



## ABORTION IN EUROPE

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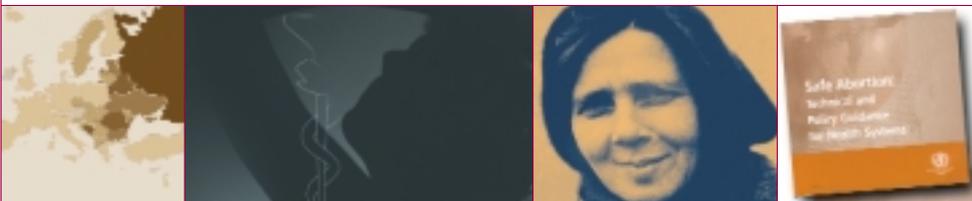
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# EDITORIAL

*Unsafe abortion: Europe is not spared*

Fred Sai



The high expectations for reproductive health, including sexual health and rights, generated by the consensus reached at the International Conference on Population and Development (ICPD) have not been realized, and even the principles on which agreements were based on are being challenged by some governments and religious groups.

The ICPD Programme of Action, agreed on by 179 countries in 1994, begins with the following words: “The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights”. Yet the refusal to apply and respect this statement is the cause of much unnecessary argument, and nowhere is this truer than with regard to contraception and pregnancy termination.

The right to religious freedom, provided by many constitutions, is flagrantly abused by some religious zealots who impose their dogma and ideology on non-adherents, at times by misusing scientific evidence. The imposed exclusion of hormonal contraception, including emergency contraception, and the disingenuous statements about the ineffectiveness of condoms are but a refusal to work according to the fundamental principle of the ICPD Programme of Action. Such propaganda does not matter much to the highly sophisticated, well-informed societies of the advanced countries. But in many countries in the world, where religious doctrine may be what the poor and disempowered live by, such misinformation almost always amounts to a denial of the basic rights to correct information and access to the fruits of modern science.

The United Nations system decided, wisely, not to hold another international conference on population and development to mark the tenth anniversary of the highly successful ICPD. It was obvious from the five-year review to assess progress and subsequent regional reviews that there are forces that would use any opportunity to seek a rewording of the agreed positions rather than a sober assessment of what has been achieved and what more needed to be done.

Partly through the efforts of the same groups, the United Nations Millennium Development Goals, launched in 2000,

omitted any mention of sexual and reproductive health and rights, and thus missed the great opportunity of giving reproductive health the priority it deserves in development planning. It must be stressed that without ensuring that women know and exercise their full sexual and reproductive rights and have full access to the benefits of modern contraception, they will never be equal or able to properly be in control of planning their lives.

Europe is not an exception. Even today, millions of individuals and couples in this Region, particularly in the more deprived countries of central and eastern Europe, do not have access to quality contraceptive services and supplies – a situation akin to the majority of Africans. Moreover, emergency contraception is either completely banned or wrapped in controversy.

In parts of the Region, the unmet needs for contraception, coupled with a tradition that promoted abortion, has led to abortion rates that are the highest in the world. Since the quality of services is often poor (e.g. the use of outdated drugs and equipment and no updating of providers’ skills), there is an unacceptable rate of morbidity and mortality associated with legal abortion. And even in the European Union, some countries still restrict or even ban abortion, especially medical abortion, or employ complicated requirements that discourage women from obtaining an abortion, which fosters illegal and unsafe abortion. It is estimated that there are more than half a million unsafe abortions throughout Europe annually. This timely issue of *Entre Nous*, following on the heels of the new WHO guidance on safe abortion, addresses these important issues and will be one more tool to help women in Europe and all over the world.

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# ABORTION IN EUROPE: TEN YEARS AFTER CAIRO

By Gunta Lazdane

**UN Millennium Development Goal No. 5:**  
**“Improve maternal health: reduce by three quarters between 1990 and 2015 the maternal mortality ratio”**

During the last ten years, many countries in Europe have developed and approved national reproductive health strategies, policies and/or programmatic documents including the component of reproductive choice and access to abortion services. This is in line with the Programme of Action of the United Nations International Conference on Population and Development (ICPD), signed by 179 countries in Cairo in 1994. Of the 52 WHO Member States in the European Region, all except Malta, which submitted a reservation, agreed that:

*“In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be given to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortion” (1).*

Fig. 1 Grounds on which abortion is permitted – percentage of WHO Member States in Europe

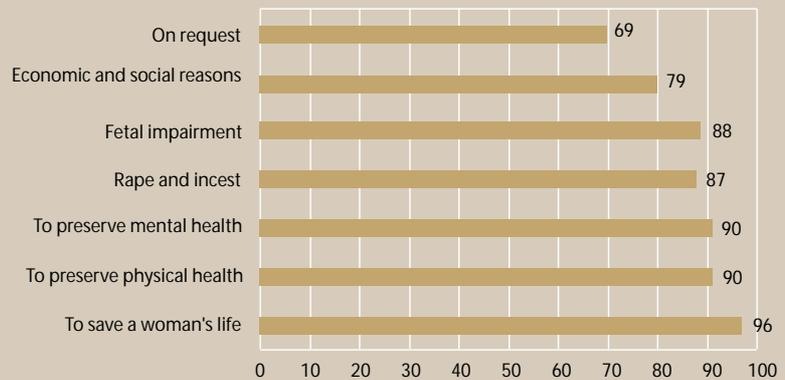


Fig. 2 Abortions per 1000 live births in the European Region

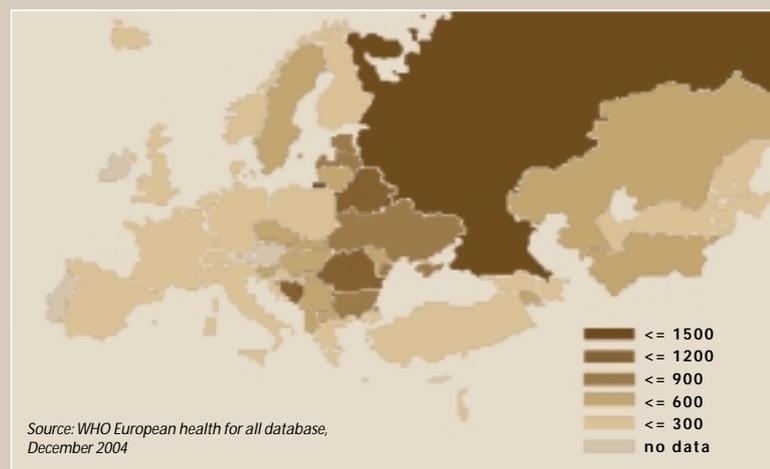
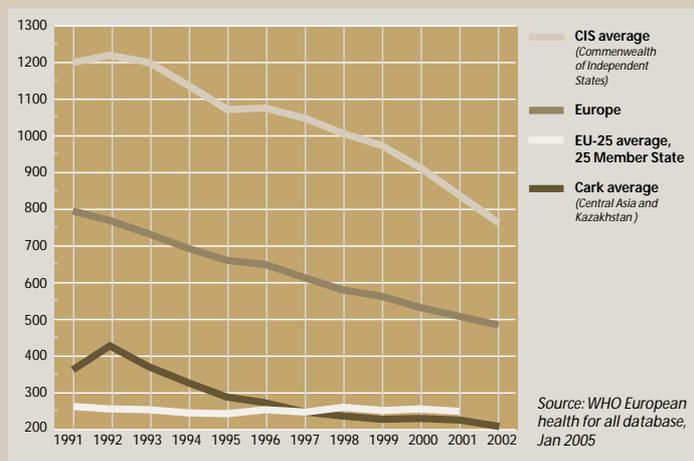


Fig. 3 Abortions per 1000 live births, 1991-2002 in the European Region



Today, in most of the WHO Member States in Europe (except Andorra and Malta), the law permits abortion in order to save the woman's life. And abortion is permitted in the majority of other countries for a number of reasons, shown below in Fig. 1.

The analysis of the incidence of induced abortion is very important to evaluate the trends and impact of national reproductive health policies and programmes. Data on the number of abortions per 1000 live births in the European Region (Fig. 2) is freely available from WHO from the online European health for all database (2). When analysing the incidence of induced abortion, three categories of countries can be distinguished in Europe:

- 1) countries with a reliable induced abortion surveillance system (e.g. Estonia, Latvia, Lithuania, the Netherlands and the Nordic countries);
- 2) countries which have planned such a system but where it remains incomplete (e.g. France, Spain, Italy, Poland and many of the countries of the Commonwealth of Independent States);
- 3) countries without a surveillance system (e.g. Austria, Greece, Luxemburg and Portugal).

National statistics, as well as surveys results, have revealed substantial declines in the incidence of abortion in the countries of central and eastern Europe, which in turn has influenced the average incidence in Europe (Fig.3).

One of the objectives of the WHO Regional Strategy on Sexual and Reproductive Health (3) is to reduce the number of abortions by providing adequate reproductive health services, by integrating family planning into primary health care policies and programmes and by removing legal obstacles to contraceptive choices.

#### Select abortion rates

Several countries have reported a rapid decline in abortion rates since 1994: the Russian Federation went from 75.1 abortions per 1000 women of reproductive age in 1994 to 45.8 in 2002; the Republic of Moldova from 53.5 in 1994 to 15.5 in 2003; the total number of legally induced

abortions in the Czech Republic fell to 11.3 in 2002 and is one of the lowest in Europe, in certain age groups.

However, the number of abortions in adolescents and young women remains high and has even been increasing during the last ten years in several countries in eastern and western Europe. Eleven per cent of all abortions in Moldova are performed on adolescents aged 15 to 19. Although the total number of abortions has decreased in the Russian Federation by almost half during the last ten years, there is still high number of abortions among those 19 years of age and younger (242 722 in 1993 and 185 290 in 2003). The percentage of late abortions in this age group remains high and it was 15.9% in the age group 15-19 and 27.6% in those younger than 15 (including 11.2% at 22-27 weeks of gestation) in 2001. From 1991 to 2000 the total number of abortions in Belarus decreased by more than half. However, the decrease of abortions in the age group 18-19 has been much slower, only 5.4% from 1997 to 2000.

According to national statistics in the United Kingdom, in 2000 the conception rate was 63 per 1,000 females aged 15 to 19, and the proportion of conceptions terminated by abortion among under 20-year-olds has slightly increased from 36 per cent in 1990 to 39 per cent in 2000 (4).

#### Unsafe abortion

Despite abortion's legality in most countries in the Region, the estimated number of unsafe abortions (see Box 1) in Europe varies from 500,000 to 800,000 unsafe abortions annually. According to several studies carried out in the Russian Federation, the number of unreported abortions is much higher than that officially registered (5,6) and adolescents, young, unmarried women and women in rural areas are those who seek unsafe abortion (7). The reasons for the high complication rates for illegal abortion vary according to the different settings: shortage of family planning commodities or medications, women unfriendly providers or facilities, crowded facilities, poor hygienic conditions, lack of proper abortion training and inadequate standards of care. It has been ten years since ICPD and women are still dying from abortion in Europe.

During the meeting of WHO European Regional Advisory Panel on Research and Training in Reproductive Health in 2003, its members analysed the present situation of reproductive health in WHO Members States and concluded that one of the three priorities in reproductive health in the European Region is "decreasing perinatal and maternal mortality and morbidity (including that from abortion)".

#### Box 1. Unsafe abortion

Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on WHO, the Prevention and Management of Unsafe Abortion (WHO/MSM/92.5).

The reduction of maternal mortality due to induced abortion to less than 5 per 100 000 live births in ten years is one of the quantitative targets of the WHO Regional Sexual and Reproductive Health Strategy (3). In several eastern European countries, a high percentage of all maternal mortality cases is related to abortion. The Russian Federation reported that 18.5% of all maternal deaths in 2002 were related to abortion; 22.3% in Kazakhstan in 2003; 13% in Tajikistan in 2002; and 6% in Armenia in 2003. Fifty per cent of maternal death cases in 2003 in the Republic of Moldova were the result of unsafe abortion and from 1990 till 2002, 30% of all maternal deaths were related to abortion in this country. However, good progress has been achieved in Ukraine, where maternal mortality as a result of unsafe abortion was 35% in 1998, 23% in 2002 and not a single case was registered in 2003. There have been no deaths due to abortion in the Baltic countries during recent years.

### Morbidity after abortion

Morbidity after abortion has been analysed in some eastern European countries. Unfortunately, there is a lack of good evidence and properly designed and carried out research. In the Reproductive Health Surveys performed with the technical assistance of the Centers for Disease Control and Prevention (USA), respondents were asked about the occurrence of medical complications for abortion in the five years preceding a survey. Early complications (within 6 months) ranged from 8 to 16 per 100 procedures. Most early complications in Romania, Georgia and the Republic of Moldova involved severe or prolonged bleeding; in the Russian Federation – pelvic infection, and prolonged pelvic pain in Azerbaijan. Among late complications, chronic pelvic pain, irregular bleeding and chronic infection were most frequently reported.

However, the high incidence of sexually transmitted infections in many of these countries, the lack of evaluation of the possible presence of infection and the prevention of complications, are most probably the causes of the high numbers of complications after induced abortions. In many countries, out-of-date methods with higher complication rate are still used for the termination of pregnancy in the first and second trimester of gestation.

### WHO assistance

At the Special Session of the United Nations General Assembly in 1999, on the five-year follow-up of the Cairo conference, governments agreed that:

*“... in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health”.*

For more than three decades, WHO has assisted governments, international agencies and non-governmental organizations to develop norms and standards, to plan and deliver services. In 2003, WHO issued the publication *Safe abortion: Technical and policy guidance for health systems*, which provides a comprehensive overview of the many actions that can be taken to ensure access to high quality abortion services as permitted by

the law. It is available in English, French, Polish, Portuguese, Russian and Spanish.

This safe abortion guidance has been distributed to all ministries of health in Europe and leading international agencies, professional associations and non-governmental organizations and is available online. However, to improve the reproductive health of the population, it is not enough to publish evidence-based, up-to-date guidelines. Their subsequent implementation in countries is the crucial component to achieve success. WHO has assisted those Member States which have included reproductive health as one of the health priorities in their countries and shared the experience from Romania, Mongolia and other countries in combining strategic assessments and the development of national reproductive health programmes (8). This approach to improving reproductive health services, including those for abortion, is also being considered by Latvia, Lithuania, the Republic of Moldova, the Russian Federation and Ukraine, among others. Currently, the Russian Federation, with the assistance of the Reproductive Health and Research Programme at the WHO Regional Office for Europe, is developing national guidelines and standards for the termination of pregnancy.

More is to be done in Europe to reach a stage where not a single woman dies or has major health implications from abortion. Essential steps to protect women's health and to achieve common goals requires the joint forces of policy-makers, professionals, non-governmental organizations and the community at large.

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# THE STATE OF MEDICAL ABORTION IN EUROPE TODAY

By Hillary Bracken and Beverly Winikoff



**M**ifepristone, also known as the “abortion pill”, RU-486 or by the tradename Mifegyne in much of Europe, has been approved for use together with a prostaglandin for ending pregnancies in 21 countries of the European Region.

The method offers women a safe and effective alternative to surgical abortion. However, despite widespread approval and over a decade of experience providing the method, women's access to and use of this technology remains limited in many settings. Existing abortion law, regulations concerning where, when and by whom abortions may be performed, standard medical reimbursement and payment practices, and local abortion politics have shaped provider and women's access to the method. Indeed, an overview of medical abortion services in the Region shows very clearly, once again, that though technology may have a strong impact on society, the existing social, political and economic structures in each country are crucial in shaping how technologies are used and how accessible they are to people. This article provides some insights into the forces that have conditioned the experience of medical abortion introduction and use in a small selection of countries in Europe.

Mifepristone was created in France by a group of scientists and managers at the Roussel Uclaf pharmaceutical company in Paris. France, the United Kingdom and Sweden were the first countries to register the drug.

Mifepristone was approved for use in France in 1988, the United Kingdom in 1991 and Sweden in 1992. Since 1992, the compound has also been judged to be safe and effective by drug regulatory bodies in over thirty countries worldwide. Mifepristone and misoprostol have now been used for early abortion by millions of women and such use has been associated with a very low rate of complications, comparable to rates for early surgical abortion (1-2).

The standard protocol requires 600 mg of mifepristone (or three 200 mg pills) provided to women in a licensed medical facility. Two days after the administration of the mifepristone, the woman must return to the clinic, where she is given a prostaglandin. The approved regimens specify the prostaglandin as either miso-

prostol (400 mcg) administered orally or gemeprost (1 mg) administered vaginally. Standard practice in most centres requires that women remain at the facility for three to four hours following prostaglandin administration and return 14 days after mifepristone for a follow-up visit. Mifepristone is approved for early abortion up to 49 days from the onset of the last menstrual period in France and most of the other European countries, but up to 63 days in the United Kingdom and Sweden.

In Scotland and Sweden, use of medical abortion has become more widespread and includes off-label variants of the regimen, perhaps because these two are the only countries with registrations to 63 days, have had experience with the medication for well over a decade and are home to some of the pre-eminent medical abortion researchers. The most common variant for abortion up to 63 days since the last menstrual period is the use of a reduced dose of 200 mg mifepristone followed by 800 mcg vaginal misoprostol. This regimen has been recommended both by the World Health Organization (WHO) and the Royal College of Obstetricians and Gynaecologists (RCOG) (3,4).

In all three of the early registration countries, medical abortion is now used in a substantial proportion of all terminations in the first trimester, except in England and Wales. In 2002, more than half of abortions within approved gestational limits were performed using mifepristone: in France (56%), Scotland (61%) and Sweden (51%) (5). Even in countries where mifepristone was more recently approved, use is increasing. In 2003, only four years after mifepristone approval, approximately 40-50% of early abortions in Switzerland were performed using mifepristone (6).

## Drug approval processes

The registration of mifepristone in European Union member states has been facilitated by the principle of mutual recognition. Since 1995, the European Agency for the Evaluation of Medicinal Products in London can shepherd the process of multiple registrations after a product has been registered in one EU member state. If the product does not come into conflict with national legisla-

tion in another member state, then authorization at a national level proceeds on the basis of the first registration. In accordance with the principle of mutual recognition, mifepristone was registered in 1999 following the French (country of initial registration) label and is approved for use up to 49 days' gestational age in the following EU countries: Austria, Belgium, Denmark, Finland, Germany, Greece, Luxembourg, the Netherlands and Spain. Because the United Kingdom and Sweden had prior registrations, they were not included in the group registration of other EU countries. The method is also registered in Azerbaijan, Belarus, Georgia, Latvia, the Republic of Moldova, Norway, the Russian Federation, Switzerland and Ukraine under various labels, mostly very close to the EU mutual recognition label of 1999. The product was never offered for registration in Portugal or Ireland, where abortion is very highly restricted, or in Italy, for other reasons.

While a centralized approval process has facilitated registration in most member states, the approval process and later use have also been shaped by local politics surrounding abortion. For example, in Germany a new distribution system was introduced to ensure greater control over the distribution of the drug: Mifegyne is delivered directly to every single doctor by the national distributor, which is completely different from the distribution system in place for all other drugs. In Austria, the Minister of Health at the time of mifepristone approval restricted the use of Mifegyne to hospitals, although most abortions are performed by providers in private practice rather than public hospitals. Consequently, providers who perform abortions have no legal right to prescribe mifepristone and providers with the right to distribute the drug do not perform abortions (7).

In central and eastern Europe and in the countries of the former Soviet Union, the drug approval process has also been informed by local abortion politics. Since the end of World War II, women in most of the former Soviet bloc have had easy access to abortion, which was paid by social security. With the striking exceptions of Poland and Slovakia, liberal abortion laws remain in place in most of these countries and recognize a woman's

right to abortion without restriction up to at least 12 weeks of pregnancy. Despite the legal commitment to abortion, however, access to abortion services has been challenged in recent years. Concerns about declining birth rates and pressure from local and international religious groups have reduced support for family planning and abortion (8).

Some governments have successfully opposed the approval of medical abortion. While mifepristone was finally approved in Latvia in 2002, the approved protocol made the method unattractive for both providers and women: The label required that women remain in an approved facility for the duration of the procedure or up to ten days, at which point completion would be confirmed by ultrasound. In Lithuania, drug approval met with similar opposition from individuals within the Ministry of Health and the Catholic Church. In 2002, a committee commissioned by the Ministry of Health to review the registration determined that mifepristone presented significant risks to women's health including the potential to increase the national suicide rate. Both countries entered the European Union in 2004, which may make drug approval more likely in Lithuania and more acceptable in Latvia.

The expansion of the number of pharmaceutical companies that market mifepristone in other areas of the world has facilitated the availability of medical abortion in some eastern European countries. According to Dr. Rodica Comendant, Director of the Association Against Infectious Diseases in Obstetrics and Gynecology of the Republic of Moldova, Shell Pharma Company recently registered the MTPILL, produced by the Indian company Cipla, for medical abortion in the Moldova. In Ukraine, a Chinese company recently registered a new product including both mifepristone (Mifolian) and a misoprostol product manufactured by the same company. The new product promises to expand access to the method as misoprostol is not registered in Ukraine and is only available via the black market. Indeed, fluid borders have made the method available prior to approval, even in countries where abortion is not legal under a wide range of conditions. In Poland, where abortion is provided in very limited circumstances, anecdotal evidence suggests

that providers are using medical abortion (9). Nonetheless, under such circumstances, lack of proper training of medical personnel and inadequate information may inhibit the access of women to the method and to good quality services.

#### Existing abortion regulations

In most countries, the provision of medical abortion is regulated according to the laws and regulations governing the practice of surgical abortion. Such laws and regulations govern both who can perform an abortion and where the procedure may take place. In some instances, countries also require mandatory counselling and waiting periods for women seeking medical abortion. As most of these laws were written and implemented prior to the advent of the technology of medical abortion, some of the provisions make little sense for the elaboration of medical abortion services and may create distortions in the ways such services can be developed and offered. As one example, most European countries maintain regulations that require a physician with certain specialty qualifications to prescribe mifepristone and misoprostol.

When medical abortion was approved for use in the United Kingdom in 1991, hospitals were initially slow to adopt the drug. Two systems reasons may have been important in causing this effect: First, because existing abortion regulations required that every patient getting a medical abortion was to have a hospital bed, the waiting time after the prostaglandin exhausted extra hospital resources. Second, the entire financial burden fell on the pharmacy budgets, and these were managed separately from the overall budgets for beds and operating theatres. Since drugs were replacing surgery, their provision was a net burden on pharmacies, which received none of the benefits of the savings incurred by fewer surgeries. Once the method could be offered in the public sector as an outpatient procedure and administered by a nurse (as long as a physician prescribed the medication), these impediments were less serious and use increased (5).

Many other countries also have specific regulations regarding where an abortion may be performed – whether in a public hospital or private clinic that meets established standards. Countries also vary widely as to the proportion of

abortions that are performed in a public versus a private facility. Not surprisingly, the availability of abortion providers shapes where the method is used. In Spain, while mifepristone is approved for use in all public and private facilities, there are very few abortion providers in the public sector. Consequently, most medical abortions, like abortions services more generally, are only available at private facilities, which may be costly to the client. In contrast to the highly regulated abortion services of Europe, some countries outside of Europe have liberally interpreted requirements for the use of medical abortion and consequently have made medical abortion more accessible to women.

#### Reimbursement practices

Standard insurance reimbursement practices may also shape the way the method is offered to women. In France, the implementation of the 2001 abortion reform law, as mandated by a decree issued in July 2004, requires that a provider must offer medical abortion clients four patient consultations over the course of three weeks: A woman must come to the clinic one week before receiving the drugs as part of the mandatory reflection period. She then returns a minimum of one week later to diagnose and confirm the pregnancy and swallow the mifepristone. Next, she is required to return 36-48 hours later for the administration of misoprostol. Finally, she must return two weeks later for her follow-up visit (10). French guidelines stipulate that each 600 mg is to be used in only one abortion procedure. Consequently, there is little financial incentive for providers in the public sector to use a reduced dose regimen (5). The same may be true in other countries where governments cover most of the cost of the procedure according to the registered norms.

Insurance reimbursement rates may also discourage providers from adopting the method. In Germany, Femagen, the German distributor for the French company Exelgyn, was forced to stop distribution of Mifegyne only one year after the drug was introduced, because of low sales. Distribution was immediately taken over by another company in 2000 yet today, five years after the approval of mifepristone, only 9-10% of all abortions are carried out using mifepristone. The



number of medical abortions has been increasing slowly, and the low demand may be attributed in part to reimbursement practices that do not compensate providers equally for medical and surgical procedures. Other factors that may contribute to low uptake are a lack of technical support and practice guidelines from professional groups and low knowledge of the method among counsellors and the general public (11).

In the countries of central and eastern Europe, where abortion has historically been available free of cost in the public sector, health sector reforms have resulted in changes in the cost of abortion services for women. In the Russian Federation, abortions are free in government hospitals and while state insurance covers surgical procedures at certain gestational ages, medical abortion is not covered at all.

#### Clinical practice patterns

The use of medical abortion may also be shaped by norms in clinical practice such as off-label drug use. For example, in the Russian Federation, the need for off-label use of misoprostol in the prescribed mifepristone regimen has proven a barrier to use of the method. Indeed, several mifepristone products are currently available in the Russian market, including Mifegyne, a Russian product called Penkraston, and, most recently, the Chinese drug Mifolian. Unlike in many countries of the former Soviet Union, misoprostol is also available in Russia. Nevertheless, misoprostol is only registered for gastro-intestinal indications, and Russian providers are reluctant to use it for off-label indications. As a result, very few providers offer medical abortion.

On the other hand, clinical guidelines offered by professional bodies may be a powerful tool for shaping clinical practice. As mentioned previously, both RCOG and WHO have published clinical guidelines for the use of mifepristone-misoprostol for early abortion (3,4). In France, clinical guidelines issued by the Agence Nationale d'Accreditation et d'Evaluation en Sante, a professional organization sponsored by the French Ministry of Health, has recommended the use of a reduced dose of mifepristone of 200 mg for use in medical abortion up to 49 days. The existence of these guide-

lines has encouraged the use of a reduced dose of mifepristone among physicians - particularly in the private sector. According to an informal survey conducted recently by Dr. Danielle Hassoun, providers are beginning to adopt this reduced dose. Of 194 French obstetricians and gynaecologists surveyed, almost one half reported that they were using a reduced dose of either 400 mg (21 per cent) or 200 mg (25 per cent) of mifepristone (10).

Indeed, providers in many European countries have been hesitant to introduce home administration of misoprostol, a practice which has been shown to be safe and effective in published studies conducted in the United States, Vietnam, Tunisia, Turkey and Sweden (12-14). Demonstration studies can offer providers practical clinical experiences with new protocols, provide useful data to revise professional clinical guidelines and counter providers' fears, which are largely unfounded, that their innovations are illegal. To this end, in August 2004 the British Pregnancy Advisory Services, a primary abortion provider in the United Kingdom, pressured for medical abortion to be offered in an easier and more acceptable manner, including, potentially, home use of misoprostol (15).

#### Conclusion

Now that mifepristone is registered in many European countries and the drug is off-patent, either the availability of a new generic product or the importation of drugs from outside Europe, meeting European standards, could make medical abortion more accessible to women throughout the Region. Nonetheless, the history of medical abortion introduction in Europe, as well as in most other countries, underscores how access to a new reproductive technology is shaped by existing regulatory mechanisms, insurance reimbursement schemes and politics surrounding reproductive rights. Technology alone does not ensure greater reproductive choice for women. Indeed, the current state of medical abortion in Europe highlights the need for creative and sustainable strategies to ensure that the technology is available and accessible in practice and not just in theory.

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Gynuity Health Projects is a research and technical assistance organization dedicated to the idea that all people should have access to the fruits of medical science and technology development. Gynuity works globally to ensure that reproductive health technologies are widely available at a reasonable cost, provided in the context of high-quality services, and offered in a way that recognizes the dignity and autonomy of each individual. Our efforts are focused particularly on resource-poor environments, underserved populations, and challenging subject matter. For further information about our activities and for downloadable documents, please see our website, [www.gynuity.org](http://www.gynuity.org).



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# ABORTION SAFETY CHALLENGED IN SWEDEN

By Silvia Sjö Dahl

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**Sweden has an established tradition of playing a leading role with regard to issues of gender equality both nationally and internationally.**

The Swedish Government has repeatedly made clear its intention to follow up on sexual and reproductive health and rights issues with regard to the Millennium Development Goals, asserting the notion that the right of a woman to decide over her own body is a precondition for their achievement. In spite of this, challenges to legal abortion are still made in the country, most recently at the parliamentary level.

In the spring of 2004, a group of Swedish parliamentarian, known as the Forum for Family and Human Dignity, hosted a seminar where Ms Wanda Franz of the American National Right to Life Committee spoke on the linkage between abortion and breast cancer, in spite of it being scientifically unproven. One of her main messages was that abortion should be opposed, even in cases of rape or incest. As a reaction to this unusual position in Sweden, a counter-seminar to discuss this and abortion issues in general, was organized by a women's network within the Central Party. This seminar ultimately led to a meeting on abortion hosted by the Swedish Association for Sexuality Education (RFSU) and involving representatives from all political parties, concerned ministries, researchers, NGOs and Sida (the Swedish International Development Agency). The meeting provided a forum for discussions on the issue and strategies to be adopted by different actors in their efforts to increase access to safe abortion globally.

For more information about this meeting or other RFSU activities, including their recently published book *Safe Abortion a Prerequisite for Safe Motherhood*, please visit their website.



[www.rfsu.se/rfsu\\_int/](http://www.rfsu.se/rfsu_int/)

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# WHY IPPF HAS CHOSEN ABORTION AS ONE OF THE FIVE "A'S"

By Jeffrey V. Lazarus

In its new Strategic Framework 2005-2015, the International Planned Parenthood Federation (IPPF) chose to set its priorities around five issues: adolescents, abortion, AIDS, access and advocacy. As these issues all start with the letter "A," they are referred to as the "five A's": *Entre Nous* interviewed Carine Vrancken, the president of the IPPF European Network and a member of the Governing Council of IPPF, to hear why abortion was chosen as a priority area, given both the controversy around it and the loss of funding from the US government to IPPF.



**Carine Vrancken:** Giving an answer to this question is difficult, not because it is difficult to find the reasons why, but because it is so self-evident for IPPF to set abortion as a priority. How could IPPF, a human rights organization working in the field of sexual and reproductive health and rights [SRHR], not take up the challenge to strive for the right of every woman to have access to abortion? Would it not be hypocritical to fight for accessible and affordable contraception, but be silent about the needs of women who are confronted with an unwanted pregnancy?

*There has been much political taboo surrounding the abortion issue. How does IPPF deal with this?*

**CV:** The taboo around abortion was for a long time only broken by referring to abortion as a health risk for women. When you look at the issue from a health perspective the emphasis lies on the consequences of unsafe abortion. The consequence of this perspective is that you only see the "problem side" of abortion. When you look at abortion from a rights perspective it is easier to see the 'solution side' of abortion. The consequence of

taking up a rights perspective on abortion is that you can no longer be silent on the need of women confronted with an unwanted pregnancy and their need for an abortion. The result is that you have to strive to make abortion accessible and affordable for all women. The full significance of the step from a health to a rights perspective becomes clear as we look at what happened at all international conferences since the ICPD [International Conference on Population and Development] in Cairo, in 1994. Since then, the opposition has successfully blocked all language in consensus documents on women's right to access safe abortion. It is not a surprise that at international forums, abortion is mainly discussed in the context of reducing the impact of unsafe abortions on women's health rather than as a rights issue.

In IPPF we often quote the words of one of the founders, the Swede Elise Ottesen Jensen, who was the one who said to be "be brave and angry". After more than 50 years [IPPF was founded in 1952] these words are still relevant. I refer to the relationship between being angry and at a certain point in time the need to act. Being angry because of the fact that millions of women are denied the right to have access to safe abortions is one step. An inevitable second step should be that we "act bravely" to make abortion accessible and affordable for all women.

*One of George Bush's first acts as the new president of the US in 2001 was the reinstatement of the Mexico City Policy, also known as "the Global Gag Rule". This policy states that foreign NGOs receiving US international family planning funds may not use these funds and on top of that may*

## IPPF

As the largest voluntary organization in the field of sexual and reproductive health and rights, the International Planned Parenthood Federation (IPPF) helps improve the lives and well-being of hundreds of millions of individuals around the world. The IPPF European Network is one of IPPF's six regions. With 39 member associations in as many countries, the Network increases support for and access to sexual and reproductive health services and rights throughout Europe and central Asia.

## Mission Statement

"To advance the basic human right of all people to make free and informed choices in their sexual and reproductive lives; and to fight for the accessibility to high quality information, education and health services regarding sexuality and sexual identities, conception, contraception, safe abortion, sexually transmitted infection and HIV/AIDS."

not use their own funds to offer information about abortion, to perform abortions, to lobby their own governments to advocate for legal abortion or to provide information about the availability of abortion. How has IPPF reacted to this?

**CV:** When IPPF is attacked these days by anti-choice groups it is because of its stance on abortion, because it refuses to be “gagged” when it comes to abortion. It would be much easier, financially, for an organization like ours to be silent about the issue of abortion, but when we really want to live up to the legacy of our founders, we have to take it on. IPPF has to fight for a woman’s right to have access to abortion because it gives women the ability to make responsible decisions about when they consider it appropriate and sensible to have children. And if this means losing part of our funding, that is very sad, but we cannot ignore human rights for financial gain.

*Opponents of abortion claim that it is unnatural and “anti-life”.*

**CV:** Everybody knows that as long as there will be men and women, these men and women are going to have sex. When you don’t want to accept this fact, you refuse to accept human nature. We also know that the result of sex can be a pregnancy. Some of these pregnancies are welcomed with indescribable happiness, others are an unbelievable nightmare. In all times men and women have sought after methods, safe and unsafe, to terminate unwanted pregnancies. The simple reason for this search was usually that they thought it would be irresponsible to have children they couldn’t take care of properly. This reality means that IPPF cannot ignore the issue of abortion. It would even be an unethical stance to do so. But even apart from this ethical perspective, there are figures you can’t ignore. I don’t know how many times they have been mentioned, but they can never be repeated enough: of all pregnancies 22%, or about 46 million, end in an induced abortion. Twenty million of these abortions are performed under unsafe conditions and about 68 000 women die every year from the consequences. For me these figures are a good enough reason for IPPF to set abortion as one of its priorities.

*IPPF argues that by using contraception, abortion rates will fall as a result of fewer unwanted pregnancies. But this does not always seem to be the case, even in your home country of Belgium. Why is that?*

**CV:** To answer this question we have to take into account the total fertility rate. The availability and use of contraception often goes hand in hand with a wish to have fewer children. The joint influence of increasing contraception use and decreasing TFR shows that the number of unwanted pregnancies increases instead of decreases under such circumstances.

*Europe is usually considered the region of the world with the lowest and most liberal abortion laws. Yet there are clearly differences between countries. How does IPPF view the situation and what are you doing with regard to those countries where abortion is still illegal?*

**CV:** In the countries of the member associations of the IPPF European Network, the abortion rates range from the lowest in the world to some of the highest. Generally speaking, the countries with the lowest rates are countries in western Europe (e.g. Belgium has 111 abortions per 1000 live births; France 263:1000). Countries in eastern Europe can have abortion rates that are ten times higher (e.g. Russia 1416:1000 and Romania 1156:1000). But even in western Europe, where abortion is often available upon request (up to 12 weeks of pregnancy), there are still countries with extremely restrictive abortion laws (e.g. Portugal, Ireland, Poland and Malta), resulting in women having to take the risk of an unsafe abortion or having to travel to another country to have a safe abortion. This practice is often called “abortion tourism”, and is a sad reality for far too many women in Europe, in addition to discriminating those with fewer financial resources.

But even in countries with women-friendly abortion laws, the defenders of sexual and reproductive health and rights have to be watchful because abortion laws and access to affordable abortion are under attack. One subtle way is the increasing number of doctors and other providers refusing to perform abortion on the grounds of conscientious objection, while at the same time they refuse to refer women to other providers. There

are examples of liberal abortion laws in former communist countries that have gradually been restricted due to pressure from conservative groups. An extreme example is Poland, where abortion is only available up to 12 weeks of pregnancy in case of rape, if a woman’s life is at risk, or if there is a serious foetal malformation. The reality is that even women pregnant after rape rarely get an abortion because of unclear and complicated procedures.

For decades, the Netherlands was considered the example of how things should be done in the field of sexual and reproductive health and rights: contraceptives were free; prevention was high; they offered high-quality abortion services for free and on top of that they had one of the lowest abortion rates in the world. But since the new government took office, it is not what it used to be: contraceptives are no longer for free (except for girls under 21), the family planning services of the Rutgersstichting are no longer subsidized and an evaluation of the current abortion law is planned.

*What do you think the future holds?*

**CV:** I’d like to conclude with a quote from Ann Furedi, the chief executive of bpas, the leading abortion care provider in the United Kingdom: “The right to abortion is a political issue. A woman’s ability to control her fertility shapes her whole life. Birth control allows us to enjoy sex and participate in public life. Without it, the choice is between celibacy and the constant risk of maternity. To deny a woman the right to abortion is to limit her human potential, which is why the right to abortion was one of the first demands of women’s liberation. But the individual choice of abortion is profoundly personal. A woman does not exercise her right to abortion like she exercises her right to vote. For a woman, abortion is the considered answer to her personal, private problem; it is not a demonstration of her views or beliefs.”

When we really believe in sexual and reproductive health and rights, we should never forget that abortion is not a problem; abortion is a solution for women who face an unwanted pregnancy.

*Shifting focus to the woman:*

# COMPREHENSIVE ABORTION CARE IN CENTRAL AND EASTERN EUROPE

By Traci L. Baird, Sarbaga Falk and Entela Shehu

Among its many accomplishments related to reproductive health and rights, the International Conference on Population and Development (ICPD) was notable for calling attention to the need for concerted action to address the public health crisis of unsafe abortion. In the ten years since that landmark conference, numerous groups and individuals in central and eastern Europe (CEE) have worked hard to improve the quality of abortion care available to the millions of women living in the region.

The challenges are significant, however, and despite these efforts, too little has improved for women and the health care providers who serve them. Reliance on abortion for fertility control is still widespread and well-accepted, resulting in some of the highest abortion rates in the world (1). Yet widespread shortages of equipment and medications, crowded facilities, poor hygienic conditions, lack of training, use of out-dated abortion technologies, inadequate standards and guidelines, and the fact that post-abortion contraception is often not provided, combine to create an unnecessarily low standard of care (2). Although many fewer women die from abortion-related causes in Europe than in other parts of the world, abortion-related deaths represent just over a quarter of maternal deaths in the region – an unacceptably high toll (3).

## Addressing needs: woman-centred comprehensive abortion care

Fortunately, these problems are not without solutions, and the CEE region offers numerous excellent examples of innovation in abortion care. A key strategy pursued by Ipas, in partnership with a number of regional organizations, is the introduction of woman-centred, comprehensive abortion care (4). This model approach to providing abortion services takes into account various factors that influence a woman's individual physical and mental health needs—including her personal circumstances and her ability to access services.

## The objectives of woman-centred, comprehensive abortion care (CAC) are:

- to provide safe, high-quality services;
- to decentralize services to the most local level possible;
- to make services affordable and acceptable for all women;
- to help health-care providers understand each woman's particular social circumstances and individual needs and to tailor her care accordingly;
- to reduce the number of unplanned pregnancies and abortions;
- to identify and serve women with other sexual or reproductive health needs;
- to make abortion care affordable and sustainable within mainstream health systems.

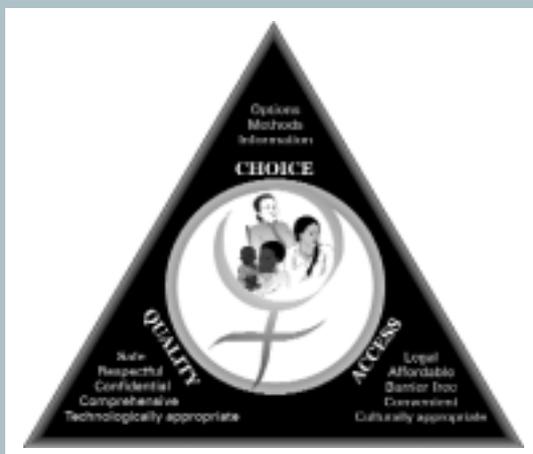
opportunity to make choices about their bodies and health without interference from others. With regard to pregnancy and abortion, this includes the right to determine whether and when to become pregnant, to continue or terminate a pregnancy, and to select among available contraceptives, abortion methods, providers and facilities.

The "access" element emphasizes the importance of abortion services being available and accessible to women who need them. In virtually every country, women with money and connections can obtain safe abortions. But everywhere, economic, geographic, linguistic and cultural barriers impede many women – especially poor women – from accessing such services. In Romania, for example (as in many other countries), abortion facilities are located in urban areas, leaving rural women with limited access to services (5).

Ensuring the "quality" of services requires attention to many factors that vary within local contexts and according to available resources. Fundamental components of high-quality abortion care include: tailoring care to each woman's individual needs; providing accurate, appropriate information and counselling; offering post-abortion contraceptive services, including emergency contraception; referring to or providing reproductive and other health services; and ensuring confidentiality, privacy, respect and positive interactions between women and health care staff.

Adoption and use of internationally recommended medical technologies are particularly important in any effort to improve the quality of abortion care. In its 2003 publication *Safe Abortion: Technical and Policy Guidance for Health Systems* (see the Resources section of this issue), the World Health Organization recommends use of manual and electric vacuum aspiration and medical abortion for first-trimester abortion,

to minimize risk of procedural or post-abortion complications which can lead to infertility or other morbidities. In the second trimester, WHO recommends



The CAC approach comprises three key elements: choice, access and quality. In its broadest definition, "choice" means ensuring that women have the right and

shifting services to dilatation and evacuation and medical methods (6).

Appropriate clinical standards and protocols for infection prevention, pain management, complications and other clinical components of care are also essential.

### Introducing woman-centred, comprehensive abortion care

Conditions and practices in the CEE region offer specific challenges to introducing the CAC model. Regarding women's choice, for instance, with fertility rates having fallen below replacement level in most countries in the region, some policy-makers, health care providers and non-governmental organizations (NGOs) have called for limiting comprehensive contraception and abortion programmes, in the false hope that such actions would lead to increases in birth rates (2).

In some countries, such as Poland and the Russian Federation, more restrictive abortion laws have been enacted since ICPD. Russia's recent curtailment of women's rights to second-trimester abortion seems especially counter-productive, since women seeking abortion after the first-trimester bear a large part of the burden of unsafe or inaccessible services. Fully 80% of abortion-related deaths of Russian women result from clandestine abortions performed in the second-trimester of pregnancy outside medical institutions (7).

In other countries, such as Slovakia, Lithuania, and Hungary, conservatism is contributing to increased barriers to women exercising their rights regarding pregnancy and abortion. For example, in Slovakia the government and the Holy See drafted an agreement designed to enable health care providers to "conscientiously object" to performing abortions or prescribing contraception (2). Lithuania has a liberal abortion law; however, negative population growth and the increased influence of the Catholic Church are making it challenging to promote advances in reproductive health. For example, the Lithuanian parliament has voted against passing a reproductive health and rights law (8). Hungary made its abortion law more restrictive in 2000, now requiring women to have "counselling" by a health employee whose responsibility it is to try to persuade the

woman to continue her pregnancy, followed by a mandatory waiting period. The new law also restricts government funding of abortion (9).

In light of these tendencies, an essential component of Ipas' and its partners' strategy in central and eastern Europe is policy advocacy aimed at increasing public and policymakers' awareness of women's rights and the public-health imperative to protect them. A key regional actor in this arena is the ASTRA network, which comprises European NGOs working on sexual and reproductive health and rights. (Ipas is an associate member). ASTRA's activities include country-level projects and regional efforts to advocate for better policies on sexual and reproductive health and rights (SRHR), including those focused on the role of the European Union in protecting SRHR.

Among the challenges in ensuring women's access to high-quality abortion care in the CEE region is making services available closer to where women live - at additional hospitals and clinics, through private practices or other primary-care settings. This strategy runs counter to evolving health systems' continuing focus on closing hospitals and prioritising tertiary health facilities rather than primary health care, in some countries. It is also difficult to realize in regions enduring political conflict, where many displaced or refugee women rely on health services in temporary camps, which rarely, if ever, offer abortion services, even if they are legally permitted. Accessing safe abortion care from health facilities in the host country is difficult for many refugee women who may not speak the language, leaving them at risk of seeking services from untrained providers.

In terms of quality of abortion care, a primary challenge in central and eastern Europe is the need to update the clinical methods used, since - along with the skill of the practitioner - the choice of technique may influence abortion-related morbidity. In many countries in the region, sharp curettage is still used for most first-trimester abortions, despite evidence that it is associated with higher procedural complications than vacuum aspiration (10). As previously suggested, the World Health Organization recommends that health systems replace this

method with vacuum aspiration or medical abortion.

### Progress in select central and eastern European countries

The transformation to woman-centred comprehensive abortion care is in process in several CEE countries, which have followed different paths to improving abortion care.

#### Romania

In Romania, for example, the Ministry of Health and a broad range of internal stakeholders worked with the World Health Organization and Ipas on a strategic assessment of abortion and contraceptive services in 2001 (5).

Through fieldwork including more than 500 interviews with policy-makers, health care providers, women, and others, the Romanian assessment team ascertained that the quality of abortion services was poor and that adoption of a model of comprehensive abortion care would address many of the deficiencies. The team identified a number of priorities including: introducing vacuum aspiration where sharp curettage was used, improving pain-management practices, linking contraceptive services to abortion care, and improving the privacy and confidentiality of services.

Health care leaders moved quickly to develop and implement national standards and practice recommendations for abortion consistent with WHO guidance. In 2004, the Romanian Parliament approved the reproductive health bill, which will become a law if approved by the president. It calls for the provision of high-quality abortion care with manual vacuum aspiration (MVA) (see box) and medical abortion. Additional steps taken to facilitate access to MVA services included the establishment of commercial distribution for MVA instruments and the translation of technical materials on providing high-quality abortion care into Romanian. Although funding constraints currently hinder broad-scale training, the groundwork laid through the assessment process and subsequent activities has resulted in consensus among policy-makers on the importance of improving quality of care, leaving the Romanian health care system poised to transform services.

### *Republic of Moldova*

In nearby Moldova, the transformation of abortion services started in 2002, when the US-based National Abortion Federation (NAF) trained seven providers at the Clinical Municipal Hospital N1 in Chisinau in the use of MVA for outpatient early abortion. By 2003, the abortion caseload had more than tripled at the new MVA Centre created by the hospital's gynaecology unit. The caseload increase is attributed to the high quality of care, which drew women from other facilities, and to the fact that most procedures are done with local, rather than general, anaesthesia. As providers shifted from use of general to local anaesthesia, they learned to talk with and support their patients, treating them as partners in their care. To date in 2004, MVA training is incorporated into the university curriculum and a total of 80 gynaecologists have received MVA training. In addition, the MVA Centre holds one-day trainings for other doctors.

Providers are pleased with MVA services, which, they say, are not only safe and effective but also save time and costs. Women who received care are also pleased: ongoing monitoring during 2003-2004 at the MVA Center shows that more than 90% were very satisfied with their care and would recommend it to others needing an abortion (11).

With support from Ipas and NAF in developing providers' training skills, the MVA Centre has trained gynaecologists from all over Moldova and in other countries. Other steps that have been important in transforming and sustaining the quality of abortion care in Moldova include registration of MVA for commercial distribution, dissemination of technical materials on MVA and abortion care in Romanian, and the Ministry of Health's 2004 recommendation of MVA for first-trimester abortion, accompanied by approval of clinical guidelines. Currently, a team from Moldova is planning a national strategic assessment of fertility regulation to expand understanding of the situation in the country and ultimately to design additional strategies to address current needs.

### *Albania*

As in most of the rest of the region, abortion services in Albania lack key elements of woman-centred, comprehensive care.

For instance, vacuum aspiration is not available in all abortion settings; general anaesthesia is widely used for first-trimester abortions; and many women leave health-care facilities where they have obtained abortions without receiving counselling or contraceptive methods to help them avoid repeat unwanted pregnancies.

In a growing number of Albanian settings, however, care is improving, and the Ministry of Health is poised to support the broad introduction of WHO's technical and policy guidance. Services are already using recommended abortion methods in facilities at the Marie Stopes Clinic and the University Maternity Hospital in Tirana, as well as district hospitals in three other cities, where first-trimester abortions are offered with MVA and local anaesthesia. Ipas looks forward to working with the Ministry to expand awareness and use of the WHO guidance and is working with other partners to help Albania realise a broader transformation of abortion care.

In other countries, too, efforts are underway to conduct strategic assessments on abortion care, to introduce and implement the WHO safe-abortion guidance, to improve clinical care and technologies available for abortion, and to develop national standards and guidelines for abortion care. Experience both within the CEE region and throughout the world shows that, regardless of the approach taken, the step with the largest positive impact for women, health care providers and the health care system is conceptual rather than practical: Once health leaders and practitioners fully understand and embrace the idea of woman-centred, comprehensive abortion care, they usually have the internal momentum to promote desired changes and to make them sustainable. A key underlying goal of the CAC model, sustainability, occurs when training, supervision, equipment provision and facilities' maintenance are integrated into routine operations of the health-care system such that supplies and standards of care are maintained without interruption.

Clearly, efforts to improve the quality and accessibility of abortion care require the energy of committed professionals and organizations. Many such efforts in

the region are supported by technical assistance from WHO, the International Planned Parenthood Federation European Network and Ipas, among others. They also require donor funding, which, with a few notable exceptions, is in unfortunately short supply for abortion-related programmes in this region. The local, regional and international expertise that is primed to collaborate to improve abortion care in this region, and the history of success in the countries where limited investments have prompted lasting changes, should motivate donors to consider funding this scope of work.

By mobilizing resources, sharing experiences across countries and fostering the energies and efforts within countries, Ipas and its partners hope to see more countries transform their abortion services so women have access to truly high-quality, woman-centred, comprehensive

### **Manual Vacuum Aspiration (MVA):**

Ipas' work to improve the quality of abortion care in Europe includes training and equipping health-care providers to provide safe, effective abortion services. Consistent with WHO recommendations, Ipas aims to replace sharp curettage with safer methods, including manual or electric vacuum aspiration and medical abortion.

Safety and effectiveness data show that MVA leads to fewer complications than sharp curettage and is a very safe modern method of abortion appropriate for a variety of settings (12). Qualities that make MVA more appropriate for low-resource settings and outpatient services include being portable, non-electric, reusable and relatively low-cost. MVA instruments are easy to use, and abortion procedures with MVA are quiet and convenient. Local rather than general anaesthesia is recommended for pain management, and products of conception are easily visible, enabling accurate assessment of procedure completion. MVA can be used for:

- first-trimester abortions
- treatment of incomplete abortion
- menstrual regulation
- endometrial biopsy

## Ipas

Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. For three decades, Ipas has sought to expand the availability, quality and sustainability of abortion and related reproductive health services. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive health choices. Ipas's global and country programmes include training, research, advocacy, information dissemination and distribution of reproductive health technologies.

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## Recommended websites

[www.astra.org.pl](http://www.astra.org.pl) Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights.

[www.reproductiverights.org](http://www.reproductiverights.org) The Center for Reproductive Rights is a non-profit legal advocacy organisation.

[www.ipas.org](http://www.ipas.org) –For information on women's reproductive health, rights and policy, and Ipas products, publications, activities and news.

[www.ipas.org/english/womens\\_rights\\_and\\_policies/policy\\_updates/2004/updates](http://www.ipas.org/english/womens_rights_and_policies/policy_updates/2004/updates) Ipas has recently launched the Global Abortion News Updates feature on its website.

[www.ippfen.org](http://www.ippfen.org) The IPPF European Network (IPPF EN) is a voluntary organisation in the field of sexual and reproductive health and rights.

[www.prochoice.org](http://www.prochoice.org) The National Abortion Federation (NAF) is the professional association of abortion providers in the United States and Canada.



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# HIV-POSITIVE WOMEN AND THEIR RIGHT TO CHOOSE

By Marcel Vekemans and Upeka de Silva



**Women of childbearing age living with HIV, like those who are HIV negative, are faced with the decision to have children or not. However, in the case of the HIV positive woman, the issue is more complex, for personal, familial, social, cultural, religious and medical reasons.**

These women are often stigmatized for being HIV positive and, if pregnant, for irresponsibly being sexually active and becoming pregnant while HIV positive. Sometimes, they are under pressure by family or health workers to have their pregnancy terminated, while in other cases they are pressured by partners and families to have children. Women living with HIV can also be demonized for seeking or having an abortion. Finally, when they do decide to carry their pregnancy to term, they are often blamed for bringing an HIV-infected child into the world.

Some HIV-positive women are pregnant as a result of rape, entailing further stigmatization. On top of all these societal pressures, they invariably suffer from feelings of guilt, low self-esteem and self-stigmatization. Stigmatization or other factors can also lead to women preferring to rely on unskilled service providers instead of utilizing official services, for fear that the service will not remain confidential.

This is a tragic picture, which paints HIV-positive women as both culprits and victims. While this is fortunately not necessarily true for all women, it is nevertheless all too often a reality. This article addresses the overall situation, what we are doing, and what we could do to protect the sexual and reproductive health rights of women living with HIV.

The discussion below raises some rather controversial questions, intended to challenge those of us who are service providers and/or advocates of sexual and reproductive rights to take positive steps

to secure the reproductive rights of all women, regardless of their age, or marital or HIV status.

## A global overview

In countries with a high HIV prevalence, girls and young women are at greater risk than men of HIV infection, accounting for over 50% of people living with HIV. Nearly 230 million women worldwide - one in six women of reproductive age - lack information on and access to a full range of contraceptive methods. Often, they are also unable to negotiate contraceptive use (1). At present, less than one in ten people who need antiretroviral therapy receive it (2). In some parts of Africa one-third or an even higher proportion of all pregnant women are HIV positive or have AIDS. In Botswana and Swaziland, for example, nearly 40% of pregnant women are HIV positive (3). Unfortunately, in many countries, only a small proportion of those living with HIV know their status, so the size of the problem is most likely much larger.

HIV positive women are a heterogeneous group; there are women who have only one partner, women who have or have had more than one partner; married and unmarried women; women of all ages, including very young women; and women who are injecting drug users, sex workers and those who have been infected as a result of female genital mutilation, rape, unsafe blood transfusions or through medical care provided in settings where universal infection prevention measures are inadequately performed. Given the variety of situations, it is vital that services are tailored to individual circumstances, with the provision of clear and factually correct information, based on respect for the woman's sexual and reproductive health rights. To date, few studies have explored how HIV positive women make childbearing decisions and more research is required on this issue.

## Making choices about childbearing and rearing

The discussions around childbearing and living with HIV are dynamic and complex, making it impossible and even inappropriate to prescribe a unique and ideal approach. Yet, if we truly believe in promoting a holistic rights-based approach to sexual and reproductive

health, then every woman's right to reproductive self-determination should be upheld, including that of women living with HIV/AIDS.

In other words, as there is no universally valid approach to specialized HIV/pregnancy counselling, and there will be as many different solutions to the problems raised by pregnancy in HIV/AIDS patients as there are various individual situations, the need to listen to and respect a woman's decisions becomes crucial. She has the right to have children and the right not to have children, secured by access to affordable contraception including emergency contraception and, if needed, to safe, legal abortion. These are difficult reproductive decisions that we need to pay greater attention to by ensuring that our programmes and policies are based on respect and an understanding of the complexities of women's lives.

## International policies

The World Health Organization (WHO) stated in 2004 that service providers should "ensure that access to abortion services, where legal, for women with HIV infection is provided in an equitable and non-coercive manner" (4).

The International Planned Parenthood Federation (IPPF), adopting a similar stand in terms of HIV-positive women's options for unintended pregnancy, states that "if the client is currently pregnant but does not wish to continue her pregnancy, she should be referred to safe abortion services where legally permitted. Post-abortion contraception should be offered as an option for those who do not wish to become pregnant again" (5).

While it is important to be aware of such international policies relating to the reproductive options of HIV-positive women, service providers and advocates also need to be fully aware of the intense emotional struggles that these women face when exercising their decisions about childbearing and rearing. Although policy documents speak of consent, free will, choice and safe abortion, they are rarely part of the realities of many HIV-positive women's lives.

## Wanted pregnancies

The right to found and plan a family and decide whether and when to have chil-

dren is a fundamental part of a woman's sexual and reproductive freedom. Yet, women living with HIV are frequently denied this right primarily because society and service providers, in particular, more often than not do not believe that HIV-positive women should have children or even be sexually active in the first place. On the other hand, we live in a world where motherhood is seen as an integral part of being an adult woman and in some societies childless women are often stigmatized. For many women living with HIV, bearing children is also something to look forward to as it provides hope and an increased sense of self-esteem and pride. So whether they are forced into motherhood or whether they truly wish to experience motherhood, we as advocates of sexual and reproductive health rights and providers of comprehensive rights-based services need to make sure that their choices are safe for them and can be realized.

HIV transmission from an infected mother to a child can occur during pregnancy, labour and delivery, or during breastfeeding. In the absence of any intervention, the risk of mother-to-child transmission (MTCT) of HIV is 15–30% in non-breastfeeding populations, and

increases by 5–20% in breastfeeding populations. The risk of MTCT can be reduced to below 2% by interventions that include antiretroviral prophylaxis given to women during pregnancy and labour and to the infant in the first weeks of life, obstetrical interventions including elective caesarean delivery and completely avoiding breastfeeding (6). Being HIV positive also increases the risk of spontaneous abortion, anaemia and haemorrhage related complications, and post-partum infections. Yet, we need to be aware that given these figures, women who choose to have children often focus on the 55% chance of not transmitting the infection and are willing to take on the risks.

Our role then is to dispel myths about living with HIV and parenting, to provide information on breastfeeding and to support them in safe conception, delivery, labour and childrearing. The woman's right to benefits of scientific progress should form the basis of our interventions so that we enable HIV-positive women to not miss out on the experience of motherhood. Furthermore, wherever possible, assisted reproductive techniques should also be made available to women who choose to have children.

At no time should an HIV-positive woman be forced to undergo an abortion or sterilization.

### Unwanted pregnancies

The stigma attached to a woman who is HIV positive and faced with an unwanted pregnancy is, in many societies, immense. This is even more so if the woman is young and unmarried and further compounded if she chooses to have an abortion. Today, an estimated two in five pregnancies worldwide are unplanned. Women living with HIV are no less likely than other women to become pregnant, and are no more likely to terminate a pregnancy.

In addition to the reasons that an HIV-negative woman might have for choosing an abortion, an HIV-positive woman might also be concerned about her lack of access to antiretroviral therapy, feel guilty about bringing an infected child into the world and be anxious about being unwell. She may also be unable to make an independent and informed decision due to the judgemental attitude of health care workers or the lack of proper counselling.

Arguments have been presented in support of making HIV infection a rea-

## Recommendations

Whatever initiatives we take, we need to always be aware that women, especially young women, often have very little control over their sexual and reproductive lives.

### Services

We can no longer adopt a blinkered view on HIV prevention or safe abortion. Instead, we need to ensure that service providers in vertical health care programmes such as family planning and HIV programmes work together to adopt a positive attitude towards women's sexuality and provide comprehensive services including:

- service providers should address the needs of women living with HIV with confidence and in a manner which is respectful of their dignity and rights;
- keep staff up to date with the latest information on safe abortions, safe pregnancies and HIV treatment;
- build staff capacity to enable them to deal not only with the medical aspects of living with HIV, pregnancy and abortion but also the psychological and emotional needs of the clients;
- ensure that counsellors have clear protocols on pre and post-test HIV counselling and are aware of the emotional impact of receiving a positive diagnosis especially during pregnancy;
- train staff to understand and address the links between sexual violence, HIV and unwanted pregnancies;
- ensure that women living with HIV are made to feel welcome and reassure them of their right to privacy and confidentiality;
- train staff to work with HIV-positive women to enable them to access contraception and have a safe and satisfying sex life;
- services that provide post-abortion care should pay special attention to whether or not the woman is HIV positive so that they are able to provide the necessary extra care to prevent post-abortion complications;
- ensure that emergency contraception



son for legal abortions. The risks that this runs are, among others, that women might be obliged to disclose their HIV status in order to have an abortion and that HIV-positive women might then be coerced into undergoing an abortion and concomitant sterilization based on the belief that they should not be bearing children or be sexually active.

On the other hand, there are, for example, some anti-choice groups that claim that the increased availability of antiretroviral therapy should mean that HIV-positive woman should no longer be allowed to abort on the grounds of HIV infection.

Despite these arguments, making available safe abortion services is extremely important for HIV-positive women as unsafe abortions become unsafe due to the greater risks these women face of suffering complications such as sepsis and haemorrhage.

### Conclusion

What emerges from the documentation relating to HIV-positive women and their sexual and reproductive health is the lack of respect and value placed on women's lives. As more and more women of reproductive age face violations of their

reproductive rights, and are faced with difficult reproductive decisions, the need to adopt a holistic and rights-based approach to sexual and reproductive health becomes imperative. We would like to take this opportunity to call on you to take urgent action to pay greater attention to giving women reproductive options, enabling them to exercise those choices, and to ensure that programmes and policies are based on respect and an understanding of the complexities of women's lives, as outlined in our recommendations.

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is widely promoted and made available especially for young women;

- propose HIV testing for those who test for pregnancy or are planning a pregnancy to enable them to take advantage of prevention of mother-to-child transmission measures and provide them with options on the outcome of the pregnancy and information on a safe pregnancy. This should not be used to coerce terminations or sterilizations;
- if they choose to have a baby, information and services should be provided on safe conception, pregnancy, delivery and breastfeeding and post-partum contraceptive services and counselling;
- provide access to support groups for positive mothers so that they receive continued care and support;
- if they choose not to have a baby, providers should ensure that they

have access to safe abortion services and comprehensive high quality counselling.

### Programmes and policies

- in order to ensure that programmes and policies respond to the real needs of the intended beneficiaries, identify mechanisms for involving HIV-positive women and especially young women at all levels of decision-making;
- address the absence or limitations of existing health care services in terms of human resources and finances;
- have clear policies on meeting the needs and rights of women living with HIV and promote these in such a way that those who need the services the most are able to access them;
- strategies to preventing unwanted pregnancies among HIV-positive women should go beyond contraceptive use and should recognize that

many of these women have little or no control over decisions about pregnancy;

- advocate for and ensure greater access to antiretroviral therapy and reinforce prevention messages when people are feeling better after antiretroviral treatment;
- undertake campaigns to protect the right to choose;
- work with men to help them understand the issues around being HIV positive and pregnant and help them to support their partners;
- work with donors to ensure that funding is not compartmentalized and that comprehensive programmes can be implemented.

# THE CASE OF THE RUSSIAN FEDERATION

By Evert Ketting

**Maternal mortality due to unsafe abortion is very rare in Europe. According to the most recent 2004 estimates of the World Health Organization (1) 300 out of 67,900 unsafe abortion death cases world wide in the year 2000 occurred in Europe.**

In its previous report, published in 1998, WHO estimated this number to be 500 cases annually (2), indicating that the number of fatal cases is probably still declining. Almost all these fatal cases are believed to occur in Eastern European countries, particularly in the Russian Federation.

According to data released by the Ministry of Public Health of the Russian Federation, 233 women died from abortion related causes in 1991, and this number gradually declined to 122 in year 2000. This means that almost half of all abortion related maternal deaths in Europe occur in the Russian Federation. But the Russian Federation does not even have the highest maternal death rate due to abortion in Europe. In Romania, 38 and 37 cases were reported in the years 2000 and 2001 respectively (3) while the population size of Romania is only about 16% that of the Russian

Federation, thus indicating a mortality rate due to abortion which is almost double the Russian one. Data from other central and eastern European countries, particularly Poland, where abortion is basically illegal, are largely unknown or probably unreliable.

In general, reliable data on abortion related maternal mortality in Europe are very scarce, and even less was until recently known about the background factors to this tragic phenomenon. With assistance from the Open Society Institute, an in-depth study on some characteristics and background factors of women who had died after abortion in the Russian Federation in 1999 was

recently carried out. The results were published in the September 2004 issue of *Studies in Family Planning* (4). This article summarizes and discusses some of the main findings of this study, excluding technical medical information.

## The Russian legal and social context of abortion

After the Communist revolution of 1917, Russia became the first country to legalise abortion, on 16 November 1920. Under Stalin, this law was repealed in 1936, mainly for pronatalist reasons. Abortion remained illegal until 1955, but it is likely that women quite massively resorted to illegal abortion during the period 1936-1955. After 1955, when abortion became legal on request of the woman in the first trimester of pregnancy, the number of women having legal abortions increased to about 7 million annually in the 1970s (5), but the actual number of abortions, including those that were illegal, was still much higher. Surveys during the period 1965-1982 suggested total annual numbers of abortions between 8.5 and 11.7 million, and abortion rates between 170 and 220 per 1000 women of fertile age (5).

In 1987, the law was further liberalised, also permitting so called "mini-abortions" within 20 days of a missed period on an outpatient basis, and it extended the number of legal grounds for obtaining abortion in the second trimester. Further liberalisations were adopted in 1993 and 1996, extending the number of medical and social indications in the second trimester. By that time, the Russian Federation had one of the most liberal abortion laws in Europe, which made it even more surprising that some 150 women annually died from the consequences of abortion.

In August 2003, after data for the mortality study had been collected, the number of social reasons for abortion was reduced from 13 to only four: rape, imprisonment, death or severe disability of a husband, or a court decree stripping the women of her parental rights. Access to second trimester abortion will probably be severely restricted by this measure,

which could have serious consequences because 6-7% of abortions in Russia are usually performed in the second trimester.

Following the introduction of modern family planning in Russia in the early 1990s the abortion rate gradually declined. The reported rate dropped from 100.3 to 50.5 between 1991 and 2000. However, it is unclear to what extent this decline is real or caused by increased underreporting, particularly in the larger cities where private abortion clinics have been established. It seems unlikely that this impressive decline in abortion rate is entirely caused by improved prevention of unwanted pregnancy through better contraceptive use.

Unfortunately, reliable recent data on contraceptive use are not available in the Russian Federation. In 1998, UNFPA still estimated that only 21% of Russian couples were using any method of contraception and only 13% a modern method (6), but in the 2004 edition of the State of the World Population, an estimate for Russia is not included anymore, probably because recent data are non-existent. In a national survey carried out in 2000 among 15-18-year-old boys and girls it was found that only 6.4% of sexually active girls used oral contraception during their last sexual intercourse, and 40.7% used a condom. More than 50% did not use a method or an unreliable one (7). The same study indicated that 9.3% of the sexually active girls had already been pregnant, and most of them had had an abortion. This percentage is high if we take into account that the average period since the debut of sexual activity of these girls was only 1.3 years. This means that more than 7% had become pregnant after one year of sexual activity.

### The Abortion-Related Maternal Mortality study

This research project was carried out by the Scientific Research Centre for Obstetrics, Gynaecology and Perinatology of the Russian Academy of Medical Sciences in Moscow. The author of this article assisted in data analyses and in

preparing the English language report published in *Studies in Family Planning*. All data presented below are taken from this report, unless otherwise indicated.

Three datasets were used for this study. The first were national data on abortion and abortion-related mortality reported to the Ministry of Health in 1999. The number of reported abortion-related maternal deaths was 153. The second dataset was obtained from the State Statistical Committee (SSC), where the number of abortion-related deaths was 130. The difference between the two numbers is caused by differences in definitions and in reporting procedures. The third dataset was compiled especially for this study. It consisted of detailed medical files of the women who died after abortion in 1999. A total of 113 files was obtained in this way, that is 74% of the total number of abortion-related maternal deaths reported to the Ministry of Health and 87% of those reported to the SSC. The remaining cases could not be traced.

The outcomes of the study indicate that abortion-related maternal mortality (ARMM) is a national problem, and that it is not concentrated in some remote or rural regions. This is quite remarkable, because one would expect that the quality of abortion provision could be lower in remote areas, or that women in those areas could have more problems in obtaining access to legal and safe abortion services as a result of very long distances to health facilities in sparsely populated regions in Russia. This is not the case; there are no real regional or urban-rural differences in ARMM.

Another remarkable outcome is that young women do not have a higher risk of dying from abortion related causes than relatively older women. On the contrary, women under 20 and women in the age group 20-29 are underrepresented among the ARMM cases. This is an outcome that would not immediately be expected because young women are usually at greater risk of having late abortions, which are more dangerous. This is not the case in Russia: 55% of women dying from abortion related causes are 30

and older, whereas less than 40% of all women having abortions are in that age group.

One of the main results of the study is that particularly women who have abortions in the second trimester of pregnancy are at increased risk of dying from the procedure. Whereas only 6.6% of all women having abortions in 1999 were in the second trimester, among those who died this was 76%, and of those women 24% were more than 21 weeks pregnant. This means that ARMM is mainly concentrated in the late abortion cases.

Undoubtedly, the most important result of the study has been that most fatal cases resulted from abortions performed outside medical institutions. Among the 113 fatal cases studied in depth, there were 10 cases of spontaneous abortion (9% of the total). Furthermore, 27 women (24%) had an abortion inside a medical institution; and 76 women (67%) had an abortion outside a medical institution.

The fact that only 24% ARMM cases occurred after a legal abortion in a qualified medical institution should be stressed. This outcome means that the risk of dying after such a procedure is not substantially higher than in western countries, particularly if performed at an early stage of pregnancy. Among abortions performed in the first trimester of pregnancy, the risk of death is 0.54 per 100,000 abortions, and that is almost equal to the 0.4 per 100,000 found in the United States (US). As in other countries, the death risk from abortion in the first part of the second trimester is substantially higher compared to the first trimester. In Russia this risk is about 11.5 per 100,000, which is higher than in the US, where this is about 6.9. The most risky legal abortions in Russia are those performed after 21 weeks, with a relative death risk of 45.1 per 100,000. This very small category is responsible for 37% of ARMM inside medical institutions.

However, the main cause of the high ARMM is that probably fairly large numbers of Russian women have abortions outside (qualified) medical institutions. This factor explains two thirds of the

ARMM. Moreover, these fatal cases tend to have been performed late in pregnancy: 58% after 13-21 weeks of pregnancy and 20% after 22 or more weeks. Also here we see that it is particularly older women who are at risk; almost two-thirds of these fatal cases occurred in women 30 years or older.

### Causes of ARMM

The abortion-related maternal mortality ratio in the Russian Federation is 6.3 per 100,000 known abortions, which is about 10 times higher than in western Europe and North America, and it explains about a quarter of maternal mortality in general. Based on the results of our study, the question formulated in the title of this article "why do women still die in a country where abortion is legal?" may be answered as follows:

In the first place, this is because probably large numbers of women have abortions outside medical institutions, where the procedures are not safe, and particularly because some of these women have these abortions at advanced stages of pregnancy, which makes the procedures even more risky. The questions that cannot be answered by this study is what causes women to make these risky choices, and where and from whom did they actually get this risky procedure? Our data seem to suggest that many women seek such abortions when their pregnancy is too far advanced for them to obtain a legal abortion. The difficulties these women potentially face include ignorance of the legal right to obtain an abortion, being ineligible for legal abortion, shortage of specialized second trimester abortion services, financial barriers, and a fear of seeking official permission from a committee for an abortion. Unfortunately, it should be feared that more women could face such difficulties after the sharpening of legal social reasons for second trimester abortion in August 2003. It should not be excluded that as a result of that measure, the ARMM could increase.

The second reason why women still die from abortion in Russia is that many of them tend to have abortions at advanced stages of pregnancy. This increases not

only the risk of serious complications if the abortion is carried out illegally, but also to some extent if performed in a hospital by qualified doctors. Therefore, it is important that measures are taken that enable women to seek and have abortions early in pregnancy.

Only third, in terms of reasons why women die, comes the medical competence of doctors and the quality of health facilities and procedures used for abortion, particularly in the second trimester. Although there is still a need for improvement in this respect, the main causes are in the legal and public health field.

An important unanswered question is the extent of what is called here "abortion outside medical institutions". It is not only known where these abortions are carried out and by whom, but it is also very difficult to estimate the total number. In its 1998 overview (2) WHO estimated that in all of central and eastern Europe 500 women would die from unsafe abortion, and the total number of unsafe procedures was estimated at 900,000. In the most recent 2004 overview (1) these estimates have been reduced to 300 and 400,000 respectively. If these latter estimates are realistic this could mean that 150-200,000 unsafe abortions are still performed annually in the Russian Federation, which would be 8-10% of all abortions. Because this is a serious and sizeable public health problem, of which the true extent is virtually unknown, additional social scientific research in this area is crucial.

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# ABORTION IN EUROPE: ARE THE LAWS AND PRACTICES PATIENT CENTRED?

By Christian Fiala

**The diagnosis of an unwanted pregnancy is a crisis situation for most women, even if the extent of the crisis varies greatly.**

For most women the diagnosis of an unwanted pregnancy is unexpected. The women are therefore unprepared and may not fully comprehend the matter or know where to go to get counselling, be it for carrying the pregnancy to term or having an abortion. In effect, the diagnosis of an unwanted pregnancy places the women concerned in an informational state of emergency. She needs a great deal of information within a very short space of time. This search for information is made significantly more complicated by a number of factors:

- The information concerns one of the most intimate areas of life;
- This area is particularly taboo in many societies;
- The pregnancy is sometimes not the result of an existing, socially accepted relationship, which is why the fact of pregnancy itself must not become public;
- The woman's own social circles, and also professionals in the social-services field, often react with moral condemnation, refusal of assistance or even misleading information;
- The information required is extensive and complex. It affects both physical and psychological processes;
- The impending decision has major effects on the woman's social environment, on her future life, and is irreversible;
- With a partner, a second person is immediately and directly concerned and more or less involved in the decision;
- Not least, the information requirements are very different for each individual, and sometimes vary widely, as a result of which it is not always easy to provide the necessary information.

Societies react differently to these requirements, although the last 200 years were dominated by a rigid paternalism. Coupled with religious beliefs in some countries, this was often the expression of a male-dominated conviction among the dominant social strata that pregnant women could not responsibly make deci-

sions regarding their own pregnancy. Society therefore "had" to intervene in order to ensure that the "right" decision was taken. This paternalism led, among other things, to a ban on abortions, which again was one of the reasons for the very high level of maternal mortality. This is still the case in many low-income countries, because abortions are illegal there owing to the laws imposed by former colonial powers.

With the improvements in technology, especially during the second half of the twentieth century, and a recognition of women's rights, the situation has slowly changed over recent decades and women or couples now have a high degree of autonomy over their fertility. As a result of this autonomy, Dutch women, for example, have the lowest rate of abortions worldwide (1). On the other hand, some countries still have regulations that reflect outdated procedures and thinking and do not adhere to medical and social service standards that have been established in the meantime. One example is a compulsory counselling session before an abortion. Even though this has been abolished in some countries, such as France two years ago, it still exists with varying guidelines in some other countries. For example, in the Netherlands and Austria all doctors can provide this counselling and there is no regulation as to its content, while in Germany it is more rigidly prescribed and impedes access to abortion. It remains unclear why it is so difficult to offer counselling voluntarily, as this is the usual practice for other medical procedures.

## **Obligatory waiting periods**

Another example is an obligatory waiting period for reflection between counselling and the abortion. The very idea of a legally required waiting period between counselling and medical treatment is, for good reason, unusual in medicine. Rather, the law has given a special status to the doctor-patient relationship and it is particularly protected. It is incumbent alone upon the two parties involved to find the best procedure for a particular situation. If there is now a legally binding

period for consideration before terminating a pregnancy, it seems to be based on three basic misunderstandings:

- pregnant women have to be protected from themselves so that they do not hastily decide against having a child;
- women with an unwanted pregnancy would only enter into the actual decision-making process after counselling with someone they do not know;
- a reflection period (usually of an arbitrary length) could reduce the number of abortions.

In countries that do not have such an obligatory waiting period, women with an unwanted pregnancy and professionals working in the field, see no need to introduce one (2). As shown in Table 1, this obligatory waiting period varies greatly from country to country regarding the length, how it is calculated and possible exceptions. It can be assumed that the needs of the women in these countries do not essentially differ, so that

for most women the waiting period must seem arbitrary and not corresponding to their needs.

Above and beyond this, in some countries there are special regulations, such as those stipulating that the woman may not be treated or cared for by the same specialists who are counselling her. Such a regulation is unique in medicine. On the contrary, it is self-evident that the specialists with whom one has established trust in the course of preliminary consultation and examination should also carry out any procedure and are also responsible for care during the process.

The continuity of care is particularly important in a crisis situation such as an abortion, so that the women do not have to repeat their whole story every time they come to the service. Only in this way can a certain trust develop which acts as a positive influence on the course of treatment. It is hard to comprehend why this important quality standard should not be applied in particular in the crisis situation of an unwanted pregnancy. In

other branches of medicine such an approach would be regarded as unethical or even as mental cruelty.

In Switzerland, even after the recently liberalised law, a woman still has to declare in writing that she is in distress before she can have a legal abortion. Here, too, this kind of procedure, unusual in medicine, accords no recognizable advantage for the woman concerned. Rather, it seems to be something which will provide legitimacy to the action, whereas it probably serves only to make the woman concerned feel she has to justify herself to society for what she is doing.

### Positive developments

There are nevertheless some important positive developments. One of them is the increasing spread of the internet. This brings many advantages to women with an unwanted pregnancy. Without a great deal of effort, they have unhindered access to a large amount of information from varying perspectives. Most importantly, their private sphere is secure; they do not have to explain anything about themselves nor do they have to justify themselves to anybody. We found that visiting websites on abortion had a positive influence on counselling and treatment, provided that these sites had no religious background. There are two main disadvantages to the internet in this regard: on the one hand, not all women have access to it. On the other hand, it is often hard to distinguish between factual evidence and emotional propaganda and misinformation.

### Multiple methods for abortion

There is a great difference in abortion procedures between countries. Whereas, for example, in the Netherlands most surgical abortions in the first trimester are carried out under local anaesthetic, in other regions general anaesthesia is the standard. Also, a surgical abortion in the fifth or sixth week is a matter of course in the Netherlands and even exempt from the legal waiting period. But in other countries, surgical abortion at this early stage in pregnancy is not offered and is

Table 1. Overview of obligatory waiting periods in selected European countries

Country	Waiting Period	Details
Belgium	Six days	From first contact with any counselling body
Germany	Three days	Three full days, certified by confirmation from an approved counselling centre
France	Seven days	From first contact with a specialist, doctor/counsellor/midwife/nurse; can be shortened near the end of the term of legal abortion
The Netherlands	Five days (applicable only after the 44th day since last menstrual period)	Five full days after the first contact with a specialist, with many exceptions: can be shortened near the end of the term
Italy	Seven days	From first contact with a doctor (certification required)

*No waiting period in Austria, Denmark, Finland, Norway, Spain, Sweden, Switzerland*

even considered to be medical malpractice by some doctors.

Whereas in France, Scotland and Sweden in some institutions more than 50% of women choose a medical abortion, in Germany, the Netherlands and Austria this is only a very small percentage.

It cannot be assumed that women's needs in the aforementioned countries are so different as to explain the so widely varying frequency of the various methods. It must instead be assumed that the difference in frequency of methods is the expression of different organizational, legal or financial circumstances, or just a continuation of traditions that have not been called into question.

In summary, one can say that in most countries the general conditions in the run-up to an abortion, as well as in carrying it out, are hardly or not at all oriented to the requirements of the women concerned and often leave little room for individual needs. Rather, the professionally inexperienced and those not personally involved manifest themselves in an apparently arbitrary way depending on the country. Unfortunately, the restrictive conditions lead to precisely the opposite of what they are intended to achieve.

If one compares the frequency of abortions in various countries, it is clear that the countries with the lowest rate of abortions are those where the general conditions are most oriented to the needs and where women have the greatest possible autonomy in access to sex education, contraception and abortion, e.g. the Netherlands.

There is no evidence that restricting access by e.g. obligatory counselling or waiting periods is of any benefit. They do, however, lead to a delay in the provision of abortion and have negative effects on the physical and psychological experience of those affected. Consequently, all guidelines underline the advantages of early abortion (3-5). These aspects should be highlighted in the public discussion and in the formulation of new general conditions.

Developments in recent decades have been encouraging inasmuch as the regu-

lations in many countries have been changed and are now less restrictive. The example of Canada is particularly worth mentioning. There, the long established view is that the abortion of an unwanted pregnancy is a medical treatment and requires no legal interference. Therefore, after long legal arguments, in 1988 the Supreme Court declared the law on abortion to be unconstitutional and abolished it. It will be interesting to see how long it will take for this solution-oriented approach to replace the existing ideologically motivated regulations in other countries, especially those in the European Region.

Finally, I would like to introduce another gender aspect. As men, it is well-known that we cannot get pregnant, let alone have an abortion ourselves. Maintaining the reproductive health of women, however, is also in our interests. We are directly affected by and dependent on it. We should therefore argue for conditions which permit women, who have after all become pregnant through our actions, to end an unwanted pregnancy in the best possible way and without unnecessary suffering.

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The information on the legal situation and the practice in different countries is from national sources. Links to national institutions of different countries are available at the Link section of the FIAPAC website: [www.fiapac.org/e/Links1.html](http://www.fiapac.org/e/Links1.html)

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# SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE EUROPEAN UNION

By Mirjam Hägele

On 3 July 2002, the European Parliament passed a resolution on sexual and reproductive health and rights (SRHR) (1). The resolution was a result of a report officially presented by the Belgian member of European Parliament (MEP), Anne E. M. Van Lancker, for the Committee on Women's Rights and Equal Opportunities (2). It analysed the SRHR situation in the European Union (EU) and the ten countries that joined the EU in May 2004.

The Van Lancker Report not only reveals a lack of statistical information regarding SRHR in Europe, but also large differences with regard to SRHR in individual countries. The report highlights the fact that abortion rates in the new Member States and current candidates for accession countries are significantly higher than in the 15 pre-enlargement member states, attributing it to a greater lack of modern contraceptives. According to the report, "Due to limited availability and the high cost of appropriate contraceptives, as well as the lack of counselling services in central and eastern Europe, abortion still remains the principal means of fertility regulation".

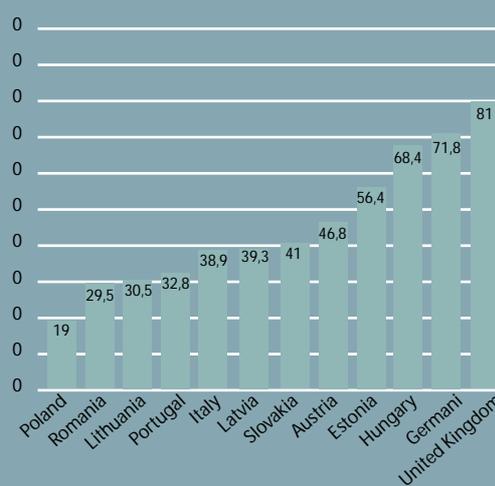
The report continues, that 65 per cent of women in the "old" European Union Member States (i.e. the 15 members prior to enlargement in May 2004) use contraceptives; this figure drops to 31 per cent in the new members and candidates for accession countries. Poland is at the bottom of the table in the region, with only 19 per cent of women said to be using modern contraceptives (3). The Van Lancker report also identifies that family planning does not form part of general health policy in Greece and Spain, and that Ireland only supports "natural methods" of contraception at the city and state levels, and there is a serious deficiency in the dissemination of contraceptives. General inadequate provision in the candidates for accession countries and new Member States gives great cause for concern on account of high rates of sexually transmitted infections and high abortion rates in some countries.

It is known that abortion rates are much higher in many of the new member and current candidates for accession states than in the old EU member states. Amongst this group, Sweden has the highest abortion rate, with 18 per 1,000

women aged 15-44. In eastern Europe, Romania is highest with 52 per 1,000 ending in abortion. A Romanian woman can expect to have a pregnancy terminated on average more than twice in her life (2.2) (4).

Ultimately, reported abortion rates reflect, in part, the legal status of abortion, which in Europe varies greatly from country to country. Most EU Member States and candidates for accession have liberal abortion laws. However, Ireland, Malta, Poland, Portugal, Spain and Cyprus pursue a very restrictive abortion policy. In Poland, the former liberal law has been changed and after 40 years,

Modern contraceptive prevalence in Europe in per cent in select countries



Source: Modern Contraceptive Use 2003. United Nations 2004

abortion is now permitted only on a very limited basis, while in Malta it is not allowed under any circumstances.

## Contraception and abortion in Europe

Due to a lack of information in the area of family planning and a high unmet need of modern contraception, the proportion of unplanned pregnancies in eastern and central European countries is particularly high: 80 per cent of these unplanned pregnancies are also unwanted (5). In former Soviet and other eastern European countries, most of these pregnancies end in abortion (5). This is especially the case in those countries where abortions are cheaper than contraception. In Romania, for example, cou-

ples are expected to pay for their own contraceptives, whereas pregnancy terminations are paid for by the state.

The Van Lancker Report also concludes that sexual education for young people is unsatisfactory, contributes to an increased number of teenage pregnancies throughout Europe and ultimately a high number of abortions. The disparity amongst the old EU member states, for example, is startling: in the UK, 28 out of every 1,000 girls between the age of 15 and 19 get pregnant; in the Netherlands, the rate is 7 out of every 1,000 girls. The report especially criticises the fact that young people in Bulgaria can only take part in sexual education classes with the written consent of a parent, though this is considered to be better than no sex education at all, as is the case in Poland.

The Van Lancker report stresses that abortion in the new member and accession states is one of the leading causes of maternal mortality in central and eastern Europe. WHO estimates that these abortions are responsible for more than 20 per cent of all cases of maternal mortality in some central and eastern European countries (6). This can be traced back to the fact that many of these abortions are unsafe.

### Recommendations of the Van-Lancker report

The resolution passed by the European Parliament in July 2002 and based on the Van Lancker report (2) clearly supports the Programmes of Action agreed on at the International Conference on

Population and Development (ICPD) in Cairo (1994) and the Fourth World Conference on Women (FWCW) in Beijing (1995). The resolution furthermore recommends the following measures to all EU Member states and accession countries in order to improve the SRHR situation in Europe:

- the introduction of uniform data collection;
- the development of national policies to improve SRHR;
- blanket provision of free or cheap contraception and family planning services;
- promotion of emergency contraception;
- legalisation of safe pregnancy termination for all. The resolution explicitly mentions that abortion should not be promoted as a form of family planning and that preventative measures to avoid abortion should be taken;
- governments should never prosecute women who have had an illegal abortion;
- increase the level of information on SRHR in the public domain;
- improvement of sexual education and the provision of family planning services for young people;
- orientation of national SRHR policies in alignment with the decisions made at the ICPD, FWCW and their follow-up conferences.

### Political controversy within the EU

Within the EU and the accession coun-

tries, the European Parliament's resolution has continued to lead to controversial discussions. It is especially the recommendation of the Van Lancker report to legalise abortion under certain circumstances, which has continued to spark controversy, especially since the passing of the Parliament's resolution. Although the resolution is not binding, Poland and Malta have protested strongly against it and claim that SRHR is a matter for each individual state and thus does not fall under the jurisdiction of the EU. Both governments fear that the EU wants to put pressure on national abortion laws. It is for this reason that Poland and Malta – as well as Ireland – demanded supplementary clauses when they signed their accession declarations. These clauses allow them to reserve the right to take all decisions with regard to abortion laws, under all circumstances.

A powerful opponent of many of the ICPD Programme of Action points is the Vatican, which has a strong influence in many Catholic countries, and is also a leading advocate in Brussels. Through Article 51 of the EU constitution, which calls on the EU to pursue regular dialogue with churches as part of its decision-making process, the church has secured an influential position for the future.

Furthermore, an increasing number of anti-abortion organizations are making their voices heard within the European Union. Letter and e-mail campaigns, which lobby for their issues, sometimes with false or incomplete information, form the backbone of their targeting of members of the European Parliament (MEPs). Last year, for example, the British organization "CARE for Europe (Christian Action Research and Education)" sent a letter to MEPs, which stated that people in developing countries did not need more money for family planning, as they had better access to condoms than to clean water. Furthermore, condoms did not protect against HIV and were thus, according to CARE for Europe, "as safe as Russian Roulette" (7). The organizations World Youth Alliance, KALEB e. V. ("Kooperative Arbeit Leben Ehrfürchtig Bewahren" – Co-operative work to preserve the honour of life), Pro Life Berlin and eurofam work in much the same way.

### Unplanned Pregnancy and Abortion

Region	Total annual pregnancies (in millions)	Planned pregnancies and births	Unplanned pregnancies that end in birth	Unplanned pregnancies that end in abortion
Worldwide	210	62 %	16%	22%
Eastern Europe	11	37%	6%	57%
Rest of Europe	7	67%	12%	21%

Source: Alan Guttmacher Institute: *Sharing Responsibility: Woman Society & Abortion Worldwide, New York and Washington 1999*

### EU development policy on SRHR

One focus of the European Parliament's resolution on SRHR is the EU's development policy as a whole. It calls for this policy "to take into account the devastating impact of the Mexico City policy of the Bush Administration." When President Bush froze the annual US contribution to the United Nations Population Fund (UNFPA), the EU replaced the funds. Under the leadership of Poul Nielson, then EU Commissioner for Development and Humanitarian Aid, the EU granted 32 million Euros in the autumn of 2002 to UNFPA and the International Planned Parenthood Federation (IPPF). In addition, the EU approved a further 73.95 million Euros in the summer of 2003 for the support of reproductive health in developing countries until 2006.

In the spring of 2004, the European Parliament passed the report "Population and Development: ten years after the UN conference of Cairo." Karin Junker, then social democratic MEP from Germany and Member of the European Parliamentary Committee for Development and Co-operation, drafted the report. The report calls on the European Union, the EU Member States and the accession countries to fulfil the obligations they promised at ICPD, in Cairo. The MEPs passed the report after a few amendments with 287 to 196 votes, and 13 abstentions (8).

The most recent proof of Europe's commitment to the ICPD Programme of Action was the announcement of the EU's and EU Member States' intention – on the occasion of the United Nations General Assembly Special Session to commemorate 10 years since the ICPD in Cairo (14 October 2004) – to grant UNFPA a further US \$75 million for contraceptives. Thus, Europe has effectively closed the resource gap left by the withdrawal of the US contribution. US President Bush has now withheld payments to UNFPA for the third year in a row, in spite of the contribution being passed by the US Congress. Moreover, as shown in the box, the European Council has called on member states to provide Europeans with more information and better education on sexual and reproductive health.

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### Council of Europe calls for better promotion of sexual and reproductive health in Europe

On 5 October 2004, the Parliamentary Assembly of the Council of Europe called on member states to provide Europeans with more information and better education on sexual and reproductive health. Problems include a sharp rise in teenage pregnancies, rates of sexually transmitted diseases, including HIV/AIDS, and an increase in sexual violence, the parliamentarians said. The Assembly also wants member states to share information about their more successful experiences, and to provide adequate funds for the development of STI screening, as well as counselling, services, and contraception, including for young people.

See the Council of Europe website for the text and recommendation.

<http://assembly.coe.int/Main.asp?link=http://assembly.coe.int>

# "WOMEN ON WAVES" DEBATE AT THE EUROPEAN PARLIAMENT

By Patricia Hindmarsh

At the end of August 2004, the Portuguese Government banned a Dutch ship belonging to the organization "Women on waves" from entering Portuguese waters or docking at a Portuguese port. It cited local laws and public health concerns and even ordered the Navy to deploy a warship to shadow the boat and ensure it stayed outside its territorial waters. This action prevented debates and information sessions on sexual and reproductive rights scheduled by Women on Waves with Portuguese and European parliamentarians. In reaction, the Socialist, United Left and Green parties within the European Parliament called for a debate to urge the European Union (EU) to take legal action against Portugal for breaching rights to freedom of expression and information, as well as free movement of persons and services.

## The current situation in Portugal

Portugal has a very restrictive abortion law, which only recognizes legal grounds if the pregnancy poses a risk to the woman's health or life, in the case of foetal malformation or if the pregnancy is the result of rape. Yet, even within this legal framework, women are sometimes denied terminations because health care professionals are not prepared to confront the social taboo of abortion. However, there are no restrictions on organizations promoting women's rights or advocating for changes to Portugal's current legislation. Women on Waves does not offer medical abortion in countries where it is not legal (1). There was, therefore, arguably no legal provision to prevent Women on Waves from entering Portuguese waters.

In the past, there have been several attempts to change Portugal's abortion laws. For instance, in January 2004, pro-choice groups in Portugal gathered 120 000 signatures calling for a new referendum to legalize abortion. However, Prime Minister Jose Manuel Barroso (the new President of the European Commission) decided against holding one.

The debate in the European Parliament was initiated by Ms Ilda Figueiredo, Portuguese member of the United Left and of the Working Group on Population, Sustainable Development and Reproductive Health in the European Parliament, an all-party group that advocates for sexual and reproductive health and rights.

Ms Figueiredo called on the Commission to state its view on the situation and urge Portugal to change its attitude and lift the ban on the Women on Waves ship. During the debate, Ms Figueiredo referred to the so-called "van Lancker" report, adopted by the European Parliament in July 2002 (2) and called on the EU member states to make abortion safe and accessible where legal, and refrain from prosecuting women for illegal abortions. She also stressed that the situation in Portugal is one of hypocrisy and violence against women, as it often results in clandestine and therefore unsafe abortions.

Instead of focusing on the question of the legality of Portugal's action, several parliamentarians took this opportunity to call for a complete ban on abortion throughout the EU, a matter over which the EU has no competence. Hans Blokland, Dutch member of the Independence/Democracy group, stated that "The Portuguese government should be praised that it deems unborn life worthy of protection", while Urszula Krupa, member from Poland for the Polish League for Families, stated: "I am thankful to God that I have the opportunity of speaking in the European Parliament about the most important contemporary issue – protection of life, especially in the situation where every year 50 million children are killed in their mother's wombs". She embarrassed other members, however, when she went on to ask: "Is killing helpless children in their mothers' wombs different from the extermination in Beslan? On what basis would the European Union usurp the right to decide about the life and death of humans?" (3)

According to Michal Tomasz Kaminski, Polish member of the Union for Europe of the Nation's group, it was also a debate about how contemporary Europe is treating unborn children: "In this room, after new European elections, there are more MEPs who have the courage to say: unborn children have the right to life! They have the right to life in Europe and everywhere!" (3)

In total, 27 parliamentarians took the floor: 14 were pro-choice (members of the Socialist, United Left, Liberals and Democrats, and the Green parties) while 11 were anti-choice (members of the People's party, Union for Europe of Nations, and the Independence and De-

mocracy group) - all four Polish speakers being anti-choice.

In order to calm the emotional debate, EU Commissioner Margot Wallström said that "The Commission intends to seek information on the precise motives and implications of the decision", before considering legal action as to whether Lisbon violated EU law. She added that under EU law, member states could restrict fundamental rights such as freedom of movement of people "only when it is justified ... for public security and public health". She added that "The Commission believes that any member state adopting a decision restricting the free movement of persons must respect fundamental rights, including the freedom of expression as general principles of [EU] community law." (3)

A strengthened anti-choice sentiment within the newly enlarged European Parliament cannot be denied - this debate provided an excellent opportunity to gage the mood of the European Parliament - and the increasing number of conservative female parliamentarians bent on reversing women's rights is cause for alarm. Therefore, eyes are now turned towards the Commission to take a firm stand to uphold women's rights across the EU.

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# RESOURCES

Q Web – Women’s Empowerment Base contributed to the compilation of this resource section. See [www.qweb.kvinnoforum.se](http://www.qweb.kvinnoforum.se) for additional resources.



## Safe Abortion: Technical and Policy Guidance for Health Systems

**World Health Organization, 2003**  
[www.who.int/reproductivehealth/publications/safe\\_abortion/safe\\_abortion.html](http://www.who.int/reproductivehealth/publications/safe_abortion/safe_abortion.html)

This is a comprehensive overview, including technical and policy guidance, on the provision of safe abortion. It is available in English, French, Polish, Portuguese, Russian and Spanish.

## Unsafe abortion

**Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000 - 4th edition**  
[www.who.int/reproductive-health/pages\\_resources/listing\\_unsafe\\_abortion.html](http://www.who.int/reproductive-health/pages_resources/listing_unsafe_abortion.html)

WHO has developed a systematic approach to estimating the regional and global incidence of unsafe abortion and the mortality associated with it. Estimates based on figures for the year 2000 indicate that 19 million unsafe abortions take place each year, that is, approximately one in ten pregnancies end in an unsafe abortion, giving a ratio of one unsafe abortion to about seven live births. The publication stresses that: "Where contraception is inaccessible or of poor quality, many women will seek to terminate unintended pregnancies, despite restrictive laws and lack of adequate abortion services. Prevention of unplanned pregnancies must therefore be the highest priority, followed by improving the quality of abortion services and of post-abortion care".

## Maternal Mortality in 2000: Estimates developed by WHO/UNICEF and UNFPA

[www.who.int/reproductivehealth/publications/maternal\\_mortality\\_2000/](http://www.who.int/reproductivehealth/publications/maternal_mortality_2000/)  
Published in 2004, this report defines and measures maternal mortality in all countries and provides comparisons with data from 1990 and 1995. Margins of uncertainty associated with the estimates are still wide, but the current estimates indicate that maternal mortality is still a major problem globally, and also a problem in parts of the European Region.



## Abortion Policies: A Global Review

**United Nations Population Division, Department of Economic and Social Affairs, 2003**

[www.un.org/esa/population/publications/abortion/](http://www.un.org/esa/population/publications/abortion/)  
Abortion Policies: A Global Review presents a country-by-country examination of national policies concerning induced abortion and the context within which abortion takes place.



## Ipas - Global Abortion News Update

[www.ipas.org](http://www.ipas.org)  
IPAS has recently launched a Global Abortion News Updates feature on its website. It provides an overview of new developments in abortion law and pol-

icy from around the world, including links and contact details. Updates are posted regularly. Other valuable Ipas resource include: "Making safe abortion accessible: A practical guide for advocates" and "Abortion methods and Post-abortion care".



## Held to ransom

[www.heldtoransom.org](http://www.heldtoransom.org)

This IPPF website is dedicated to addressing the policy implication of the US Mexico City policy, the so-called Global Gag Rule. This rule states that the United States will not allow its financial aid to be used to fund groups that provide abortions or any kind of abortion-related advice or referrals.



### East Central Europe Abortion Laws and Policies in Brief

[www.crlp.org](http://www.crlp.org)

The Center for Reproductive Rights is a non-profit US-based legal advocacy organization working to ensure safe, legal and accessible abortion care worldwide through a range of legal and policy strategies. The Center produced this and similar web resources such as “Safe and legal abortion is a woman’s human right“ to outline arguments for why abortion is to be considered a human right and to provide reference material on policy and rights related to abortion.

### Catholics for a Free Choice

[www.cath4choice.org](http://www.cath4choice.org)

CFFC is a non-governmental organization based in Washington, DC, that has special consultative status with the Economic and Social Council (ECOSOC) of the United Nations. CFFC shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women’s well-being and respect and affirm the moral capacity of women and men to make sound decisions about their lives, and works to infuse these values into public policy, community life and Catholic social thinking and teaching.

Most recently, they launched a “Catalyst for Change Speakers Bureau” to inter alia provide recommendations for the US government, the United Nations Population Fund (UNFPA) and religious communities aimed at fostering human rights and informed choice.



### EuroNGOs



[www.eurongos.org](http://www.eurongos.org)

The European NGOs for Sexual and Reproductive Health and Rights, Population and Development (EuroNGOs), formed in 1996, seeks to increase awareness and support for the ICPD Programme of Action in Europe. EuroNGOs unites and collaborates with a wide range of sexual and reproductive health and rights advocates, including NGOs, parliamentary groups, foundations and donor agencies from Europe and other parts of the world. Through its newly launched website, annual meetings, publications and multiple listserves, EuroNGOs shares information and encourages cooperation with many different groups, particularly young people.



### FIAPAC

[www.fiapac.org](http://www.fiapac.org)

The International Federation of Professional Abortion and Contraception Associates (FIAPAC) is a leading professional organization in the field. They seek to secure the right to a legal and safe abortion for all women who desire it. Through

congresses and other meetings they work to harmonize legislation concerning abortion and for freedom of access to all abortion methods in all countries. See their website for more details and information from their last international meeting, held in Vienna in September 2004.



### XVII World Congress of Sexology 10-15 July 2005, Montreal, Canada

[www.montrealsexo.com](http://www.montrealsexo.com)

The conference theme “Unity in Diversity” highlights the diversity of approaches and disciplines in the field of Sexology, and participants will include clinicians, researchers, educators, activists and policy-makers. See the website for the full scientific programme and registration details.

### ASTRA Network in Eastern and Central Europe

[www.astra.org](http://www.astra.org)

ASTRA is a network composed of sexual and reproductive health and rights organizations in central and eastern Europe. Their website includes policy documents related to sexual and reproductive health and rights with links to abortion-related materials

## *Entre Nous*

*The European Magazine  
for Sexual and Reproductive Health*

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