Report on successes in achieving UN Global Strategy for Women’s and Children’s Health – September 2012

Independent Expert Group on Information and accountability

Submission by Ipas

Information related to women’s access to safe abortion care

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The IERG has requested information on programs that have demonstrated success towards achieving women’s access to safe abortion care, as well as obstacles to realizing this and ensuring proper accountability. In this submission, we will provide information with regard to the following points:

Successes in enhancing access to safe legal abortion

1. Revision of laws to enable women and girls to access safe legal abortion
2. Increasing women’s knowledge about how to access safe legal abortion
3. Improving provision of safe legal abortion and postabortion care through clinical training and equipping of health-care providers
4. Improving women’s care by training health-care providers on reproductive rights
5. Improving provision of safe legal abortion through improvements to health systems

Obstacles to women’s and girls’ access to safe legal abortion

- Stigmatization of abortion and conscientious objection to provision of abortion care

Successes in enhancing access to safe legal abortion

1. Revision of laws to enable women and girls to access safe legal abortion

Policy implications of the examples below: an essential element needed to enable women and girls to access safe abortion is to ensure that this medical procedure is legally available. Once a law has been amended, however, efforts must ensure that steps are not taken to later rescind the law or otherwise impede its implementation.

Ethiopia

In 2005, the government of Ethiopia reformed its Penal Code to provide access to safe, legal abortion care in cases of rape or incest, to preserve a woman’s life or health, to protect girls who are physically or mentally unprepared for childbirth because of age and for women with physical or mental disabilities.¹ Technical guidelines for implementing safe abortion care were issued in 2006 by the Ministry of Health.²
A two-year monitoring project to assess services at 50 public sector facilities in Tigray showed notable improvements over time in almost all aspects of safe abortion care: availability, distribution, use and quality of services and improvement in post-abortion contraceptive uptake.\(^3\) In March 2007, slightly more than 30% of all women who received abortion services left the facility with a contraceptive method. This increased to almost 80% in two years. The evidence also suggests that the complementary interventions (training of clinical providers, equipment and infrastructure support, supervisory and monitoring visits) contributed to these improvements. By the end of the monitoring exercise, 38 of 50 facilities met the criteria for comprehensive safe abortion care, thus achieving 86% of the recommended level of coverage.

The distribution of services also improved substantially from 2007 to 2009. About half of all health facilities in Ethiopia provided induced abortion services. However, the proportion was much higher for public hospitals (76%) and private or nongovernmental organization (NGO) facilities (63%) than for public health centers (41%). These proportions are changing as efforts are being made to expand abortion services in public facilities.\(^4\)

**Mexico City Federal District**

In 2007, the Mexico City Federal District reformed its Penal Code to permit legal abortion in the first trimester of pregnancy.\(^5\) Whereas previously adolescent and adult women had sought expensive clandestine abortions in the District, today public hospitals and clinics provide women residing in the District with free and safe legal abortion care; women from other parts of the country can also receive services according to a sliding payment scale. Between 24 April 2007 and 29 September 2011, 67,200 women had legally terminated unwanted pregnancies in the District; 4.67% were younger than 18 years of age and less than 1% had had more than one abortion in that time period.\(^6\)

In response to legal challenges, the Mexican Supreme Court affirmed the constitutionality of the law reform in August 2008, stating: “the measure used by the Legislator turned out to be...ideal to protect women’s rights, because the counterpart of the non-criminalization of pregnancy termination is women’s freedom to decide on their body, their physical and mental health, and even their life...”\(^7\)\(^8\)\(^9\) Salazar Ugarte further notes that the law fulfills Article 4 of the Mexican Federal Constitution, which stipulates that every person has the right to decide freely and in an informed and responsible way on the number and spacing of their children; he adds that the law also fulfills the requirements of action of a secular, democratic State by providing services to all persons without discrimination.\(^10\)

Ipas Mexico works with several community allies to publish and distribute subway maps that indicate stops near hospitals and other facilities where safe abortions can be obtained.\(^11\) On the flip side of the maps, information about the law is clearly spelled out: “In Mexico City you can choose to have an abortion within the first 12 weeks of pregnancy. There’s no longer a need to keep it clandestine. The law is now on your side.”
Individuals and organizations opposed to abortion have reacted to liberalization of the law in the Federal District with a number of initiatives. As mentioned above, the law was challenged, unsuccessfully, before the Supreme Court. Nineteen of the 31 states in Mexico have passed constitutional amendments protecting life from conception or granting rights to fetuses. Two of the state amendments have been challenged before the Supreme Court; in September 2011, the Court upheld the amendment in Baja California state by a vote of 7 to 4; seven justices stated that the amendment was unconstitutional and four voted for its constitutionality – a “super majority” vote of 8 was needed to rule that the amendment violated the national constitution. A Court ruling on the other case is still pending.

2. Increasing women’s knowledge about how to access safe legal abortion

Policy implications of the examples below: even in countries where abortion laws are fairly liberal, women and girls continue to seek out clandestine abortions or seek services too late in pregnancy to obtain a legal procedure because they do not know that safe and legal abortions are an option. Health systems must therefore ensure that women are aware of services and where these can be obtained.

Zambia
In Zambia, Ipas has partnered with local organizations such as Tiye-Tiye to use street theater as a way of informing community members about the availability of safe legal abortion services. Discussion with the audience, which is part of the performances, is an integral part of the strategic effort to increase knowledge about reproductive health and safe abortion.

One skit centers on the story of Monica, a university student who has an unwanted pregnancy despite using contraceptive pills; she has an unsafe abortion. A trained facilitator periodically halts the action during the performance to ask audience members for their thoughts on what Monica should do and how her family and community could help. Audience members share details from real-life experiences and give suggestions.

When addressing married men, the facilitator discusses how they value a woman, the support she gives within the family, what would happen if she wasn’t there and how to keep her healthy. In every instance, facilitators drive home the message that safe abortion care, when needed, is available at designated local health centers in the Lusaka and Copperbelt regions.

In some group discussions, facilitators use visual aids such as flip books to disseminate accurate information on safe abortion and help women discuss and understand their options. The chairwoman of Tiye-Tiye says: “This work has given us knowledge that was hidden from us before. I am now proud that women come to me for more information on safe abortion... [and] I don’t hesitate to call out members of my group who may be using harmful, unsafe abortion practices.”
India
In Jharkhand — a predominately rural state in east India with low literacy, little access to TV or radio, and where women rely on husbands and neighbors for information — some women do not know about the availability of safe abortion services, others are not aware that the service is legal, and many more are deterred by the long distance they must walk in order to reach the nearest health center. As a result, many rural women turn to untrained providers for assistance in terminating an unwanted pregnancy, risking their health and lives.

To address the information and knowledge gap, Ipas India designed a behavior change communication strategy aimed at informing communities about medical abortion. Based on the needs and interests of women in 253 of the state’s villages, Ipas India designed more than 500 wall signs and carried out more than 350 street performances; they also use pictorial flip charts and other materials designed for a variety of literacy levels to help women distinguish between accurate and inaccurate information.

Ipas India also works to get more specific information to women in smaller settings by assembling groups of four to six women and telling them a story using an illustrated flip book. The book depicts women in a family setting, illustrating the consequences of unsafe abortion versus the better outcomes with supportive partners and safe abortion methods in early pregnancy. Ipas India has also designed games health workers can use in group settings to give women knowledge of when abortion is or is not legal.

The next step in the program is to encourage the government to make these strategies a permanent part of its health outreach programs, so that even larger numbers of women can benefit.

3. Improving provision of safe legal abortion and postabortion care through clinical training and equipping of health-care providers

Policy implications of the examples below: in order to ensure that legal abortion services are of good quality and accessible to all women, health-care providers need to be adequately trained and equipped to offer care according to protocols in line with World Health Organization guidance on safe abortion and postabortion care. In addition, training providers to use varied technologies (vacuum aspiration and medical abortion) can help them tailor services to the needs of individual women.

India
Despite provisions for legal abortion in India, almost 10% of maternal deaths result from unsafe abortions. The Government of Uttarakhand therefore partnered with Ipas India to increase women’s access to safe services, especially in rural and remote areas, by introducing a model of comprehensive abortion care (CAC) throughout the state from July
2006 to June 2009. The intervention included a baseline assessment, establishment of training centers for comprehensive abortion care and post-training follow-up to ensure provision of high-quality services.

The follow-up evaluation study, conducted in 135 health facilities ranging from primary health facilities to district hospitals, found that the percentage of rural facilities providing regular medical termination of pregnancy (MTP) services increased substantially from 19% in 2007 to 38% in 2009. Rural health facilities with all equipment essential for providing MTP increased significantly from 15% at baseline to 47% at follow-up, while in urban hospitals, essential MTP equipment was in place at 71% of facilities at follow-up versus only 35% at baseline.

The improvement in availability of MTP service options also helped reduce unsafe abortion in the state. In early 2007, only one-third (33%) of abortions in the state were performed at public sector health facilities, whereas the follow-up assessment in 2009 showed that this figure had increased to almost one-half (48%). In addition, safer methods for abortion were used, with dilatation and curettage (D&C) being replaced with uterine evacuation and medical abortion. The percentage of women who received MTP services with appropriate technology increased significantly from 32% to 91% in rural health centers and from 26% to 78% in urban hospitals at baseline and follow-up assessments, respectively.

Follow-up further showed improvements in post-abortion contraceptive services. In urban hospitals, the percentage of women who received a modern contraceptive method immediately after the pregnancy termination increased from 53% at baseline to 75% at follow-up, while in rural health facilities, the acceptance of postabortion contraceptives increased from 75% to 93% during the same time period.

Kenya

In 2009, a pilot project introduced misoprostol for postabortion care in five health-care facilities in the Rift Valley Province of Kenya, following the 2008 registration of misoprostol for a full range of obstetric and gynecological indications. The project trained providers, established and monitored services, and seeded stocks of misoprostol. In addition, the project prepared sites and providers to offer manual vacuum aspiration (MVA) for treatment of incomplete abortions so that women would have a choice of methods.

Drug availability proved a major hurdle during the pilot project. More women chose misoprostol over MVA than anticipated, and gaps in the public-sector procurement system caused facility stock-outs of misoprostol. As a result, women often had to acquire it at local pharmacies instead. In coordination with the drug’s distributor, pharmacists in the areas around the health-care facilities had received orientation on misoprostol provision and correct dosing to promote safe prescribing practices.

While providers and women saw many advantages to using misoprostol for postabortion care, some providers noted that young women were less likely to opt for it, instead
preferring MVA treatment, which offers more immediate complete evacuation of the uterus. This finding underscores the necessity of understanding the needs and preferences of young women — and the benefits of offering women a choice of methods when possible.

In 2010, Kenyan authorities added misoprostol to the national essential medicines list, a key step toward sustainable supply of the medication. National guidelines for postabortion care that include the use of misoprostol are pending, and Kenyan authorities are working to establish more widespread uptake of the drug throughout the health system to expand access to more women.

4. Improving women’s care by training health-care providers on reproductive rights

*Policy implications of the example below:* many health-care providers do not have sufficient knowledge about and understanding of reproductive rights; capacity-building in this area can positively affect provider attitudes and contribute to improvements in the reproductive health care that women receive.

*Nicaragua*

Restrictive government policies, lack of trained health-care providers, conservative values and stigma surrounding sexuality and abortion all combine to deprive women of needed sexual and reproductive health care in Central America. Often, women who have had abortions are treated inhumanely, homosexuals are treated poorly or refused care altogether, and sex workers are judged with disdain, according to Jamileth López Gómez, a university professor and head nurse at one of Nicaragua's municipal health centers. To address this, Ipas Central America's training-of-trainers program raises awareness of how sexual and reproductive health and rights are fundamental human rights.¹⁸

A three-day training in December 2011 in Managua, Nicaragua, engaged 24 participants with varying levels of training experience from across Guatemala, El Salvador and Nicaragua. The program covered a broad range of topics, including:

- myths and realities surrounding gender and sexuality
- values that inform trainers' attitudes and beliefs about women's sexual and reproductive health and rights
- a human-rights based perspective on sensitive topics such as sexual violence, emergency contraception and abortion
- principles of adult learning and effective training.

The workshop was grounded in a broad discussion of human rights and bioethics and how sexual and reproductive rights are globally accepted under these frameworks. In one exercise, "Walking in her shoes," each participant was assigned a fictional character whose story they followed through various stages of experience with domestic or sexual violence.
Some characters were denied professional help or care, some characters' stories ended tragically, and all storylines pushed participants to challenge their assumptions about women who are victims of violence. In a post-activity discussion, participants grappled with some deeply entrenched misconceptions about why violence against women occurs and why it is so difficult for women to break out of the cycle of violence. Most participants agreed that poor treatment of patients is rampant in facilities that don't have staff trained on the importance of respectful and unbiased sexual and reproductive health care.

One important aspect of the training is that participants learn from one another's professional and personal experiences — in part because they are responsible for facilitating the activities for each other on the second and third days of the workshop to build hands-on teaching experience. Training participants also leave with greater confidence in their ability to counter the negative attitudes of health-care workers with a compelling human-rights perspective. As participant Bertha Sánchez, a social worker who has led workshops on sexuality and gender for women in her community, stated: "I believe the trainers have helped me have better arguments and solidify my ethical values."

Participants in the program often instruct varied audiences such as educators, students, health-care service providers, youth and women's groups. The goal is a ripple effect through society: as people learn the importance of respecting sexual and reproductive rights as fundamental human rights, they spread that awareness to others. Ipas maintains a relationship with these trainers and offers support as they go on to carry out their "second-generation" trainings.

5. Improving provision of safe legal abortion through improvements to health systems

Policy implications of the example below: provision of safe legal abortion and postabortion care services must be embedded within a well-organized regulatory and policy framework in order to guarantee service coverage, adequate training and equipping of health-care providers and widespread knowledge among community members of the availability of care. Donor policies that impede implementation of any of these aspects form an obstacle to women’s and girls’ right to safe legal abortion.

Nepal

In 2002, Nepal amended its abortion law to permit legal termination of pregnancy up to 12 weeks gestation for any indication on request, up to 18 weeks gestation in the case of rape or incest, and at any time during pregnancy if mental/physical health or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life (approval from a medical practitioner required). Scale-up of services throughout the country was accomplished through a series of steps to ensure that the health system was equipped to provide good quality care.19
In July 2003, an evidence-based National Safe Abortion Policy laid out the rationale for providing safe abortion, explicitly contextualizing safe abortion within safe motherhood efforts. In December 2003, a legal procedural order was issued, defining legislative mechanisms, clinical norms, regulations, roles and responsibilities for nationwide implementation of abortion care. A Technical Committee for Implementation of Comprehensive Abortion Care (TCIC) was established within the Family Health Division of the Ministry of Health and Population (MOHP), and a Safe Abortion Advisory Committee (SAAC) was created, comprising members from multiple government ministries, professional councils, NGOs and advocacy organizations, to oversee the TCIC and provide high-level policy guidance and program decision-making.

The procedural order called for use of MVA and introduction of medical abortion (MA) for first-trimester abortion. Access to equipment, supplies and drugs, particularly MA drugs, has been complicated both by poor supply chain management and by over-the-counter, black-market sales along the Indian border. In addition, the Helms Amendment — a U.S. law banning use of foreign aid for abortion — has presented challenges for abortion supply logistics. Although USAID supports post-abortion care, which involves the use of MVA, USAID-funded programs cannot purchase MVA instruments — a restriction that has contributed to equipment shortages in Nepal.

The procedural order focused on first-trimester services. By authorizing staff nurses and auxiliary nurse midwives (ANMs) to provide abortion care, many of whom already had experience using MVA for postabortion care, the government facilitated rapid decentralization of services to rural and remote areas.

Introduction of training and service delivery for second-trimester abortion, which involves more complex clinical procedures than first-trimester care, was intentionally delayed to allow health-care workers to develop strong first-trimester skills first. In 2006, a national facility-based survey found that 13% of women seeking abortion were turned away because they were more than 12 weeks pregnant. With this evidence of the strong need for second-trimester care, advocates and policymakers developed a Strategic Plan for Second-Trimester Abortion based on global experience and evidence. It provided clinical standards for dilatation and evacuation and medical induction abortion and specified facility eligibility requirements (namely, hospitals with emergency obstetric care services). The MOHP’s formal endorsement of the plan in April 2007 led to implementation of second-trimester services.

The TCIC developed systematic, comprehensive strategies for rolling out safe abortion services, including training in all recommended methods, supervision and monitoring, well in advance of service initiation. Within one year of training initiation (May 2004–April 2005), provider coverage reached up to 60 facilities in 37 districts across Nepal. As of December 2011, over 1500 health-care providers had been trained in safe abortion care, and 532 sites were authorized to provide safe abortion services, covering all 75 districts in the country.
Private facilities made up a significant portion of listed facilities at all levels of care: 139 (39%) of primary, 90 (53%) of secondary, and 6 (67%) of tertiary listed facilities are privately run.

Partners have used a variety of information, education and communication methods to generate knowledge about the availability of legal abortion in Nepal. One important strategy has been to engage various frontline volunteers in informing communities about and making timely referrals to safe abortion care. Here, too, the Helms Amendment has complicated matters, since female community health volunteers employed by USAID-funded NGOs are prohibited from incorporating safe abortion messages into their counseling services. Ipas trained more than 5400 such volunteers in early pregnancy detection using urine testing kits and referrals for antenatal, contraception and abortion services. In addition, Ipas and PSI trained local pharmacists to provide women with knowledge about medical abortion, referrals to abortion services and information on indications for legal abortion in Nepal.

Another key innovation was TCIC’s development and marketing of a safe abortion logo — a visual symbol to designate facilities offering safe abortion services that is prominently displayed at all CAC sites. Through its extensive incorporation in materials and programs, the logo has become a widely recognized symbol of safe abortion, particularly among vulnerable populations such as illiterate women. Between January 2004 and June 2011, 497,804 women had received safe, legal abortion and contraceptive services.

Obstacles to women’s and girls’ access to safe legal abortion

Stigmatization of abortion and conscientious objection to provision of abortion care

Policy implications of the example below: human rights-based care is denied to women needing postabortion care and safe legal abortions due to the prevalent societal stigmas associated with abortion and providers invoking conscientious objection. This may result in inhumane and degrading treatment or complete denial of services. More work is needed to address the stigmatization of abortion at the community and health-care provider levels and health-system regulations and policies must ensure that conscientious objection does not form an obstacle to women receiving care. In addition, systems must be in place to enable women to seek redress for violations of their rights in relation to abortion care.

Brazil
Between 2008 and 2010, Ipas Brazil and Grupo Curumim, in partnership with women’s organizations, carried out a study on women’s access to legal abortion in capital cities and large municipalities of the states of Bahía (Salvador and Feira de Santana), Mato Grosso do Sul (Campo Grande and Corumbá), Paraíba (João Pessoa and Campina Grande), Pernambuco (Recife and Petrolina) and Rio de Janeiro (Rio de Janeiro, Duque de Caxias and Nova Iguaçu).
Three research mechanisms were used: consulting secondary sources of a national data system and academic research studies; visits to maternity hospitals and general hospitals; and direct, semi-structured interviews with women who had undergone abortion procedures, health-care providers, and administrators. They further heard testimonies from relatives of women who died as a result of abortion, and reviewed research reports developed by the Program of Gender and Health Studies of the Collective Health Institute of the Federal University of Bahia.

The study team found that women residing in small or medium-sized municipalities are often transferred to maternity hospitals in capital cities for abortion-related care, because hospitals do not have appropriate care conditions, or because health professionals boycott abortion care. For example, nearly 30% and 28% of obstetric hospitalizations for treatment of abortion complications in the municipal networks of Recife and Feira de Santana, respectively, were for women who reside outside the municipalities. In João Pessoa and Campina Grande, the percentage of non-residents who received care was also high — 44% in the former and 52% in the latter.

Testimonies from women noted inhumane care in hospitals, characterized by long waits, fasting, lack of information, violation of their right to privacy, and attitudes of recrimination, blame and punishment. In Salvador and Campo Grande, there were even reports of sharp curettage procedures performed without anesthesia.

Priority care was given to pregnant women in labor at all the facilities studied, resulting in longer hospital stays for the women receiving abortion care. Women reported waiting two or three hours in the reception or triage area, even when they were in pain or hemorrhaging. As one woman in Bahía stated:

“We arrived early; I remember that there were only two people ahead of me, but they were taking a long time to treat me. Other people started arriving and they went right in front of me; I think it’s because they knew that I had induced an abortion. I think that when women induce an abortion, they punish them harshly, leaving her lying in a corner. I was with my sister and my mother; we waited in the waiting area, but they did not take me in; they didn’t even bring a bed; I remained seated. I had a very big Tampon, but even so, when I got up from the chair, I saw that my clothes were drenched in blood. The receptionist called the doctors. I think that if they had not seen all that blood, it would have taken longer. I know that I got there at 7 a.m. and they took me in around 10:00.”

A health professional in Petrolina explained:

“Sometimes even with hemorrhage...there was a case of a woman who smelled awful when she was finally able to be seen; she spent more than a day waiting in triage, with missed abortion, with sepsis, even so, she was the last one to be seen that day. That’s how it is; when it’s an abortion, they don’t even want to know whether it was spontaneous or induced; the woman is left for last in admissions.”

The team further found that providers’ attitudes are characterized by religious moral values, which make it difficult for them to treat abortion cases. Many health-care providers are
Catholic or Evangelical and explain their unwillingness to provide care as the result of their wish to defend life. Providers were seen to judge women, adopt punitive and discriminatory attitudes, or refuse to perform legal abortion procedures. A health professional in Rio de Janeiro noted the difficulties in providing legal abortion services: “Even so, I perceive resistance from obstetricians and anesthesiologists to perform the procedure due to personal issues. The maternity hospital plays its part, but providers whose position is to preserve life end up judging the women and refusing to perform the procedure.”

Due to the clandestine nature of many abortions and knowledge about institutional violence, women were found either not to seek abortion care or to do so late. When they presented at a facility, they often said they were spontaneously bleeding, without mentioning having induced an abortion, as a strategy to protect themselves against providers’ judgments and discrimination, as well as against the growing threat of being reported or imprisoned.

To increase government accountability for the provision of postabortion care and safe legal abortion, the team made the following recommendations:

- Increase coverage of obstetric care in all of the municipalities, taking into account the administrative complexities
- Organize obstetric and neonatal care networks that ensure services for high-risk pregnant women in emergency situations, including referral and counter-referral mechanisms
- Increase coverage of care for women and adolescents who are victims of sexual violence, ensuring abortion services in cases where they are legal
- Humanize care provided to women who undergo abortions in hospitals
- Disseminate the Ministry of Health’s Technical Guidelines for Humane Abortion Care, and monitor and evaluate their implementation in health facilities
- Increase the use of the MVA in facilities that are already using it and implement the procedure as routine practice in Brazilian maternity hospitals
- Create mechanisms and routines to decrease the duration of hospital stays for women who undergo abortion
- Respect women’s privacy during abortion care
- Make ultrasound available in municipalities in order to reduce women’s waiting time to undergo the abortion procedure
- Facilitate the purchase of medications, specifically misoprostol, through new decrees and resolutions that ensure that smaller maternity hospitals and hospitals in rural areas can obtain them
- Prioritize the improvement of family planning services in municipalities and monitor the steps taken
- Ensure postabortion family planning services are available in maternity hospitals, referring clients for basic care
- Ensure psychosocial care for women who undergo abortions in public maternity hospitals
Develop an ongoing education process for health-care providers, based on a gender and sexual and reproductive rights perspective, focused on the client-provider relationship and issues related to unsafe abortion and legal abortion.

Engage the feminist movement in developing abortion-related, ongoing education processes to be implemented with health professionals.

Stimulate research on abortion and contraception issues based on women’s perspectives given in the environment in which they live and their specific cultural backgrounds.

Support sexual and reproductive rights campaigns, targeting the most vulnerable populations, especially women who reside in municipalities in the interior, young women, and adolescents.

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