafe abortion and its health consequences, and abortions in these settings contribute substantially to maternal illness and death. Abortions that occur outside of the law are usually clandestine and unsafe because the procedures are performed by unskilled providers or under unhygienic conditions, or they are induced by the pregnant woman herself. In addition to endangering women, unsafe abortion and its consequences place a costly burden on health systems.

Some countries have responded to these concerns by making legal reforms. Since 1995, legal restrictions on abortion have been reduced to varying degrees in 26 countries and in Mexico's capital city. Many of the reforms were spearheaded by women's health and rights organizations that waged hard-fought legal and educational campaigns to bring about change. Some successful strategies have emerged and are well-documented. They include conducting research on the incidence, consequences and costs of unsafe abortion; disseminating the findings to advocacy groups and political organizations; building coalitions among reproductive rights activists and legislators; mobilizing public opinion through mass media campaigns; and using legal strategies that frame access to safe abortion as a public health issue and a human right.

Less has been published about how laws are implemented and what impact they have on abortion services and women's health. Experience in several countries suggests that legislative change does not automatically lead to universal access to safe abortion services within the bounds of the law, especially in poor countries. In India, for example, abortion has been legal on broad grounds since 1971, but four decades later, fewer than half of procedures are likely safe. Similarly, although a liberal abortion law was enacted in South Africa in 1997, the majority of terminations in 2008 in the Southern Africa subregion (where residents of South Africa account for nearly 90% of the female population) were still unsafe.

This brief summarizes a longer report examining the implementation and impact of less restrictive revised abortion laws in six settings. Case studies presented in the report drew on findings from a wide range of reports, as well as questionnaires and interviews with experts from both government and nongovernmental organizations. As part of this undertaking, Guttmacher researchers developed a framework for understanding and evaluating the processes that would ideally follow the passage of a revised abortion law (see box, page 3). Each of the six case studies addresses the elements laid out in this framework.

Six settings in which abortion laws recently changed

Between 1997 and 2007, Cambodia, Colombia, Ethiopia, Mexico City, Nepal and South Africa undertook reforms to ease restrictions in their

Grounds for Legal Abortion Under Revised Laws In Six Country Settings

Cambodia, 1997[1]	During the first 12 weeks,* permitted on any grounds. After 12 weeks, permitted if (1) the pregnancy is abnormal or poses a risk to the woman's life, (2) the baby may develop an incurable disease after birth or (3) the pregnancy resulted from rape. Requests for abortion must be made by a minor's parents or guardians.
Colombia, 2006[2]	Permitted with no gestational limit if (1) the pregnancy threatens the woman's life or health, as certified by a doctor, (2) a doctor certifies that the fetus has grave malformations incompatible with life or (3) the pregnancy resulted from criminal acts reported to proper authorities.
Ethiopia, 2005[3]	Permitted before the fetus is viable (conventionally interpreted as 28 weeks after the last menstrual period) if (1) the pregnancy resulted from rape or incest, (2) the health or life of the woman or baby is in danger, (3) the fetus has an incurable and serious deformity, (4) the woman has physical or mental disabilities or (5) the woman is a minor and is unprepared to raise a child.
Mexico City, 2007[4]	During the first 12 weeks, permitted on request. After 12 weeks, permitted only to protect the woman's life or health and in cases of rape and fetal impairment.
Nepal, 2004[5]	During the first 12 weeks, permitted on any grounds. In weeks 13–18, permitted if the pregnancy resulted from rape or incest. At any gestation, permitted 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, 1997[6]	During the first 12 weeks, permitted on request. In weeks 13–20, permitted if a medical practitioner believes that (1) the pregnancy poses a risk to the woman's physical or mental health, (2) there is 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) continuing the pregnancy would significantly affect the woman's social or economic circumstances. After the 20th week, permitted if a medical practitioner, in consultation with another medical practitioner or a registered midwife, believes that the continued pregnancy would (1) endanger the woman's life, (2) result in a severe fetal malformation or (3) pose a risk of injury to the fetus.

*The first trimester of pregnancy is usually calculated as 12 weeks from the first day of the woman's last menstrual period.

abortion laws. These countries span the development spectrum. Cambodia, Ethiopia and Nepal are among the world's most impoverished countries, with relatively low levels of education, low health spending per capita, and high maternal and infant mortality. In contrast, South Africa, Colombia and Mexico City have relatively advanced economies and health systems. These differences have had implications for each country's ability to translate new laws into practice. Other important contrasts between the settings, including cultural factors and religious beliefs, have also influenced the receptivity to abortion law reforms.

All of the settings had highly restrictive laws before the reforms—abortion was either not permitted at all or was only permitted in exceptional circumstances. The scope of the reformed laws varies widely (see table). In four countries, abortion is now legal without restriction within set gestational age limits (12 weeks in Cambodia, Nepal and South Africa, and 28 weeks in Ethiopia) and on a more limited basis after that. The Mexico City law permits abortion on request until the 12th week of pregnancy, but not later. The Colombian law allows abortion only in cases of rape, incest or fetal malformation, and to save the woman's life or health; it does not specify a gestational age limit.

Public awareness of changes in the law

Outreach activities occurred in most of the settings examined, though to different extents. Outreach may have been limited intentionally (because public officials may view legal abortion as a political liability) or restrained by a lack of resources or the persistence of widespread stigma surrounding abortion.

Despite the lack of comprehensive public awareness campaigns, knowledge of changes in the abortion law appears to be high in the two most economically developed settings, Mexico City and Colombia. Both have numerous print and television news outlets with large audiences, which offer thorough coverage of outstanding political issues, including changes in the abortion laws.

Guidelines and their dissemination

Clinical and administrative guidelines are important to formalize and standardize abortion service delivery and medical care. Where they exist, such guidelines are generally developed and disseminated by government agencies, often with support from NGOs, international agencies and other stakeholders. 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 have contributed to progress in improving access to legal abortion services. Colombia's service guidelines, based on a manual by the World Health Organization, are accessible and complete, but because of unrelenting political opposition to abortion services and a host of other factors, there has been little opportunity to use them. Guidelines have also been developed and disseminated in South Africa, though dissemination was not as widespread there as in Ethiopia or Colombia.

Framework for Action After Abortion Law Reform

The following steps are likely to help achieve successful implementation of a new law:

- Disseminate information about the new law to government agencies, public and private health care providers, and the general public.
- Publish and disseminate regulations, guidelines and protocols for providing safe abortion services.
- Train health workers to perform safe abortions, and provide supplies and equipment for safe abortion at authorized facilities.
- Monitor and evaluate of the incidence of safe and unsafe abortion and the health impact of new abortion services.

Guidelines exist in Mexico City and Nepal, though it appears that they have not been widely disseminated or used.

Creation and uptake of safe abortion services

Providing safe abortions through the public health system is challenging for countries with underfinanced, overburdened health systems. After revising its abortion law, Nepal worked with international NGOs to implement a carefully planned strategy to make services available, which included developing manuals, training public- and private-sector providers, and issuing necessary supplies and equipment. In Mexico City, high-level Ministry of Health officials started planning for the provision of safe abortion services before the new law passed, and training of doctors began soon after the law was enacted. In South Africa, safe abortion services have been made available in many public health facilities, though the provision of services is not sufficient to meet the overall demand. Even in Ethiopia and Cambodia, where health care infrastructures are relatively weak, limited services have been instituted, and one-fourth to one-half of abortions are now performed legally in facilities.

An important factor determining access to safe abortion services is the number of providers trained in safe abortion techniques. In South Africa, Nepal and, to a more limited extent, Cambodia, efforts to establish services have benefited from authorizing and training midlevel providers, such as nurses and midwives, to perform abortions.

Impact of the revised law

A critical question about abortion law reforms is whether they affect the number and safety of abortions performed, and ultimately whether they contribute to improvements in women's health. The evidence is limited, however, because many women and providers are reluctant to report abortion due to the stigma associated with it, particularly when it is restricted. Moreover, in Colombia and Mexico City, legal services have not been available long enough to allow measurement of their impact.

In South Africa, where the new law has been in place the longest, the difference in national abortion incidence before and after reform is not known; however, in the Southern African subregion, which is comprised primarily of South Africa, the overall abortion rate has declined even while the rate of safe abortion has increased. Evidence suggests that the revised law in South Africa is associated with a dramatic reduction in abortion-related maternal deaths in facilities.

The measurable impact of the revised laws in the other settings has varied tremendously:

- In Ethiopia, where levels of unsafe abortion prior to the new law are unknown, safe legal procedures made up slightly more than a quarter of all abortions in 2008. A subnational study indicates that the incidence of complications from unsafe abortion has declined.
- In Mexico City, the very large gap between the number of reported legal abortions and the estimated number of abortions derived from independent research suggests that most abortions are still obtained outside of officially sanctioned facilities.
- In Nepal, the impact of the new abortion law on the overall incidence of abortion cannot be determined because there were no reliable estimates of abortion incidence before the law was revised. There is evidence that the law reform has contributed to a decline in complications from unsafe abortion.
- In Colombia, the narrow terms of the law reform preclude any notable impact on the incidence of safe and unsafe abortions or on related maternal mortality or morbidity.

Resistance to the new laws

The findings in the six settings show that resistance to legal abortion can intensify after abortion laws are reformed. In Colombia, for example, the Catholic Church assumed a largely hands-off role before the 2006 court decision that liberalized abortion, but opposition intensified dramatically thereafter. Opposition to implementing safe and legal abortion services can take many forms and must continually be addressed.

Across settings, the case studies showed that resistance among health providers, political backlash and continuing stigma are common reactions to abortion law reform. 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 settings have demonstrated that antiabortion legislators often capitalize on such provisions. In such settings, health planners may have to anticipate staffing shortages due to the reluctance of some health professionals to address sexuality, unplanned pregnancy and abortion, and to participate in related services.

Once law reform has taken place, educating women and men about the new right to abortion, helping them protect this right and overcoming related stigma may pose new challenges to providers and other stakeholders involved in making safe abortion available. In addition, establishing a public health service to provide a procedure that had been previously outlawed, stigmatized and clandestine is no simple task. It may require acknowledging

pervasive societal and cultural disapproval of abortion and developing educational strategies to counteract deep-seated attitudes.

Further actions needed

Strong policy and program actions are needed to ensure that the provisions of the new abortion law and related regulations are clearly described, well-understood by health professionals and the public, and implemented in ways that make safe and legal abortion services an integral part of reproductive health services. Specific actions include the following:

- Governmental and nongovernmental stakeholders should use the media and other available avenues to inform the public and health providers that restrictions on abortion have been eased, where procedures can be obtained legally and which health professionals provide them.
- In predominantly poor and rural settings with weak health systems, useful strategies to increase the accessibility of services include promoting low-cost, safe abortion techniques and increasing the use of midlevel providers. Referral to facility-based services for complications must be provided on an ongoing basis.
- To address shortages of skilled providers, partnerships should be encouraged between ministries of health, medical schools and nurse-training colleges to recruit and train providers in safe abortion techniques, as well as other skills related to reproductive health. Advocates should press for midlevel providers to be included among those legally permitted to perform abortions.
- Program planners and legal experts should anticipate and plan for backlash against abortion law reforms. Conscientious objection should be addressed clearly in laws and official guidelines, explicitly spelling out what actions facilities must take to ensure that women are able to obtain safe abortion services—if needed, by referral to other staff or facilities that will provide the services.
- Donors, researchers and public health advocates around the world should continue working toward improved reporting of legal abortions, reliable collection of data on abortion-related maternal deaths and illnesses, and robust estimation of the incidence of unsafe abortion.

REFERENCES

1. 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.

2. Congress of 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.

3. Ethiopian National Legislative Bodies No. 414, The Criminal Code of the Federal Democratic Republic of Ethiopia, 2004, <http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/70993/75092/F1429731028/ETH70993.pdf>, accessed Dec. 15, 2011.

4. Office of the Governor of the Federal District, Mexico City, Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law (in Spanish), 2007, pp. 2–3, <http://www.gire.org.mx/publica2/GacetaGDF_Aborto260407.pdf>, accessed Feb. 10, 2012.

5. Nepal Department of Health Services Division, *National Safe Abortion Policy,* Kathmandu, Nepal: Ministry of Health, 2002.

6. Republic of South Africa, No. 1891, Act No. 92, Choice on Termination of Pregnancy Act, 1996, <http://www.info.gov.za/gazette/acts/1996/a92-96.htm>, accessed Nov. 22, 2011.

CREDITS

This report, written by Lori Ashford, independent consultant, and Gilda Sedgh and Susheela Singh, both of the Guttmacher Institute, summarizes the findings of *Making Abortion Services Accessible in the Wake of Legal Reforms: A Framework and Six Case Studies,* New York: Guttmacher Institute, 2012, <www.guttmacher.org/pubs/abortion-services-laws.pdf>. Unless otherwise noted, references to all information can be found in the longer report. This brief was edited by Haley Ball, Guttmacher Institute.

The authors thank the following colleagues for reviewing early drafts of the brief: Akinrinola Bankole, Guttmacher Institute; Kelly Blanchard, Ibis Reproductive Health; Luisa Cabal and Lillian Sepulveda, Center for Reproductive Rights; Tamara Fetters and Charlotte Hord Smith, Ipas; and Iqbal Shah, World Health Organization.

This brief was made possible by grants from the Dutch Ministry of Foreign Affairs and the John D. and Catherine T. MacArthur Foundation.

Suggested citation: Ashford L, Sedgh G and Singh S, Making abortion services accessible in the wake of legal reforms, *In Brief*, New York: Guttmacher Institute, 2012, <www.guttmacher.org/pubs/FB-abortion-services-laws.pdf>.

Advancing sexual and reproductive health worldwide through research, policy analysis and public education

125 Maiden Lane
New York, NY 10038 USA
Tel: 212.248.1111
info@guttmacher.org

www.guttmacher.org