



# **ACCESS TO ABORTION REPORTS: An Annotated Bibliography**

**January 2009**

**Prepared by**

**The International Reproductive and Sexual Health Law Programme**

**Faculty of Law, University of Toronto  
84 Queen's Park Crescent, Toronto, Ontario, Canada  
Tel: (416) 978-1751 Email: [reprohealth.law@utoronto.ca](mailto:reprohealth.law@utoronto.ca)**

Available at: <http://www.law.utoronto.ca/documents/reprohealth/abortionbib.pdf>

# **ACCESS TO ABORTION REPORTS**

## **An Annotated Bibliography**

### **AN INTRODUCTION TO THE ANNOTATED BIBLIOGRAPHY**

The legalization of abortion is necessary to ensure safe abortion. It is not, however, sufficient. Widespread evidence indicates that many women cannot access abortion services to which they are legally entitled. This is true in jurisdictions that permit abortion for both specific indications (e.g. risk to life or health, rape, severe fetal malformation and socio-economic factors), and without restriction as to reason for at least some period of pregnancy.

India and Zambia are commonly cited as examples of countries where legal reform has proven insufficient to guarantee access to safe abortion. In both countries the practice of unsafe abortion remains widespread and abortion-related maternal mortality remains high, even though abortion is legally permitted on broad indications.<sup>1</sup> Women's continued lack of access to safe abortion results from a failure to ensure the law's effective operation in practice. Barriers include: provider objection, lack of provider training, equipment and facilities, affordability and inadequate public funding, formal and informal procedural requirements, failure to respect confidentiality, stigma and discrimination, and misinformation regarding the legality of abortion.

United Nations treaty monitoring bodies have called on states to ensure that women can effectively access legal abortion.<sup>2</sup> In 2007, the Committee on the Elimination of Discrimination against Women noted its concern that "in spite of the legalization of abortion in specific cases [in Mexico], women do not have access to safe abortion services ..."<sup>3</sup> It urged the Mexican government "to implement a comprehensive strategy which should include the provision of effective access to safe abortion in situations provided for under the law ..."<sup>4</sup>

### **The Annotated Bibliography**

This annotated bibliography brings together government reports, non-government reports, and secondary literature that investigate women's access to legal abortion services under different legal regimes. These reports are distinct from reports on the incidence of induced abortion. Access reports document the implementation or effects of laws regulating access to abortion services.

---

<sup>1</sup> See e.g. M. Berer "Making Abortions Safe: A Matter of Good Public Health Policy and Practice" (2000) 78(5) Bull. World Health Organization 580. In India, there continues to be a ratio of approximately 6:1 clandestine to legal abortions, contributing to over 15 per cent of the maternal death rate. International Planned Parenthood Federation, *Death and Denial: Unsafe Abortion and Poverty* (London, UK: IPPF, 2006).

<sup>2</sup> See e.g. *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Poland*, CEDAW, UN Doc. CEDAW/C/POL/CO/6 (2007), at para. 25; *Report of the Committee on the Elimination of Discrimination against Women: Mexico*, CEDAW, UN GAOR, 61st sess., supp. no. 38 (A/61/38) part III (2006), at paras. 613-614; *Report of the Committee on the Elimination of Discrimination against Women: Saint Lucia*, CEDAW, UN GAOR, 61st sess., supp. no. 38 (A/61/38) part II, at paras. 154, 181-182; *Concluding Comments of the Committee on the Elimination of Discrimination against Women: Colombia*, CEDAW, UN Doc. CEDAW/C/COL/6 (2007), at paras. 22-23; *Concluding Observations of the Human Rights Committee: Argentina*, HRC, UN Doc. CCPR/CO/70/ARG (2000), at para. 14; *Concluding Observations of the Human Rights Committee: Poland*, HRC, UN Doc. CCPR/CO/82/POL/Rev.1 (2004), at para. 8; *Concluding Observations of the Committee on Economic, Social, and Cultural Rights: Poland*, CESCR, UN Doc. E/CN.12/1/Add.82 (2002), at para. 29.

<sup>3</sup> *Report of the Committee on the Elimination of Discrimination against Women: Mexico*, *ibid.* at para. 613.

<sup>4</sup> *Ibid.* at para. 614.

- Do women have access to the services to which they are legally entitled?
- What barriers impede women's safe and effective access to legal abortion?
- What are the consequences?
- If denied access to legal services, where do women obtain abortion services?

The purpose of this annotated bibliography is to contribute to other efforts to improve understanding of existing gaps between the formal legal regulation of abortion and the operation of laws in practice.<sup>5</sup>

The reports are listed alphabetically by region and country. Where reports are unavailable, annotations are based on secondary material. These annotations seek to identify: the report's central thesis; barriers affecting access to safe abortion; consequences of the legal regulation of abortion; and recommendations for legal reform. Restatements of law, where provided, pertain to the law as it was in effect at the time of the report's publication.

This annotated bibliography remains a work-in-progress. The list of reports is non-exhaustive. We also recognize that English-language reports are over-represented.

Suggestions for inclusion of additional reports are most welcome. Please send all comments and suggestions to Joanna Erdman ([joanna.erdman@utoronto.ca](mailto:joanna.erdman@utoronto.ca)).

## **Collective Report Findings on Access Barriers to Legal Abortion**

Several types of access barriers to legal abortion emerge from the collected reports. The reports also demonstrate a common set of consequences resulting from these access barriers, and their effects on the lives and health of women. Last, the reports offer a series of recommendations for reform.

### ***(1) Access Barriers***

#### Provider Barriers

- *Lack of Trained Providers* (geographical disparity, lack of adequate training)
- *Unnecessary Provider Restrictions* (restricted to gynecologists, failure to train or authorize midwives and mid-level providers)
- *Provider Refusal or Objection* (fear of criminal prosecution, threat of violence, and conscientious objection)
- *Failure to Refer* (failure to refer in good faith, deliberate delays)

#### Facility Barriers

- *Geographical Disparity in Facility Availability* (limited access in rural areas or outside major urban centers)
- *Failure to Certify or Accredite Sufficient Number of Facilities*

---

<sup>5</sup> See e.g. United Nations, *World Abortion Policies 2007* (United Nations, United Nations, Population Division, 2007); United Nations. *Abortion Policies: A Global Review* (New York: United Nations, Population Division, 2002). Available at: [www.un.org/esa/population/publications/abortion/profiles.htm](http://www.un.org/esa/population/publications/abortion/profiles.htm).

- *Lack of Available Operating Room Time*
- *Unreasonable Facility Restrictions* (restricted to hospitals, gynecology wards or specialized health centers)
- *Hospital Policies* (gestational limits, age of consent, options counselling)

#### Commodity Barriers

- *Inappropriate, Outdated Abortion Technologies or Procedures*
- *Regulations that Restrict Access to or Distribution of Supplies*

#### Procedural Barriers

- *Mandatory Wait Periods*
- *Mandatory Pre-abortion Counselling*
- *Rape Administrative Protocols*

#### Authorization Barriers (form of Procedural Barrier)

- *Restrictive and Inconsistent Interpretation of Statutory Authorization Provisions* (failure to define policy respecting legal abortion, failure to provide guidance on exercise of discretion respecting authorization)
- *Mandatory Provider Authorization* (committee or multiple providers)
- *Judicial Authorization*
- *Spousal and Parental Authorization* (notification or consent)
- *Lack of Mechanism for Review of Denied Authorizations*

#### Economic Barriers

- *Affordability* (service costs, additional patient fees, extortion, lack of exceptions)
- *Exclusionary Private and Public Insurance Policies*
- *Government or Public Resources* (failure to commit adequate public resources)

#### Information Barriers

- *Lack of Knowledge among Providers on Legal Status of Abortion and Related Administrative Regulations* (fear of criminal prosecution)
- *Lack of Knowledge among Women on Legal Status of Abortion*
- *Failure to Disseminate Public Information on Available Legal Abortion* (to counter use of euphemisms, ensure information provided in a manner that respects privacy of providers)
- *Failure to Develop Standards and Protocols for Abortion Service Delivery and Technologies* (permitted abortion technologies, providers and facilities)
- *Gatekeepers that Seek to Block Access* (switchboard operators, nurses, counsellors)

#### Stigma Barriers

- *Community Norms and Attitudes*
- *Mistreatment in Clinical Setting* (paternalistic tradition in delivery of health services)
- *Provider, Peer and Public Disapproval*

## **(2) Consequences of Access Barriers**

- *Long Waiting Periods* (receive abortion services later in gestation with attendant health risks or denied or limited access due to gestational limits)
- *Require Women to Seek Services from Private Facilities* (higher and private fees)
- *Require Women to Seek Services in Other Jurisdictions* (reproductive tourism.<sup>6</sup> Results in: unnecessary costs; delay; and time away from work or family obligations. Discrimination: privilege of wealth, legal immigration status)
- *Require Women to Seek Services Outside the Formal Health-Care System*
- *Require Women to Carry Pregnancy to Term*

## **(3) Recommendations for Reform, such as:**

- *Ensuring Non-Discriminatory Access to Abortion Services*
- *Ensuring Access to Humane Post-Abortion Care*
- *Improving Counselling Process*
- *Ensuring Access to Complete, Accurate, and Timely Information about Abortion and Abortion Facilities*
- *Enhancing Public Education and Information Dissemination around the Idea of Safe Abortion*
- *Drafting and Implementing Guidelines on Access to Legal Abortion*
- *Considering Measures to Address the Lack of Facilities Providing Abortion Services*
- *Increasing Number of Staff Trained in Abortion Services*
- *Investigating and Disciplining Public Officials who are Abusive or Neglectful in their Provision of Abortion Services*
- *Emphasizing the Importance of Quality of Care*
- *Building Community Consent for Abortion through Negotiation and Dialogue*

---

<sup>6</sup> See e.g. International Planned Parenthood Federation, *Abortion Legislation in Europe* (2004).

## ACCESS TO ABORTION REPORTS

### AFRICA

#### Ethiopia

Report by Zewdu Alem, Inter Africa Group, Addis Ababa, Ethiopia (1996) (on file with the Center for Reproductive Rights).

#### Ghana

Lassey, A.T. "Complications of Induced Abortion and Their Preventions in Ghana" (1995) 72(12) East Africa Medical Journal 774-777.

#### South Africa

Centre for Health Systems Research and Development. *Assessing Termination of Pregnancy by Minors in the Free State: Identifying Barriers and Possible Interventions: Four Reports* (Republic of South Africa: Ipas, 2005). Available at: <http://www.ufs.ac.za/faculties/content.php?id=113&FCCode=01&DCCode=161>

Objective: to identify and describe barriers that minors face in accessing termination of pregnancy services in the Free State province.

Restatement of law: the *Choice on Termination of Pregnancy Act* ("CTOPA") was passed and took effect from 1 February 1997. It recognizes the right of women to choose to have an abortion as part of the exercise of their right to reproductive health.

Barriers to access: lack of awareness about reproductive and sexual matters; lack of awareness about the right to abortion and location of services; inaccessible reproductive and sexual health services (lack of youth-friendly services; conscientious objection; lack of facilities, distance from facilities, transportation and poverty; quality of services); unequal gender power relations; community norms and attitudes.

Recommendations for reform include:

- undertaking an information campaign on abortion to educate communities about its availability and the location of providers offering such services;
- educating all health care workers about the CTOPA and its legal implications (e.g. re-introduce values clarification workshops for all health care workers);
- considering out-sourcing post-counselling services or decentralising post-counselling to more health care facilities in the Free State;
- developing a strategy for introducing psychological support for abortion service providers;
- considering measures to address the lack of facilities providing abortion services;
- determining why not all designated facilities are providing abortion services and what needs to be made available for these facilities to provide abortion services;
- formulating protocols to guide the functioning of abortion facilities, as well as the management and treatment of abortion clients.

Secondary Source: Engelbrecht, Michelle Catherine *et al.* "The Implementation of the Choice on Termination of Pregnancy Act: Some Empirical Findings" (2000) 23(2) Curatoris 4-14.

Barriers to access: inadequate post-counselling and to a lesser extent pre-counselling; unsatisfactory abortion facilities (e.g. insufficient number of consultation and counselling rooms); failure to refer.

Recommendations for reform include:

- ensuring abortion procedures are performed at clinics/hospitals;
- increasing the number of trained staff;
- ensuring facilities are adequate and accessible;
- ensuring psychological support for staff.

### Secondary Sources:

Althaus, Frances. A. “Work in Progress: The Expansion of Access to Abortion Services in South Africa Following Legalization” (2000) 26 *International Family Planning Perspectives* 84-86.

Restatement of law: CTPA granted women the right to obtain an abortion on request during the first 12 weeks of pregnancy.

Barriers to access: geographical disparity in facility availability; lack of knowledge on legal status of abortion; community norms and attitudes; limited availability of abortion facilities and skilled providers (e.g. women still travel long distances to obtain abortion services); delays.

de Roubaix, M. “Ten Years Hence – Has the South African Choice on Termination of Pregnancy Act, Act 92 of 1996, Realised its Aims: A Moral Critical Evaluation” (2007) 26(1) *Medicine and Law* 145-177.

Dickson, Kim Eva *et al.* “Abortion Service Provision in South Africa Three Years after Liberalization of the Law” (2003) 34(4) *Studies in Family Planning* 277-284.

Objective: to present findings of a survey undertaken to describe the availability and accessibility of abortion services in 1999, three years after the abortion law was passed.

Restatement of law: the CTOPA permits termination of pregnancy upon a woman’s request during a period of up to and including twelve weeks of gestation, under certain defined circumstances from the thirteenth to the twentieth week of gestation, and in limited circumstances after the twentieth week of pregnancy.

Barriers to access: gross inequality (geographic distribution) in service availability; some facilities equipped to perform abortion service do not provide those services; long waiting times; women required to travel long distances to access abortion services.

Recommendations for reform include:

- training midwives and general practitioners to provide abortion services;
- providing more services at the primary-care level;
- implementing information campaigns on the topics of abortion rights and the provisions of the new law;
- developing Department of Health directives;
- determining provincial norms for first- and second-trimester abortion, and monitoring compliance with these norms.

Engelbrecht, Michelle Catherine. *Thesis Dissertation: Termination of Pregnancy Policy and Services: An Appraisal of the Implementation and Operation of the Choice on*

*Termination of Pregnancy Act (92 of 1996)* (2005). Available: <http://etd.uovs.ac.za/ETD-db/theses/available/etd-08212006-132756/unrestricted/EngelbrechtMC.pdf>

Hansson, D. & Russel, D.E.H. "Made to Fail: The Mythical Option of Legal Abortion for Survivors of Rape and Incest" (1993) 9 *South African Journal on Human Rights* 500-524.

Restatement of law: The *Abortion and Sterilization Act* criminalizes abortion in all circumstances, except where: (1) the continuation of the pregnancy endangers the life or constitutes a serious threat to the women's physical health; (2) the continuation of the pregnancy constitutes a serious threat and creates a danger of permanent damage to the woman's mental health; (3) where there is a serious risk that the child to be born will suffer from a physical or mental defect, causing serious irreparable handicap; (4) when the pregnancy is shown to be the result of rape or incest; (5) when a foetus is conceived by a woman who due to a permanent mental handicap or defect is unable to comprehend the consequential implications of or bear the parental responsibility for the infant.

Barriers to access: androcentric nature of law, both in books and in practice; 'roadblocks' to women's access to decision-making authority, education, information and other human and material resources necessary to utilize available legal options; discriminatory access (discrimination against women in general, and perpetuation of existing race and class discrimination among women); male-dominated and victim-blaming medico-judicial system; gatekeepers of legal abortion (doctors and magistrates).

Recommendations for reform include:

- providing for the right to legal abortion on request, and without medical authorization;
- ensuring that all women, and especially those most oppressed, are made aware of this right;
- ensuring women have easy, inexpensive or free access to the requisite medical resources.

Harrison, Abigail. *et al.* "Barriers to Implementing South Africa's Termination of Pregnancy Act in Rural Kwazulu/Natal" (2000) 15(4) *Health Policy and Planning* 424-431.

Objective: to explore attitudes and beliefs about abortion and the CTOPA among primary care nurses and community members in a rural district in order to better understand barriers to implementation of the new law.

Restatement of law: under the CTOPA, abortion is legal upon request by women prior to twelve weeks gestation, up to which point trained midwives can provide the service. The Act further provides for abortion from thirteen to twenty weeks gestation on physical and mental health grounds if performed by a doctor who is of the opinion that the pregnancy poses a risk to the woman, that the foetus may suffer a physical or mental abnormality, that the pregnancy results from rape or incest, or that the continued pregnancy would affect the social or economic circumstances of the mother.

Barriers to access: community norms and attitudes; provider refusal to provide abortion services; lack of awareness of legal status of abortion; absence of professional awareness and confusion amongst nurses.

Recommendations for reform include:

- implementing measures in addition to legalization abortion;
- locating abortion within broader reproductive health services;
- enhancing public education and information dissemination around the idea of safe abortion as a critical intervention for improving women's health;
- emphasizing the importance of quality of care;



- building community consent for abortion through negotiation and dialogue.

Jewkes, Rachel K. *et al.*, “Why are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa?” (2005) 112(9) BJOG: An International Journal of Obstetrics and Gynaecology 1236–1242.

## **Uganda**

Singh, Susheela *et al.* *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences* (New York: Guttmacher Institute, 2006).

Objective: to make the new findings on abortion and unintended pregnancy available to policymakers, health planners, health care providers, advocates for women, educators and other concerned individuals; to increase awareness about the complex causes and far-reaching consequences of unintended pregnancy; and to encourage the development of programs and policies aimed at reducing both unintended pregnancy and unsafe abortion in Uganda.

Restatement of law: abortion is banned in Uganda except to save a woman’s life.

Barriers: poverty (wealthy women can obtain services of trained healthy professionals); stigma surrounding abortion; lack of education; severe legal restrictions on lawful abortion; community norms and attitudes; low status and limited decision-making power of women.

Recommendations for reform include:

- considering and debating strategies to address the high levels of unsafe abortion and low levels of contraceptive use;
- increasing the financial resources available to improve reproductive health care and to increase contraceptive use;
- directing resources to improve the availability and quality of postabortion care for women with complications;
- broadening training in the use of manual vacuum aspiration;
- conducting education in schools and other community settings, as well as through the mass media, emphasizing the health and societal benefits of family planning;
- improving knowledge about, access to and use of effective contraceptives;
- enlisting men in efforts to improve reproductive health conditions among couples in Uganda.

## **Zambia**

Castle, Mary Ann. *et al.* “Observations on Abortion in Zambia” (1990) 21 Studies in Family Planning 231-235.

Objective: report describes the findings of a preliminary investigation of women who sought treatment for abortion from the Gynecological Emergency Ward at the University Teaching Hospital (UTH) in Lusaka, Zambia.

Barriers to access: discriminatory access (poor women); lack of knowledge amongst poor women regarding abortion process; physician reluctance to schedule abortions; conscientious objection; community norms and attitudes; delays.

Recommendations for reform include:

- improving qualitative research on reproductive health care delivery for women who seek abortion.

Koster-Oyekan, Winny. “Why Resort to Illegal Abortion in Zambia? Findings of a Community-Based Study in Western Province” (1998) 46(1) *Social Science & Medicine* 1303—1312.

Objective: to present part of the findings of a community-based study on the causes and effects of unplanned pregnancies in four districts of Western Province, Zambia.

Restatement of law: abortion in Zambia is legal on social and medical grounds under the 1972 *Termination of Pregnancy Act*.

Barriers to access: community norms and attitudes; geographic disparity in facility availability; economic barriers (affordability); conscientious objection; unnecessary provider restrictions.

Recommendations for reform include:

- improving access to abortion services (affordable, confidential, safe, and legal abortion services should be available to safeguard women from dangerous, illegal abortions);
- adapting abortion legislation to local circumstances;
- encouraging legal abortion providers to act as medical professionals and assist women seeking abortion;
- reminding health staff of the medical ethics of patient confidentiality;
- making people aware of their rights and available services;
- ensuring free provision of abortion services.

## **ASIA PACIFIC**

### **Australia**

Australia. *Royal Commission on Human Relationships. Final Report. Volume 3, Part IV. Sexuality and Fertility* (Canberra: A.G.P.S., 1977), 134-220 (Members: Elizabeth Evatt, Felix Arnott and Anne Deveson).

Department of Health (Western Australia). *Report to the Minister for Health on the Review of Provisions of The Health Act 1911 and The Criminal Code Relating to Abortion as Introduced by the Acts Amendment (Abortion) Act 1998 (2002)*. Available at: <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>

Object: to review the operation and effectiveness of the provisions of the *Health Act 1911* and the *Criminal Code* related to abortion.

Restatement of law: abortion up to 20-weeks of pregnancy is justified if the woman has given informed consent to the procedure. Abortion is also available, provided the woman gives informed consent, where there exists: serious personal, family or social consequences if the abortion is not performed; serious danger to the pregnant woman’s physical or mental health if the abortion is not performed; or the pregnancy of the woman is causing serious danger to her physical or mental health.

Barriers to access: intimidation from protestors at abortion facilities; provider refusal to give information on abortion services for personal, moral or religious reasons; refusal to refer patients seeking abortion.

Recommendations for reform include:

- reviewing effectiveness of information provided to Medical Practitioners and establishing mechanism to monitor medical practitioners’ knowledge regarding legal requirements for informed consent;
- considering role of specially trained Advanced Practice Nurses in providing medical risk

- counselling;
- producing evidence-based guidelines concerning medical risks of abortion;
- investigating gaps and proposing strategies to address gaps in availability of counselling and support services;
- conducting audit addressing quality of care for women requiring an abortion.

## **Fiji**

Fiji. *Second Report of the Senate Select Committee on Population Trends in Fiji: A Review and Recommended Revisions of Abortion Laws in Fiji* (Suva, Government Printing Department, 1976) (Parliamentary Paper No. 15 of 1976).

## **Indonesia**

Djohan, Eniarti. *et al.* “The Attitudes of Health Providers Towards Abortion in Indonesia” (1993) 1(2) *Reproductive Health Matters* 32-40.

## **New Zealand**

Abortion Supervisory Committee. *Report of the Abortion Supervisory Committee for 1998* (Wellington: Abortion Supervisory Committee, 1998).

New Zealand. *Contraception, Sterilisation and Abortion in New Zealand: Report of the Royal Commission of Inquiry* (Wellington: Government Printer, 1977) (Chair: McMullin).

## **CARIBBEAN**

### **Barbados**

Barbados. *Report of the National Committee on the Law of Abortion* (Bridgetown, 1975).

### **Guyana**

Secondary Source: Nunes, Frederick E. & Yvette M. Delph, “Making Abortion Law Reform Happen in Guyana: A Success Story” (1995) 6 *Reproductive Health Matters* 12-23.

### **Trinidad and Tobago**

Aspire. *Toward Responsible Parenthood, An Appeal for the Review of the Legal Status of Abortion* (Trinidad and Tobago, 2002).

## **EUROPE**

### **Belgium**

Vrancken, C. “The Complications and Compromise of Abortion Services in Belgium” (1997) 26(1) *Choices: Sexual Health and Family Planning in Europe* 21-24

## Bulgaria

Vasliev, D. Tridset Godini Legalno Izkutveno Prekusvane na Bremennostta v Bulgariia: Izuvdi I Problemi (Thirty years of legal induced abortion in Bulgaria: conclusions and problems) (1988) 27(1) Akushestvo I Ginekologia 1-10 (in Bulgarian with English summary).

## Netherlands

Visser, M. & A. Janssen a.o. *Evaluatie van de Wet afbreking zwangerscahp* (ZonMw, The Hague, 2005), cited in Sjef Gevers, "Abortion Legislation and the Future of the 'Counseling Model'" (2006) 13(1) European Journal of Health Law 27-40, at 35.

Barriers to access: compliance with Abortion Act was satisfactory; health professionals did what the law required from them; abortion services are available and accessible where needed and are of good quality.

Recommendations for reform include:

- instead of mandating an explicit discussion of alternatives, implementing measures to oblige the physician to ascertain that there are no viable alternatives for the woman;
- improving the counseling process;
- carrying out research on how counseling takes place and on the best ways to improve it;
- further developing protocols;
- considering measures to enhance the competence of the professionals involved;
- considering measures to improve quality of counselling at short notice, including referral to psychosocial experts in the more complex cases.

## Poland

*The Federation for Women and Family Planning. Reproductive Rights in Poland: The Effects of the Anti-Abortion Law: Report 2008* edited by Wanda Nowicka, (Warsaw: Polish Federation for Women and Family Planning, 2008),

This report analyzes the legal issues and regulations involved in reproductive rights and reviews court cases conducted in Poland and the European Court of Human Rights. It shows the real effects of the current law and social policy with regard to termination of pregnancy, family planning and sexual education. It also presents the perspectives of health service providers and the role of doctors in restricting access to reproductive health services. Finally, the report publishes guidelines for Poland from international institutions which aim to improve the respect for human rights regarding reproductive health issues.

Polish edition: [http://www.federa.org.pl/monitoring/federa\\_raport.PDF](http://www.federa.org.pl/monitoring/federa_raport.PDF)

English edition: [http://www.federa.org.pl/publikacje/report%20Federa\\_eng\\_NET.PDF](http://www.federa.org.pl/publikacje/report%20Federa_eng_NET.PDF)

The Federation for Women and Family Planning. *The Anti-Abortion Law in Poland: The Functioning, Social Effects, Attitudes and Behaviours* (Report 2000, Warsaw). Available: <http://www.federa.org.pl/english/reports/report00/index.htm>

Restatement of law: Polish regulations allow for abortion if: the pregnancy constitutes a threat to the woman's life or health; there is a high probability of severe and irreversible damage to the

foetus or of an incurable disease, life-threatening of a child; the pregnancy is a result of a criminal act, and the woman is less than 12 weeks pregnant.

Barriers to access: majority of abortions conducted in private clinics or offices, and are very expensive; restrictive regulations; health providers and general public have little knowledge of law or the circumstances in which abortion is legal; concern regarding peer and public disapproval.

Dysfunctions or unintended consequences: require women to seek services outside the formal health-care system (illegal abortions are very expensive); require women to seek services in other jurisdictions; health and personal trauma for hundreds of thousands of women in Poland.

Recommendations for reform include:

- reforming legal regulations on abortion;
- securing appropriate health and educational policies, guaranteed by international obligations, which will aim to help women to prevent unwanted pregnancies.

Secondary Source: Françoise Girard & Wanda Nowicka, “Clear and Compelling Evidence: The Polish Tribunal on Abortion Rights” (2002) 10(19) *Reproductive Health Matters* 22-30.

Restatement of law: The Act allows abortions to be performed legally in three circumstances: (1) where the pregnancy constitutes a threat to the life or health of the woman; (2) where antenatal screening or other medical evidence indicates a high probability of severe, irreversible damage to the foetus or an incurable, life-threatening disease affecting the foetus; (3) where there is a confirmed suspicion that the pregnancy is a result of a criminal act.

Barriers to access: health profession and public in general have little knowledge of the content of the law; financial barriers (affordability); reduced number of legal abortions performed following introduction of restrictive abortion law; provider peer and public disapproval.

Dysfunctions or unintended consequences: abortion pushed underground; women's health endangered; women unable to access services to which they are legally entitled; undue suffering for women and their families; abortion tourism.

Recommendations for reform include:

- liberalizing abortion law.

The Federation for Women and Family Planning. *The Effects of the Anti-Abortion Law* (Report No. 2, 1996). Available at: <http://www.federa.org.pl/english/report96/index96.htm>

Restatement of law: Polish regulations allow for abortion: if the pregnancy constitutes a threat to the woman's life or health; if the pre-natal examination or other medical reasons point to a high probability of severe and irreversible damage to the foetus or of an incurable disease, life-threatening of a child; if there is a confirmed suspicion that the pregnancy is a result of a criminal act, and the woman is less than 12 weeks pregnant.

Barriers to access: absence of dispute resolution mechanisms; failure to regulate conscientious objection; failure to refer; community norms and attitudes; fear of prosecution.

Dysfunctions or unintended consequences: require women to seek services in other jurisdictions; require women to seek services outside the formal health-care system.

The Federation for Women and Family Planning. *The Consequences of the Anti-Abortion Law*, (Report No. 1, 1994).

## Romania

Institute for Mother and Child Care and Centers for Disease Control and Prevention (CDC). *Romania Reproductive Health Survey 1993: Final Report* (Bucharest, Romania: Institute for Mother and Child Care and CDC, 1995).

## Spain

**ACAI, (the Association of Clinics authorized for interruption of pregnancy) *La Interrupción de la Gestación: Un derecho sexual y reproductivo básico: Memoria descriptiva ACAI: 10 años de trabajo en el ámbito de la Salud Sexual y Reproductiva [Interruption of Pregnancy: A basic sexual and reproductive right]*** (Madrid: Asociación de clínicas acreditadas para la interrupción del embarazo, April 2008) 59 pages. <http://www.acaive.com/pdf/ACAI%20Memoria.pdf>

This memoir summarizes the goals, efforts and achievements of the men and women professionals from the Association of Clinics Accredited for the Interruption of the Pregnancy since the beginning of the association. This summary of more than ten years of work includes political and social incidents in the accredited centres, international collaboration and projects (especially through the International Federation of Professional Abortion and Contraception Associates (FIAPAC)) and the influence of our medical and health efforts. There is also a list of ACAI's main publications and research in the sexual and reproductive health area generally and particularly in interruption of pregnancy.

This memoir also tries to explain the current crisis in abortion access that is being experienced in Spain. The Spanish "anti-choice" movement is acting with an unusual virulence against the professionals and women who have had an abortion. This pressure has been supported by some politicians, judges and some parts of the media. This situation has caused the social and political mobilization of accredited centres, feminist organizations, trade unions, some political parties, jurist's associations, etc., who have pressured the Spanish Government to such an extent that the Spanish Executive is considering abortion law reform.

The law in Spain (1985) permits termination of pregnancy in the following circumstances:

- Until the twelfth week when the pregnancy is a consequence of rape.
- Until the twenty-second week, if the foetus suffers from a severe physical or mental abnormality, accredited by two doctors other than the doctor who will perform the abortion.
- There is no time limit in cases where the physical or mental health of women is at risk.

The legislative conditions and the omission of a clear definition of "health" in this law, make the Spanish Law ambiguous and insecure. This circumstance is enabling pursuit and persecution against women and healthcare professionals that have made possible the choice of abortion in this country over the last 22 years.

Recommendations for reform:

ACAI advocates clarification of the law in terms that do not question the basic health benefit of abortion, recognized by our National Health System and provided to women free of charge by publicly-funded in ACAI clinics or public hospitals.

A law that offers the professionals of the Authorized Centres for the Interruption of Pregnancy the necessary legal security for the exercise of their work and for the women who entrust them with their privacy, their security and their health...

For ACAI, abortion is only one element of sexual and reproductive health. Sexual education of youth and adolescents should be included in the curriculum of the educational system. Also indispensable is the development of sexual education programs specifically aimed at the community of immigrants who have specific peculiarities

Universal access to different birth-control methods and family planning centres should be rigorously facilitated and improved.

For all this, ACAI asks the Administration, political forces and government authorities to ensure:

1. The right of women to choose abortion as a basic health right, within the law, using the broad definition of “health and well-being” used by the World Health Organization.
2. The physical security of abortion providers will be guaranteed for the professionals who have made the right to abortion accessible in Spain for more than 20 years.
3. Political forces facilitate the necessary social consensus to reform and clarify abortion legislation to legitimize abortion and reflect the existing needs for legal abortion our society.
4. The law should clearly define “fetal viability” and “severe fetal abnormality” and specify the indications of each.

### **United Kingdom**

Ministry of Health, Home Office. *Report of the Inter-Departmental Committee on Abortion* (London, UK 1939) (Chair: Norman Birkett).

Secretary of State for Health by Command of Her Majesty. *Health Select Committee's Third Report of Session 2002-03 on Sexual Health* (2003).

United Kingdom, *Report of the Committee on the Working of the Abortion Act* (the Lane Report). Three volumes. (London: Secretary of the State for Social Services, 1974) (Chair: Lane).

#### **Secondary Sources:**

See description of the Lane Report and Access to Abortion in: Gayle Davis & Roger Davidson, ““A Fifth Freedom” or “Hideous Atheistic Expediency”? The Medical Community and Abortion Law Reform in Scotland, c.1960–1975” (2006) 50 *Medical History* 29-48.

Temkin, J. “The Lane Committee Report on the Abortion Act” (1974) 37(6) *Modern Law Review* 657-663.

Wivel, Ashley. "Abortion Policy and Politics on the Lane Committee of Enquiry, 1971–1974" (1998) 11(1) *Social History of Medicine* 109-135.

## **LATIN AMERICA**

### **Argentina**

Human Rights Watch. *Decisions Denied: Women's Access to Contraceptives and Abortion in Argentina* (New York: Human Rights Watch, 2005). Available: <http://hrw.org/reports/2005/argentina0605/>

Objective: to document the consequences of Argentina's restrictions on women's reproductive rights.

Restatement of law: Argentina's penal code stipulates that abortion is a crime in all circumstances, though the penalty may be waived if the life or health of the pregnant woman is in danger or if the pregnancy results from the rape of a mentally disabled woman. In practice, such 'nonpunishable' abortions are rare because there are no clear policies regulating access.

Barriers to access: failure to implement existing abortion law; lack of guidelines or regulations to ensure women's access to legal abortion; lack of medical accountability; fear of criminal prosecution or of being reported to authorities; imprisonment; discriminatory access.

Dysfunctions or unintended consequences: women forced to result to illegal and unsafe abortions, with resulting health consequences for women; inadequate or inhumane post-abortion care; excessive scrutiny of miscarriages.

Recommendations for reform include:

- protecting women's human rights to health, life, nondiscrimination, privacy, physical integrity, information, liberty, freedom of religion and conscience, equal enjoyment of rights, equal protection under the law, and the right to make decisions about the number and spacing of children;
- undertaking longer-term legal and policy reforms to legalize abortion and eradicate violence against women;
- ensuring women's access to complete, accurate, and timely information about contraceptives;
- ensuring women's access to a full range of contraceptives—including sterilization;
- guaranteeing access to voluntary safe abortion where the penal code waives the punishment;
- ensuring access to humane post-abortion care.

López, E. & A. Masautis. "Aborto en el Conurbano de Buenos Aires: Opiniones, Evidencias e Interrogantes" in *Encuentro de investigadores sobre aborto inducido en América Latina y el Caribe* (Research symposium on induced abortion in Latin America and the Caribbean) (Santafé de Bogotá, D.C. Colombia, Universidad Externado de Colombia, 1994).

Barriers: family planning services are more accessible for wealthier women than for those in low-income categories. Poorer women tend to have unsafe or illegal abortions more often than wealthier women.

### **Guatemala**

Prada, Elena. *Abortion and Postabortion Care in Guatemala: A Report from Health Care Professionals and Health Facilities* (Guttmacher Institute, 2005).



Objective: to address clandestine abortion in Guatemala. This report details the findings of a study that aimed to describe and quantify the level of under-ground abortion activity.

Restatement of law: induced abortions are illegal in Guatemala, except for those that are necessary to save the life of the pregnant woman.

Barriers to access: shortage of well-trained providers; widespread practice of traditional medicine; inadequate provider resources; discriminatory access to abortion for poor, rural and indigenous women.

Dysfunctions or unintended consequences: women resort to illegal abortion, with attendant health risks; no official data are available to measure extent of abortion.

Recommendations for reform include:

- strengthening efforts to make family planning services accessible and affordable;
- working with education authorities to improve family planning knowledge and improve post-abortion care;
- undertaking further research to document women's experiences and perspectives regarding unsafe abortion, as well as clinical aspects of post-abortion care;
- improving post-abortion care.

## Mexico

Human Rights Watch. *The Second Assault: Obstructing Access to Legal Abortion after Rape in Mexico* (New York: Human Rights Watch, 2006). Available: <http://www.hrw.org/reports/2006/mexico0306/>

Objective: to address barriers in accessing legal abortion after rape in Mexico.

Restatement of law: several Mexican states permit legal abortion after rape.

Barriers to access: (1) *States with no administrative guidelines for abortion after rape:* non-existing or inaccurate information on legal abortions; denial that cases of unwanted pregnancy after rape exist; aversion to facilitating legal abortion after rape; actively discouraging abortion after rape; no legal abortion for incest and "estupro;" undue delays; intimidation in the justice sector. (2) *States with administrative or legal guidelines for abortion after rape:* unduly complicated procedures; illegal delays; lack of information or biased information; "covert" provision of abortion services and continued stigmatization; intimidation in the health sector; need for accompaniment; (3) Conscientious objection by medical professionals.

Dysfunctions or unintended consequences: many women/girls opt for clandestine abortions, with attendant health risks; pressure on girls to leave school; underage victims thrown out of homes, or threatened with eviction.

Recommendations for reform include:

- proactively investigating and disciplining public officials who are abusive or neglectful in their provision of services to victims of domestic and sexual violence;
- providing guidelines on access to legal abortion in states where they do not exist;
- reviewing guidelines to ensure their effectiveness and appropriateness;
- providing adequate and continuous training for public officials on the obligation to facilitate access to adequate information regarding legal abortion and access to abortion services.

## **MIDDLE EAST AND NORTH AFRICA**

### **Israel**

*Report of the Committee for the Study of the Ban on Induced Abortions*, (1974) 17(4) Briyut Hatsibur (Hebrew).

Halpern, B. & Wollstein, M. "A Report on Six Months Experience of Committee for the Control of Abortion" (1975) 2(3-6) *Mental Health & Society* 205-211.

### **Turkey**

Secondary Source: Pinter et al. "Accessibility and Availability of Abortion in Six European Countries" (2005) 10(1) *The European Journal of Contraception & Reproductive Health Care* 51 – 58, at 56.

Barriers to access: geographic distribution (accessibility of the abortion service in Turkey mainly depends on the region); absence of training specialists in rural health facilities.

Dysfunctions or unintended consequences: rural woman may be unable to obtain abortion.

## **NORTH AMERICA**

### **Canada**

CARAL. *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion* (Ottawa: Canadian Abortion Rights Action League, 2003).

Objective: to gather reliable data on the situation of Canadian women seeking abortion; provide information on the number of general hospitals providing abortion services; provide information on barriers in accessing abortion services.

Restatement of law: abortion was decriminalized in 1988 and is acknowledged by Canada's Supreme Court and government as a medical procedure covered under the Canada Health Act (CHA, 1984). All women, regardless of age, economic status, or place of residence, are to have access to the procedure.

Barriers to access: geographic distribution (women in rural areas have to travel for procedure, and don't have access to follow-up services); hospital policy (gestational limits, age of consent, options counselling); long wait periods; "gatekeepers" to the information women need in order to access abortion services (switchboard operators); anti-choice doctors: give misinformation, lie about services, don't refer to a provider, delay appointments until pregnancy is too far along; lack of information re: access to services, health care coverage, and legal rights; need for confidentiality (especially in rural areas); anti-choice "counselling" centres; family/partner coercion; referral process: referrals to anti-choice organizations; referrals from family doctor is necessity which poses a problem when many doctors are anti-choice; information from hospitals is difficult to obtain because of security issues due to threats of violence and harassment.

Dysfunctions or unintended consequences: delays and lack of information force women to carry pregnancies to term; limited hospital availability leading to long waiting lists, or need for travel, resulting in unnecessary costs, and significant time away from work or family obligations; women are referred to anti-abortion organizations.

Recommendations for reform include:

- implementing a zero tolerance policy for employees purposely denying access to abortion;
- funding cuts to anti-abortion “pregnancy counselling centres;”
- all individuals involved in any official communication of a hospital with the public must be aware of that hospital’s policy and procedures regarding abortion services;
- implementing provincial regulations requiring publicly funded hospitals with surgical facilities to provide abortion services;
- governments and hospitals must make information on abortion easily available to the public;
- collecting and publishing information on the number and location of abortion facilities;
- establishing a national information helpline on location of nearest abortion provider;
- medical schools should acknowledge that abortion is an integral part of reproductive health care and students must be educated on the importance of providing access;
- withholding transfer payments for New Brunswick, Nova Scotia, Quebec and Manitoba for their refusal to cover clinic abortions under Medicare;
- designating anti-abortion acts of violence and harassment as Hate Crimes under the Criminal Code.

Bowes, N. *et al. Access Granted, Too Often Denied: A Special Report to Celebrate the 10th Anniversary of the Decriminalization of Abortion* (Ottawa: Canadian Abortion Rights Action League, 1998).

Canada. *Report of the Committee on the Operation of the Abortion Law* (Ottawa: Minister of Supply and Services Canada, 1977) (Chair: Robin Badgley).

Objective: to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada.

Restatement of law: induced abortion was prohibited by the Canadian Criminal Code except when performed in an accredited hospital on the prior approval of a therapeutic abortion committee that abortion is necessary to protect life or health.

Barriers to access: referral process: delays, non-referral to hospitals with committee; restrictive criteria of committee (differ depending on hospital); lack of accredited facilities; objection of providers to perform procedure; additional patient fees; uncertainty regarding terms of the law and concept of “health;” geographic distribution (no access to services in rural areas).

Dysfunctions or unintended consequences: women seeking procedure in the U.S.

Recommendations for reforms include:

- establishing a partnership with U.S. to list numbers of Canadian women going to U.S., determine the quality and safety of services provided and document reasons for not having procedure done in Canada;
- implementing new and different approaches to sex education;
- ensuring greater allocation of resources by all levels of government and voluntary associations for the support of family planning programs;
- finding ways to reduce the social inequities which are associated with obtaining therapeutic abortions in Canada;
- providing abortions in specialized units with specially trained nurses and medical personnel.

Canada, Department of Justice, Law and Government Division. “Abortion: Constitutional and Legal Developments,” Reviewed August 18, 1998, by Mollie Dunsmuir.

<http://www.publications.gc.ca/Collection-R/LoPBdP/CIR/8910-e.htm>

British Columbia, Minister of Health and Minister Responsible for Seniors. *Realizing Choices: Report of the British Columbia Task Force on Access to Contraception and Abortion Services* (Victoria: Minister of Health, 1994).

Northwest Territories, Department of Health. *Status Report: Implementation Plan for Recommendations of the Abortion Services Review Committee* (Yellowknife, NWT, 1993).

Northwest Territories, Ministry of Health, Abortion Services Review Committee. *Report of the Abortion Services Review Committee* (Yellowknife NWT, 1992).

Ontario Ministry of Health, Task Group of Abortion Service Providers. *Report on Access to Abortion Services in Ontario* (Toronto: Queens Park, 1992).

Ontario Ministry of Health. *The Joint Provincial Committee on the Report of the Committee on the Operation of the Abortion Law. Report of the Committee on the Operation of the Abortion Law* (Chair: G.G. Caudwell, 1977).

Ontario Ministry of Health. *Report on Therapeutic Abortion Services in Ontario* (Ottawa: Minister of Supply and Services, 1987) (Chair: Marion Powell).

Objective: to review access to therapeutic abortion services in Ontario public hospitals.

Restatement of law: Canadian Criminal Code prohibited all abortions except when performed in an accredited hospital on the prior approval of a therapeutic abortion committee that abortion is necessary to protect life or health.

Barriers to access: availability of physicians willing to make referrals and perform procedure; availability of hospitals with therapeutic abortion committees; restrictive criteria of committee; availability of operating room time for procedure; costs, including charges to patients for non-insured services and travel and accommodations costs to facility; negative attitudes in the community and among health professionals.

Recommendations for reforms include:

- ensuring use of trained general practitioners to provide services;
- ensuring more effective use of techniques recognized for reducing the incidence of post abortion complications;
- providing for a range of abortion services such as: multi-purpose women's clinics; regional centres affiliated with but not necessarily located in a hospital; inter-hospital counselling and referral centres; satellite medical services which travel to smaller communities;
- enhancing and encouraging existing abortion services;
- developing alternative means to reimburse physicians for abortion related services;
- increasing funding to public health units to expand family planning programs, clinics, sex education, and counselling;
- recognizing the need for financial assistance to cover transportation and accommodation costs for women who must travel to obtain abortion services;
- funding research projects examining alternate abortion techniques.

Jessica Shaw, *Reality Check: A close look at accessing abortion services in Canadian hospitals* (Ottawa: Canadians for Choice, 2006). Available:

<http://www.canadiansforchoice.ca/report.html>

Objective: Report focuses on the accessibility of hospital abortion services in Canada (with a provincial and territorial analysis). Report seeks to generate discussion and awareness.

Restatement of law: Abortion was decriminalized in Canada in 1988. Since 1988, abortion has been considered a private medical matter between a woman and her doctor. All women are to have access to the procedure.

Barriers to access:

- lack of trained providers (fear of harassment from anti-choice groups, decreased time spent in medical school training on abortion,
- hospital mergers with Catholic, antichoice hospitals);
- geographical disparity (accessibility of abortion services, wait-times, gestational limits and availability of counseling varies drastically across Canada);
- affordability (unexpected costs, travel time and other expenses);
- reciprocal billing issues (provinces refusing to cover costs of out of province abortions); unknowledgeable hospital staff (unaware of hospital's abortion policy, unable to refer women effectively);
- judgmental healthcare professionals (antichoice staff who refuse to provide women with relevant information, treat women with disrespect and pass negative judgment);
- conscience clauses (doctor's refusal to refer women to abortion service providers because of their personal beliefs);
- bad referrals (from hospitals, doctors, individuals or organizations);
- voicemail requirements (having to leave a voicemail message to schedule an abortion procedure acts as a barrier for women who do not have phones, do not want those living with them to know of the pregnancy, are in abusive relationships, or question confidentiality);
- anti-choice organizations (present as 'crisis pregnancy centres' and purposely discourage, misinform, and coerce women into not exercising right to abortion).

## SOUTH ASIA

### India

India, Ministry of Health and Family Planning, Department of Family Planning. *Report of the Committee to Study the Question of Legalisation of Abortion* (New Delhi, Government of India Press, 1967).

Ministry of Health and Family Planning (Department of Family Planning). *Report of the Committee to Study the Question of Legalisation of Abortion* (Bombay: Ministry of Health and Family Planning, 1966).

Alternative Citation: Government of India (1966), *Report of the Committee to Study the Question of Legalisation of Abortion (Shantilal Shah Committee Report)*, Ministry of Health and Family Planning, Government of India, New Delhi.

Bandewar, Sunita. "Abortion Legislation and Access to Safe Abortion Care Services: The Indian Experience" in Barbara Klugman & Debbie Budlender, eds., *Advocating for Abortion Access: Eleven Country Studies, Johannesburg* (School of Public Health Women's Health Project, University of Witwatersrand, South Africa, 2001), 135-155.

Barge, Sandhya *et al.* *Formal and Informal Abortion Services in Rajasthan, India: Results of a Situation Analysis* (New Delhi, India: Population Council, 2004). Available: [www.popcouncil.org/pdfs/abortion\\_analysis\\_india.pdf](http://www.popcouncil.org/pdfs/abortion_analysis_india.pdf)

Objective: to conduct a situation analysis of abortion services in both the formal and informal sectors in six districts of Rajasthan.

Restatement of law: under the *Medical Termination of Pregnancy Act in 1971*, women are entitled to legal abortion services in circumstances where there is: physical danger to the mother's health; rape; foetal malformations; potential injury to the mother's mental health; and, among married women, contraceptive failure. Abortion is permitted up to 20 weeks of gestation and no spousal consent is required, although guardian consent is required for women under 18 years of age.

Barriers to access: abortion providers routinely refuse to perform abortions in a number of circumstances, including if a woman presents alone, is married but nulliparous or is unmarried; although not required by law, unnecessary consent of woman's husband and other family members is sought; geographic disparity in facility availability; greater accessibility to informal providers, especially in rural areas; economic barriers (affordability).

Recommendations for reform include:

- improving the quality of abortion services in the formal sector;
- addressing the need for appropriate post-abortion care;
- adopting measures to encourage uncertified facilities to comply with legislative requirements;
- increasing opportunity for training in abortion.

Barua, A. *Study on Availability and Accessibility of Abortion Care, in AAP, Qualitative Studies, Final Report* (2003).

CEHAT. *Informal Providers of Abortion Services: Some Exploratory Case Studies* (2004).

Ganatra, Bela *et al. Medical Abortion in Bihar and Jharkhand: A Study of Service Providers, Chemists, Women and Men* (New Delhi: Ipas, 2005).

Objective: to gauge knowledge and opinions of the potential of medical abortion for early pregnancy termination in two Indian states.

Restatement of law: while misoprostol has long been available in India as a medication for gastric ulcers, mifepristone was registered for use as an abortifacient in early pregnancy in 2002.

Barriers to access: delayed abortion care-seeking; stigmatization of unmarried abortion seekers; skepticism about efficacy of medication abortion; method not effective beyond seven to eight weeks; time and opportunity costs involved in making multiple doctor visits; difficulty in accessing doctor would could provide medication abortion; economic barriers (cost); lack of physical access to trained providers; men as gatekeepers to access.

Recommendations for reform include:

- providing accurate information to all categories of stakeholders;
- increasing training for providers on appropriate use;
- introducing medical abortion into public-sector program;
- taking steps to work with chemists;
- providing accurate information on the innumerable alternative drugs being marketed as abortifacients;
- promoting pregnancy testing.

Visaria, Leela. *et al. Overview and Synthesis of Emerging Issues from the Qualitative Studies*, in *AAP-I Qualitative Studies* (New Delhi, CEHAT and HealthWatch, Tullika Publishers, 2003).

#### Secondary Sources:

Duggal, Ravi & Vimala Ramachandran. "The Abortion Assessment Project: India – Key Findings and Recommendations" 12(24 Supp) (2004) *Reproductive Health Matters* 122-129.

Object: to synthesize the findings of the six facility surveys, two community-based surveys, eight qualitative studies, policy review and commissioned working papers that were produced as part of the Abortion Assessment Project–India.

Restatement of law: under the *Medical Termination of Pregnancy Act of 1971* a woman can legally have an abortion up to 20 weeks of pregnancy if the pregnancy carries the risk of grave physical injury, endangers her mental health, if it results from contraceptive failure in a married woman, or from rape, or is likely to result in the birth of a child with physical or mental abnormalities.

Barriers to access: gross public under-funding of abortion services; inadequate and inaccessible (geographical disparity) safe abortion facilities; dearth of medically approved abortion providers and registered facilities; inadequate post-abortion family planning counselling and services; unsafe abortion is often not perceived as a women's health issue; Government's "do nothing" attitude.

Recommendations for reform include:

- integrating abortion services into primary and community health centres;
- increasing investment in public facilities;
- promoting use of vacuum aspiration and medical abortion;

- convincing providers to stop using curettage;
- broadening the base of abortion providers by training paramedics to do first trimester abortions;
- re-skilling traditional providers to play alternative roles that support women's access to safe abortion services.

Hirve, Siddhivinayak S. *Abortion Policy in India – Lacunae and Future Challenges*. Abortion Assessment Project – India, (CEHAT and HealthWatch, Mumbai, 2004).

Hirve, Siddhivinayak S. “Abortion Law, Policy and Services in India: A Critical Review” (2004) 12(24 Supp) *Reproductive Health Matters* 114-21.

Objective: to critically review the history of abortion law and policy in India since the 1960s and research on abortion service delivery.

Barriers to access: poor regulation of both public and private sector services; a physician-only policy that excludes mid-level providers; geographical disparity in facility availability; poor awareness of the law; unnecessary spousal consent requirements; contraceptive targets linked to abortion; economic barriers (informal and high fees).

Recommendations for reform include:

- training more providers;
- simplifying registration procedures;
- de-linking clinic and provider approval;
- linking policy with up-to-date technology;
- undertaking further research and ensuring good clinical practice.

Jalnawala, S.F. “Medical Termination of Pregnancy ACL: A Preliminary Report of the First Twenty-Month of Implementation” (1975) 25(5) *Journal of Obstetrics and Gynaecology of India*.

Visaria, Leela *et al.* “Abortion in India: Emerging Issues from Qualitative Studies” (2004) 39(46/47) *Economic and Political Weekly* 5044-5052.

## **Nepal**

Government of Nepal Ministry of Health And Population *et al.* *Unsafe Abortion: Nepal Country Profile* (2006).

## **Vietnam**

PATH & Reproductive Health Department, Ministry of Health. *Examining the Cost of Providing Abortion in Vietnam. Research Report* (2006).