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# **Access to Safe Abortion: Progress and Challenges since the 1994 International Conference on Population and Development (ICPD)**

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**Background paper # 3**

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## Introduction

*“Unsafe abortion continues to be a major public health problem in many countries. A woman dies every eighth minute somewhere in a developing country due to complications arising from unsafe abortion. She was likely to have had little or no money to procure safe services, was young - perhaps in her teens - living in rural areas and had little social support to deal with her unplanned pregnancy. She might have been raped or she might have experienced an accidental pregnancy due to the failure of the contraceptive method she was using or the incorrect or inconsistent way she used it. She probably first attempted to self-induce the termination and after that failed, she turned to an unskilled, but relatively inexpensive, provider. This is a real life story of so many women in developing countries in spite of the major advancements in technologies and in public health.”*

25 September 2007<sup>1</sup>

Dr. Halfdan Mahler  
Director-General Emeritus, WHO  
Director-General WHO: 1973-1988  
Secretary General, IPPF, 1989-1995

Induced abortion, safe or unsafe, legal or illegal, is a universal phenomenon and has existed throughout recorded history.<sup>2</sup> When faced with an unintended pregnancy, women seek abortion and self-induce it or find providers, irrespective of the law. Yet, abortion continues to be the most emotive and contentious issue in reproductive health. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.<sup>3</sup>

Each year 44 million abortions take place worldwide, nearly half of them safely and the rest unsafely.<sup>4</sup> Unsafe abortions present a critical public health and human rights challenge of the present time. Deaths and disability due to unsafe abortion continue to occur against the backdrop of major advances in the medical profession, especially in terms of the availability of safe and effective technologies and skills for induced abortion.<sup>5</sup>

A host of barriers and challenges result in unintended pregnancies and restrict access to safe abortion. Medical technologies for safe abortion are no longer a problem, but the availability of and access to these technologies remains a formidable challenge. Countries that are in transition from more to less restrictive abortion laws have to build the infrastructure and skills. Other countries that liberalized the law in the last 10-15 years are still struggling to provide much needed services, including change in attitude of service providers. Therefore, in many countries there is a need to ensure universal access with adequately trained providers both in provision of safe abortion procedures, and also in counselling, together with necessary equipment and infrastructure.

Legal provisions governing access to safe abortion, availability and quality of official abortion services, fees involved in the procurement of a safe abortion, the attitude of health staff and approach to clients can all be major barriers. Lack of awareness of what the law actually permits among the public, women, legal and health staff alike persists.

Access to abortion is commonly restricted, not only by the law, but also by other barriers. Stigma against abortion is a fundamental barrier to accessing abortion services. Social and cultural impediments also contribute to delays in seeking abortion to a time beyond the limit set by the

law and thus leaving no option for women other than having an unwanted birth or a clandestine risky abortion.

Political and policy barriers continue to hinder legal reforms to permit abortion on request and to make services accessible where countries have reformed the laws. No other issue in reproductive health divides politicians and policy makers as abortion. More recently, the organized opposition to provision of safe abortion and efforts to make its access more restrictive are presenting formidable challenges. Together, these barriers and challenges deprive women from accessing safe abortion and exposing them to unwanted births or to unsafe abortion and its devastating consequences of death and disability.

This paper reviews evidence on abortions laws and policies, levels and trends in the incidence of safe and unsafe abortion and of mortality due to unsafe abortion, focusing on changes since 1994 ICPD. Key findings are highlighted before describing data and methods, abortion laws and their implementation and levels and trends in unsafe and safe abortion. This is followed by evidence on levels and trends in unsafe abortion mortality and morbidity, selected case studies of transiting from unsafe to safe abortion and preserving the legal provision of safe abortion, reproductive rights and, finally, a set of recommendations are presented in the concluding section of the paper.

## **Key Findings**

- 1) Globally, the annual number of induced abortions has declined from 46 million in 1995 to 44 million in 2008. This corresponds to a decline in overall abortion rate from 35 to 28 per 1000 women in reproductive age 15-44 years.
- 2) From 1995 to 2008, the decline in unsafe abortion globally was modest; from 15 to 14 per 1000 women of reproductive age 15-44 years while the rate for safe abortion dropped from 20 to 14 during the same period.
- 3) Unsafe abortion rate declined in all regions, except in Africa where it remained constant from 1990 to 2008 at a rate of 28 per 1000 women in reproductive age 15-44 years.
- 4) The number of deaths due to unsafe abortion has declined from 69 000 in 1990 to 47 000 in 2008; corresponding to an annual decline in unsafe abortion-related mortality ratio of 1% in Africa, compared to 4% in Asia and over 6% in Latin America.
- 5) The case-fatality rate of unsafe abortion has also declined globally at a rate of nearly 3% annually, but remains many times higher than for safe abortion in developed countries.
- 6) Nearly all unsafe abortions and related mortality occur in developing countries with sub-Saharan Africa accounting for 61% of all deaths due to unsafe abortion. The case fatality rate for Africa was 520 per 100 000 unsafe abortions in 2008.
- 7) Since ICPD, countries not permitting abortion on any ground have declined from 8% to 3% in 2011 and countries where abortion is permitted on request increased from 22% to 30%. During this period, the number of countries which made grounds for abortion more liberal was much higher (70) than those making the grounds for abortion more restricted (11).
- 8) Whether legally restricted or not, abortions continue to occur with abortion rates being higher where it is restricted than where it is permitted on request or under broad grounds.
- 9) Where abortion is legally highly restricted, the incidence of unsafe abortion and related mortality is high. Legal restrictions also result in major inequity in access to safe providers, as women in urban areas and those who can afford to pay can access physicians or travel abroad to procure abortion.
- 10) Some countries have made major progress in reducing unsafe abortion and the associated burden of mortality and morbidity with concerted efforts, including political will, legal and health system reforms and by applying innovative approaches.

- 11) Since ICPD, safe and effective methods of abortion, including manual vacuum aspiration and medical abortion, have become more widely available - the combined regimen of medical abortion consisting of mifepristone and misoprostol is now approved in 57 countries. In addition, emergency contraception is approved in 140 countries and in 60 of these it is available over-the-counter.
- 12) Although it was made clear at ICPD that access to safe abortion is imperative for public health, progress made at addressing unsafe abortion has not been as rapid and effective as it could have been, due to organized minority opposition which was intensified during the last decades.
- 13) The need for better and timely reporting of data on abortion is clear and pressing.

## **2. Data and methods**

Definitions of indicators and key concepts covered in this paper are provided in Annex 1. A few detailed tables are presented in Annex 2 to Annex 6.

The overall number of induced abortions and abortion rates are estimated by pooling the unsafe abortion estimates by the WHO and estimates for safe and legal abortion compiled by the Guttmacher Institute. These estimates have been developed for 1995, 2003 and, most recently, for 2008.<sup>4</sup> Both the safe and unsafe abortion estimates are based on extensive search and a careful evaluation of the relevant data. A more complete discussion of the data and methods to estimate unsafe abortion are provided in recent publications.<sup>6,4</sup> For this paper, published estimates and studies have been reviewed, analysed and described.

## **3. Abortion laws and their implementation**

The evidence consistently shows that women all over the world are likely to have an induced abortion when faced with an unplanned pregnancy, irrespective of legal conditions.<sup>2,4</sup> Where abortion laws are liberal there is generally no or very little evidence of unsafe abortion and related morbidity and mortality. In contrast, legal restrictions result in women self-inducing abortion or seeking it clandestinely. These abortions are unlawful and generally unsafe.

The conditions under which abortion is legally permitted differ from country to country.<sup>7</sup> In some countries, access is legally highly restricted; in others, abortion is permitted on broad medical and social grounds or on request. In 2011, the latest year for which information is available, abortion is permitted to save a woman's life in 97% of 194 countries or territories (Table 3.1). The number of countries legally permitting abortion rapidly goes down as the legal grounds for abortion become progressively more liberal; only in 30% of countries is abortion available on request. Among the 49 countries that permit abortion only to save a woman's life (Table 3.2), about half explicitly permit an induced abortion under this one condition while in others the law is not explicit and therefore access to abortion can be subjected to legal scrutiny and/or provider refusal.<sup>8,9</sup> Abortion laws are diverse and can be complex, commonly stipulating limitations of gestational age. In some instances, laws set conditions that may be contrary to the stated intent, such as requirements of consent and counselling, or endorsement of several doctors which may complicate and prolong the application procedure, sometimes pushing an abortion past the legally permitted time period.

**Table 3.1** Number and percentage of countries by legal grounds under which abortion is permitted, 1994 and 2011

	Abortion is <b>not</b> permitted on any ground	To save the woman's life	To preserve physical health	To preserve mental health	In case of rape or incest	In case of foetal impairment	Economic or social reasons	On request
Number of countries in 1994	15	174	119	95	82	79	56	42
% of 189 countries in 1994	8	92	63	50	43	42	30	22
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Number of countries in 2011	5(*)	189	132	126	99	98	69	58
% of 194 countries in 2011	3	97	68	65	51	51	36	30

(\*) Dominican Republic, El Salvador, Nicaragua, Chile, Malta

Sources: United Nations, 1994<sup>15</sup> and 2011<sup>7</sup>

Since ICPD,<sup>10</sup> the trend globally has been to increase the conditions on which abortion is permitted (Table 3.1). In 2011, the number of countries that permit abortion on request, or because of foetal impairment or rape or incest increased by eight percentage points each as compared to 1994. The largest increase was in the percentage of countries permitting abortion “to preserve mental health” – from 50% in 1994 to 65% in 2011. This trend is probably a spinoff of ICPD given its emphasis on women’s reproductive health and rights, even though the ICPD Programme of Action (PoA) did not explicitly suggest liberalisation of abortion restrictions. It was however elaborated in the “Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development” agreed by the UN General Assembly in 1999.<sup>11</sup>

In the last decade or so, various countries, or parts of countries (such as States within the United States) have also experienced challenges to laws that allow for access to safe abortion. Such challenges have arisen across countries that have diverse political, demographic, and socio-economic characteristics, and have also been mounted in various UN forums. Nonetheless, in only a few countries, and in no UN agreements, have the core ICPD and ICPD+5 agreements been weakened.

Removing legal restrictions on abortion is an essential, though insufficient, action to improve access to safe abortion. Discrepancies between the wording of the law (*de jure*) and its application (*de facto*) are common, and practice therefore can help or hinder access to and provision of safe and legal abortion. The knowledge and interpretation of abortion laws by health care staff, knowledge and general understanding of the law in the community at large and by women and their families in particular, significantly affect what women with an unintended pregnancy do.

In countries where the law is liberal but services are unevenly distributed, for example, in rural areas, or services are missing or deficient, or socio-economic and other barriers restrict access, unsafe abortions continue to take place. India, where abortion was legalized in 1971, is a case in

point: although abortion is allowed on multiple grounds (although not on request), more unsafe than safe abortions take place.<sup>12</sup> Reasons include, among others, mal-distribution of government services, official and unofficial fees that women cannot afford, failure to monitor the quality and safety of services in both public and private facilities, and so on.<sup>13</sup> Some countries that restrict abortion to a few conditions show no incidence of unsafe abortion. For example, United Kingdom and New Zealand do not permit abortion on the grounds of rape/incest and socio-economic grounds, respectively, nor is induced abortion legally available on request, yet in practice almost all women have access to safe abortion. Many other patterns exist in the relationship between the law and availability of and access to safe abortion.

### *The extent of the legal right to safe abortion*

The fact that women in 140 countries can legally request an abortion for more than one reason (Table 3.2) can easily be overlooked by providers and women. In all but five countries (Dominican Republic,<sup>c</sup> El Salvador, Nicaragua, Chile, and Malta) abortion is allowed to save the woman's life; 49 countries permit for this reason **only**. Eighty-six per cent of the world's women of reproductive age live in countries that allow access to safe abortion under additional grounds other than to save the woman's life; 79% on at least two other grounds, and 65% on at least four additional grounds. Fifty-nine per cent of women aged 15-44 years live in countries where the law permits abortion on five other grounds or on request; of these, six countries permit abortion on multiple grounds but not on request. India falls in this latter grouping, which explains the high percentages (18%) of the world's women of reproductive age in this category. Generally, other reasons than to save the woman's life are often insufficiently recognized and stipulated.

**Table 3.2** Number and percentage of countries and territories by number of grounds under which abortion is permitted, and the percentage of women aged 15-44, for 194 countries in 2011

	Abortion is <b>not</b> permitted	Only to save the woman's life	to save the woman's life and any 1 other ground	to save the woman's life and any 2 other grounds	to save the woman's life and any 3 other grounds	to save the woman's life and any 4 other grounds	to save the woman's life and any 5 other grounds	to save the woman's life, all other grounds and on request
Number of countries	5	49	7	33	14	21	7	58
% of countries	3	25	4	17	7	11	4	30
% of women 15-44 in 2011	0.6	13	8	11	3	6	18	41

Sources: United Nations, 2013<sup>7</sup> and 2009<sup>14</sup>

<sup>c</sup> In the Dominican Republic, laws on abortion have been amended to remove all grounds on which abortion might be performed legally. However, it is not clear whether a defence of necessity might be allowed to justify an abortion performed to save the life of a woman.

## ***Changes to abortion laws between 1994 and 2011***

In 81 of the 189 countries or territories for which information on abortion law is available for both 1994<sup>15</sup> and 2011<sup>7</sup>, changes were introduced in the grounds on which abortion is permitted by the law. Annex 2 shows legal grounds for abortion in the 81 countries where abortion laws were made more liberal (70) or more restrictive (11).

Among the 70 countries that liberalised abortion, 12 now allow abortion to save the woman's life; Colombia and Bhutan also revised the law to allow abortion under five and three additional grounds, respectively. Sixteen countries, including among others, Bahrain, Nepal, Cambodia, Guyana and South Africa decided to permit abortion on all grounds, including on request. Liberalization in Mexico is restricted to Mexico City.

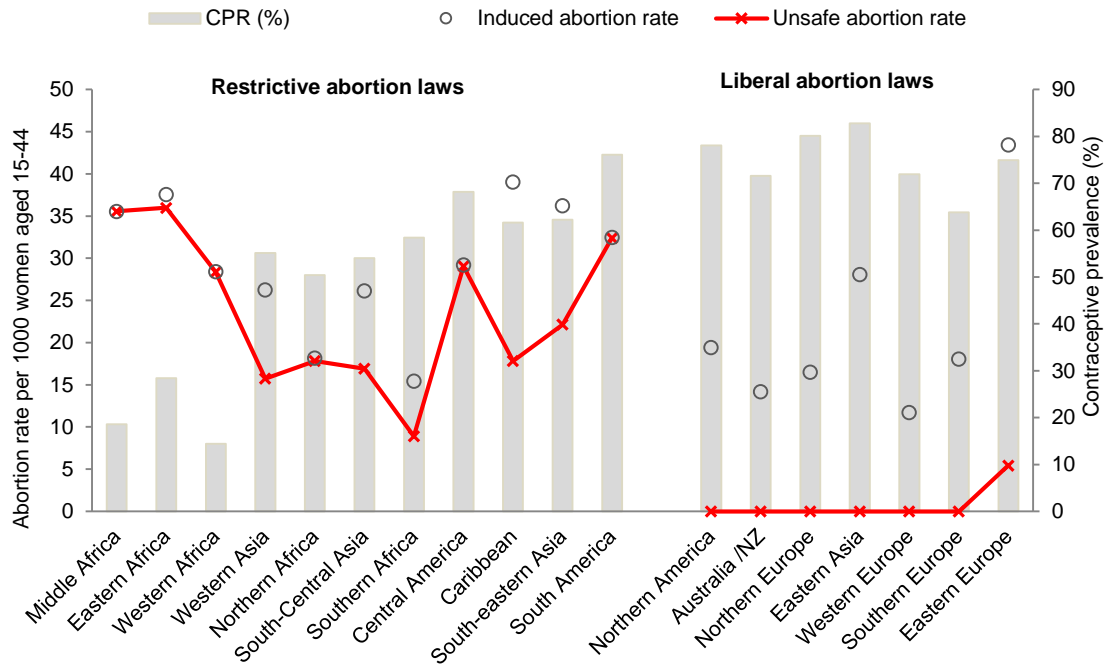
Ecuador made changes in both directions, allowing abortion to preserve the woman's health, but removing the ground of rape or incest. El Salvador and Nicaragua no longer permit abortion on any ground, removing even the earlier provision to save the woman's life. Iraq, Papua New Guinea, Malawi, and Congo limited abortion to one ground, saving the woman's life; Japan and Malaysia restricted the mental health reason and foetal impairment, respectively; while Belize, Ecuador and Algeria removed rape/incest as a ground for abortion.

## ***Abortion laws, abortion incidence and mortality***

In Western Europe subregion, where use of modern contraceptive methods is high (68.6%)<sup>16</sup> and abortion is legally permitted on request, the abortion rate is the lowest of any subregion. The available evidence indicates that overall induced abortion rates are lower where abortion laws are liberal (Figure 3.1), generally falling between 12 and 19 per 1000 women of reproductive age; only in Eastern Europe and Eastern Asia, two subregions with a long history of reliance on abortion as the primary method for fertility regulation, are induced abortion rates higher. Contraceptive prevalence (CPR) is high where abortion laws are liberal, and unsafe abortions are negligible. Only exception is Eastern Europe where CPR is relatively low due to historical reasons, but rising. On the other hand, where induced abortion is restricted, induced abortion rates are generally higher (Figure 3.1). Perhaps a more serious consequence of legal restrictions is the resultant high maternal mortality due to unsafe abortion. Countries with most restricted abortion laws show high level of maternal mortality ratios (MMRs) due to complications of unsafe abortion.<sup>17</sup> The MMRs due to unsafe abortion show a decline progressively with liberal grounds for abortion (Figure 3.2).



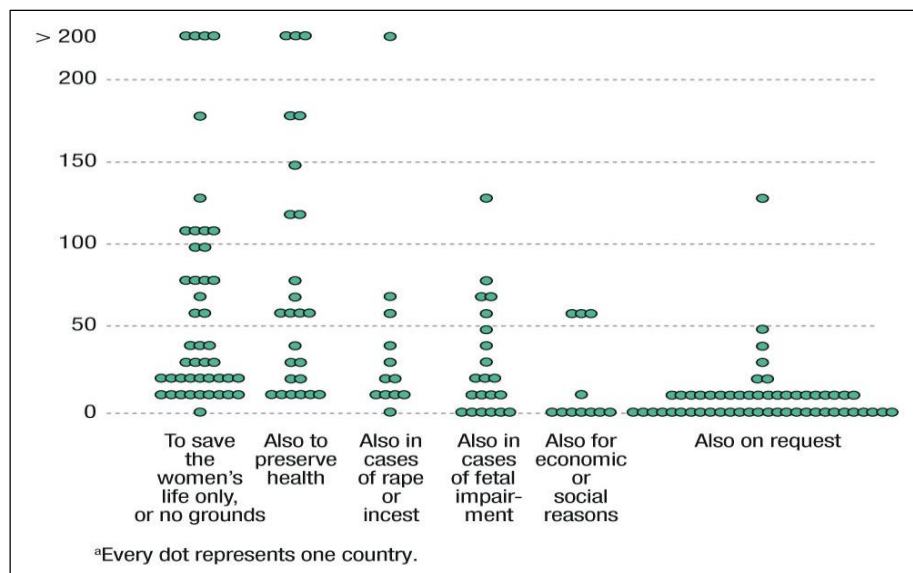
**Figure 3.1** Abortion rates in subregions that have restrictive vs. those that have liberal abortion laws, by contraceptive prevalence of any method (CPR), 2008.



The subregions are ordered by decreasing Total fertility rate (TFR): from 5.6 to 2.2 where laws are restricted and 2.0 to 1.4 where liberal.

Sources: UN 2011;<sup>16</sup> WHO 2011;<sup>6</sup> Sedgh et al. 2012<sup>4</sup>

**Figure 3.2** Deaths attributable to unsafe abortion per 100 000 live births by legal grounds for abortion, 2003 (168 countries).



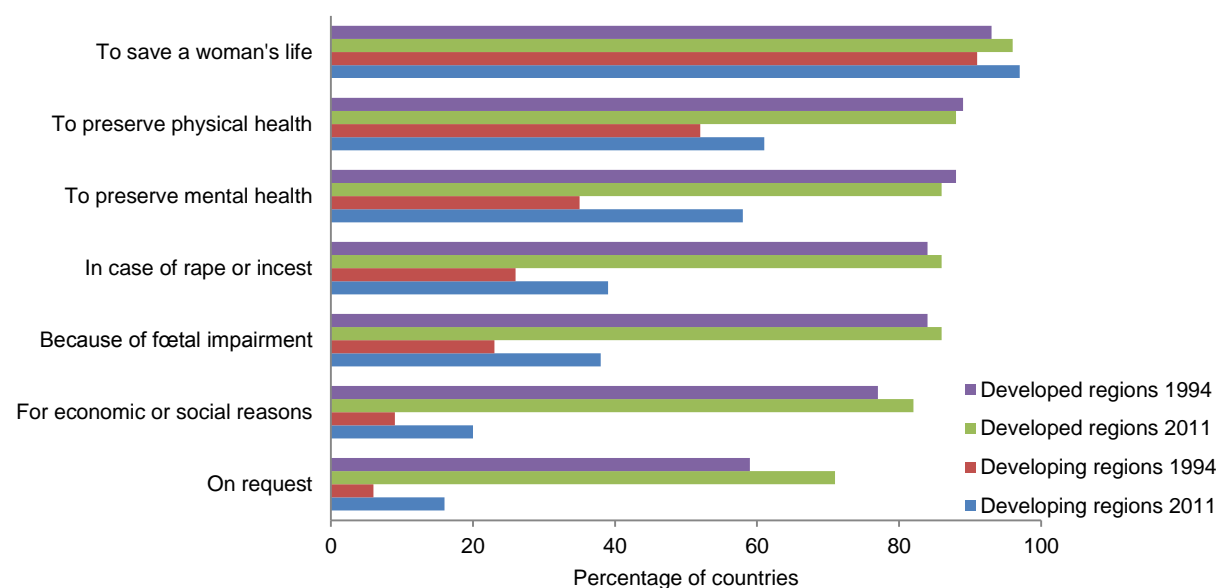
Source: WHO 2008<sup>17</sup>

## Abortion restrictions and equity

In no other indicator of reproductive health is inequity due to legal restrictions and to lack of services as glaring as in access to safe abortion care. Nearly all of unsafe abortions (98%) and deaths due to unsafe abortions (99.8%) occur in developing regions.<sup>6</sup> Although induced abortion is a universal practice, legal restrictions and lack of services expose women who are young, poor, and living in rural areas disproportionately more to the risk of unsafe abortion than those who are well-off and living in urban areas.

The differentials in the legal grounds by level of development show that in 2011 women in only 16% of developing countries could obtain abortion on request, compared to women in 71% of the developed countries (Figure 3.3). Reforms in abortion laws in developing countries since 1994 show some liberalization of strict conditions, but developing regions lag far behind the developed regions in making abortion legally permissible on broad economic and social reasons or on request (Figure 3.3). This trend impacts on women's access to safe abortions, resulting in reliance on unsafe procedures and resultant deaths and disability that are confined almost entirely to developing regions.

**Figure 3.3** Legal grounds on which abortion is permitted, by level of development, 1994 and 2011 (percentage of countries)



Source: United Nations 2013<sup>7</sup> and 1994<sup>15</sup>

Pronounced differences are found by economic status with poor women much more likely to have an abortion performed by unskilled providers than well-off women. In countries where abortion is highly restricted, women who are better-off can obtain an induced abortion from a medically trained provider (doctor or nurse) or can travel to a country with liberal laws. When abortion is legally restricted, its provision by medically trained providers becomes more expensive making it out of reach for the poor women. Information from the Health Professional Surveys by the Guttmacher Institute<sup>9</sup> shows that fewer women in rural areas were likely to have the clandestine abortion performed by doctors as compared to women in urban areas (8% vs. 32% in Guatemala; 9% vs. 26% in Mexico; 22% vs. 41% in Pakistan; and 16% vs. 42% in Uganda).

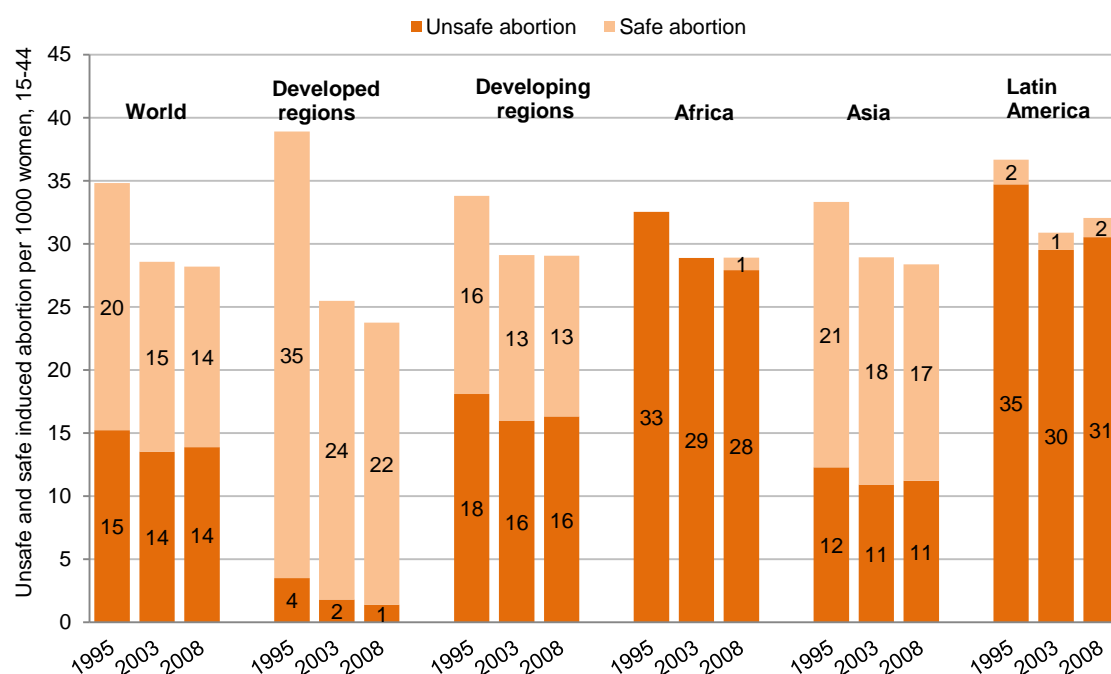
Because of lack of financial means and support, adolescents and young women are more likely to have an abortion, especially in Africa, by an unskilled provider. In 2008, 51% of all unsafe abortions in Africa were among young women aged 15-24 years.<sup>18</sup> The corresponding figure was

44% for Asia and Latin America. Young women are disproportionately more likely to have unsafe abortion when abortion is legally restricted. The comparative figures of safe abortion for the same regions are not available. However, in Eastern Asia where abortion is largely legal on request, 31% of all legal abortions are among young women aged 15-24 years. In Europe, the figure is 35%. In North America where teenage pregnancy is high, 51% of all legal abortions are among women aged 15-24 years.<sup>19</sup> The legal restrictions of abortion and lack of services thus aggravate the equity in access to reproductive health care, especially to safe abortion care.

#### 4. Levels and trends in unsafe vs. safe induced abortion incidence and post-abortion care (PAC)

Globally, the total number of induced abortions has declined from almost 46 million in 1995, to 42 million in 2003, and 44 million in 2008 (Annex 3).<sup>4</sup> While the total induced abortion rates worldwide have fallen, the proportion of all abortions that are unsafe has shown a progressive increase. In 1995, there were 20 safe and 15 unsafe abortions per 1000 women aged 15-44 years globally; in 2008 these rates declined to 14 for each one (Figure 4.1). The decline in the induced abortion rate is almost entirely due to decline in safe abortion rate. Because of the growing number of women in reproductive age over time in countries with restricted abortion laws without an appreciable concomitant decline in recourse to unsafe abortion, the global number of unsafe abortions have nonetheless increased from 19.9 million in 1990<sup>20</sup> to 21.6 million in 2008<sup>6</sup>. These rates and numbers indicate that despite some progress, unsafe abortion continues to be a major public health concern that requires concerted effort to safeguard women's health in developing regions.

**Figure 4.1** Unsafe and safe abortion rates in 1995, 2003 and 2008, per 1000 women aged 15-44 years, globally and by major regions



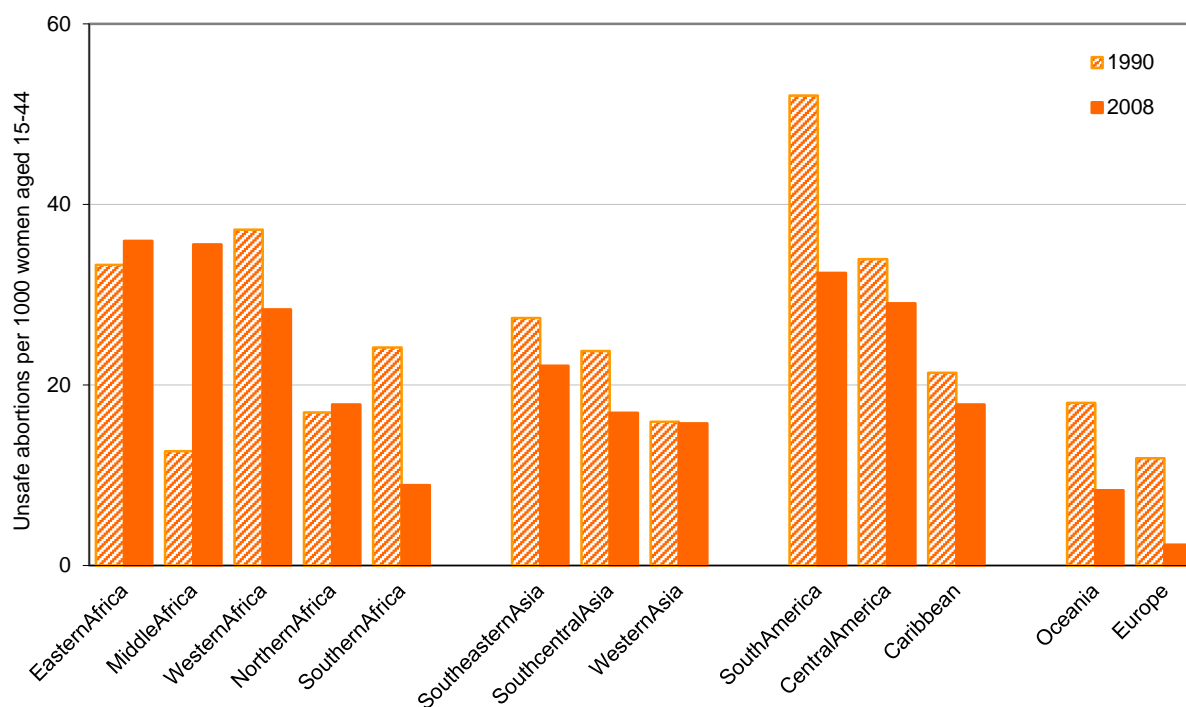
Sources: Sedgh et al. 2012;<sup>4</sup> WHO 2011<sup>6</sup>

## ***Unsafe abortion: a public health problem***

As identified in the World Health Assembly Resolution in 1967<sup>21</sup> and later by ICPD in 1994,<sup>10</sup> and the Women's Conference in Beijing (1995),<sup>22</sup> unsafe abortion is a major public health problem. Where abortion is legally restricted, women, especially the young, the poor and those living in rural areas, have little or no access to safe abortion services. In such restricted contexts, some women go on to have unwanted children; most women, however, end up having unsafe abortions. Unsafe abortions are, however, entirely preventable.

The breakdown of estimates by subregion (Figure 4.2) shows the comparative and real significance, respectively, of unsafe abortion by subregion. The most recent (2008) estimates show (Annex 4) that of the estimated 21.6 million unsafe abortions worldwide, over 30% took place in the South-central Asia subregion alone; almost as many, 29%, were in the Africa region (2 out of 3 in Eastern and Western Africa subregions); and the Latin America region, that has the highest rate among regions, corresponded to 20% of global number of unsafe abortions.

**Figure 4.2** Unsafe abortion rate per 1000 women aged 15-44, by subregions, 1990 and 2008



Source: WHO 1993;<sup>20</sup> WHO 2011<sup>6</sup>

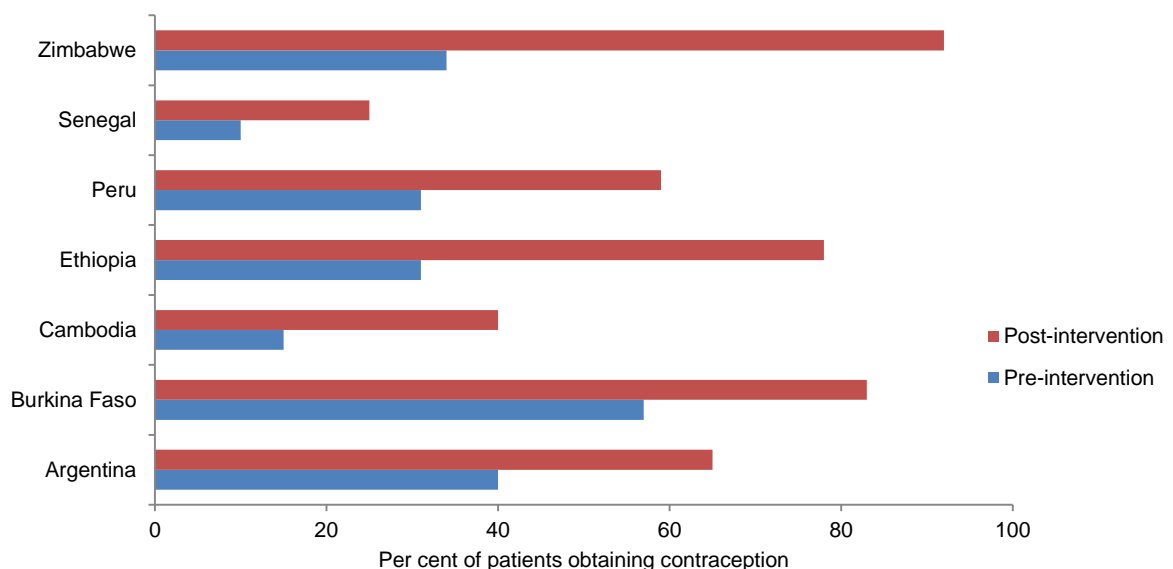
## ***Post-abortion care (PAC)***

Providing timely and appropriate care for managing complications of abortion, irrespective of the abortion law, was urged both by ICPD (*"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"*, ICPD Programme of Action, 8.25) and by the Fourth World Conference on Women (1995). Since ICPD, an increasing number of governments and organizations have been

active in training and provision of services for post-abortion care. In 2001, post-abortion care (PAC) programmes were found in 41 countries. This number has increased to at least 52 countries in 2011, 28 of these are in Africa. The number of tools, guidelines and activities for PAC has proliferated and the donor funding for PAC programmes has also substantially increased. However, it is difficult to discern trends or the impact of PAC activities globally or by region because of the missing or imprecise data. A set of PAC indicators was agreed in 2003, but remains to be integrated into PAC programmes or into the national health management information systems.

As a result of scarce or incomplete reporting, no information is available globally or regionally as to how many women accessed PAC in the past and more recently. Clinical data are largely deficient while the information about the precise number of women who had complications due to an unsafe abortion remains largely unknown. There are also no data available, globally, on the number or per cent of women who adopt a modern method of contraception following a PAC visit. Country-specific studies however show a dramatic rise in the percentage of PAC patients obtaining contraceptive methods in six countries following counseling about contraception. For example, 88% of PAC patients in Bolivia and 83% in Burkina Faso obtained contraception following counseling as compared to 10% and 57%, respectively, during the period prior to counseling intervention.<sup>23</sup> Over 90% of PAC patients in Zimbabwe received a contraceptive method before discharge, following the intervention that strengthened counseling and contraceptive services (Figure 4.3).<sup>24</sup>

**Figure 4.3** Percent of post-abortion care patients obtaining a contraceptive method before discharge following the intervention to strengthen contraceptive counseling and services, as compared to before the intervention, selected countries.



Source: USAID, 2012<sup>24</sup>

The annual hospitalization rates for abortion complications range in 13 countries from 3 in Bangladesh to over 15 per 1000 women aged 15-44 years in Egypt and Uganda. There are an additional 15-25% of women who experience complications but do not seek care at the hospitals because of stigma and social sanctions. Each year, five million women are estimated to be admitted to the hospitals in developing countries for treatment of complications from unsafe abortions. This corresponds to a rate of 5.7 per 1000 women in reproductive age of 15-44 years. It is estimated that 40% of women experiencing complications do not seek and/or receive treatment.<sup>25</sup>

It is intriguing that so little information is available on the levels and trends in PAC, a component of reproductive health care that is the least contentious and universally supported. The interpretation of an increase or decline in the number or rate of PAC beneficiaries are also difficult to interpret, for one is unable to determine whether an increase in PAC cases is due mainly to more women availing these services or the number of unsafe abortions are rising. Conversely, a decline in PAC recipients can be due to an increase in access to safe abortion, or to effectiveness of the PAC programmes resulting in high uptake of contraceptives and subsequent reductions in unintended pregnancies, or because women may seek care from private sources or due to increased underreporting. Efforts are therefore needed in the future to obtain more and complete data on PAC as well as to further intensify efforts that all women who need and seek emergency treatment of abortion complications are provided with a quality service in a timely manner.

## **5. Levels and trends in unsafe abortion mortality and morbidity**

The health burden of unsafe abortion is substantial. Each year millions of women suffer from short and long-term complications,<sup>25</sup> including infertility, and thousands lose their lives from complications of unsafe induced abortion, almost all of which could have been prevented by consistent contraceptive use and with the available methods of safe abortion.

Globally, the number of unsafe abortion-related maternal deaths has declined by one-third since 1990, from 69 000 in 1990 to 58 000 in 1997 and 2000, 56 000 in 2003, and 47 000 in 2008.<sup>26</sup> Nearly all of these deaths occur in developing countries. The increased momentum between 2003 and 2008 is on one hand linked to a decrease in maternal deaths partly attributable to improvements in maternal health services in general and on the other hand also to an increasing reliance on less risky abortion methods including medical abortion. However, even as gains are made, the decline is far from the target of a 75% reduction in the maternal mortality ratio by 2015 set for the Millennium Development Goal 5.

Unsafe abortion-related deaths and disability are difficult to measure because of underreporting or misclassification. Given that these deaths or complications occur following a clandestine or illegal procedure, stigma and fear of punishment deter women and their families from reporting the procedure. Worldwide, unsafe abortion mortality is the third major cause of maternal death after haemorrhage and sepsis in childbirth.<sup>27,28</sup> Unsafe abortion-related deaths were estimated at 47 000 in 2008,<sup>6</sup> down from 69 000 in 1990 as maternal deaths reduced to 358 000 in 2008 from a high of 546 000 in 1990.<sup>29</sup> Deaths due to unsafe abortion are mainly caused by severe infections or bleeding prompted by the unsafe abortion procedure, or due to organ damage. Complications of unsafe abortion include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs.<sup>30</sup> Each year, one in four women or an estimated five million women with unsafe abortion are likely to develop temporary or life-long disability requiring medical care.<sup>1,25</sup>

In comparison, mortality due to legally induced abortion in USA is 0.6-0.7<sup>31,32</sup> per 100 000 induced abortions, for England and Wales it is 0.5,<sup>33,34</sup> in Sweden 0.1<sup>35</sup>, and in France 0.2<sup>36,37,38</sup>. Even spontaneous abortions cause death only rarely – the mortality rate is estimated to be 1 per 100 000 spontaneous abortions.<sup>39</sup> Methods of induced abortion, surgical methods other than dilatation and curettage (D&C), and increasingly medical abortion, as recommended by WHO, are among the safest clinical interventions available in health care today.

### ***Estimated global numbers of maternal deaths due to unsafe abortion, unsafe abortion mortality ratios, and case fatality in 2008***

Close to two-thirds (61%) of the estimated 47 000 maternal deaths due to unsafe abortion in 2008 took place in the Africa region (Annex 5). Asia accounted for about one-third (36%) of unsafe abortion deaths, while the number of deaths was much smaller in Latin America (2%). Globally, the proportion of maternal deaths due to unsafe abortion has remained close to 13% since around ICPD.

Unsafe abortion mortality ratio, i.e., unsafe abortion-related deaths per 100 000 live births is an important measure of maternal death due to unsafe abortion - it is the equivalent of the maternal mortality ratio - and a more appropriate indicator than both the number and the percentage of unsafe abortion-associated maternal deaths for analyzing changes over time and across regions.

The unsafe abortion-related mortality ratio is estimated at 30 per 100 000 live births globally and 40 per 100 000 for developing countries in 2008 (Figure 5.1). Ratios are relatively high for the Least developed countries (80); sub-Saharan Africa (90); and Eastern Africa (100). Although the unsafe abortion incidence rate is high in the Latin America region (Figure 4.2 and Annex 4), the associated unsafe abortion mortality ratio is the lowest among developing regions, with an average of 10 per 100 000 live births. The mortality ratio is closer to the corresponding ratio for developed countries and may be due to a high, and apparently increasing, reliance on medical abortions<sup>40,41</sup> and a relatively well developed infrastructure for health. The risk of dying from an unsafe abortion procedure in the Africa region was almost three times higher than that in the Asia region, and more than 15 times higher than that in the Latin America region. Despite a reducing risk associated with unsafe abortion procedures in all regions the case fatality rate shows widening of the gap between the Africa region relative to Asia and Latin America since 2003 when it was just over 2 times and 13 times and higher, respectively.

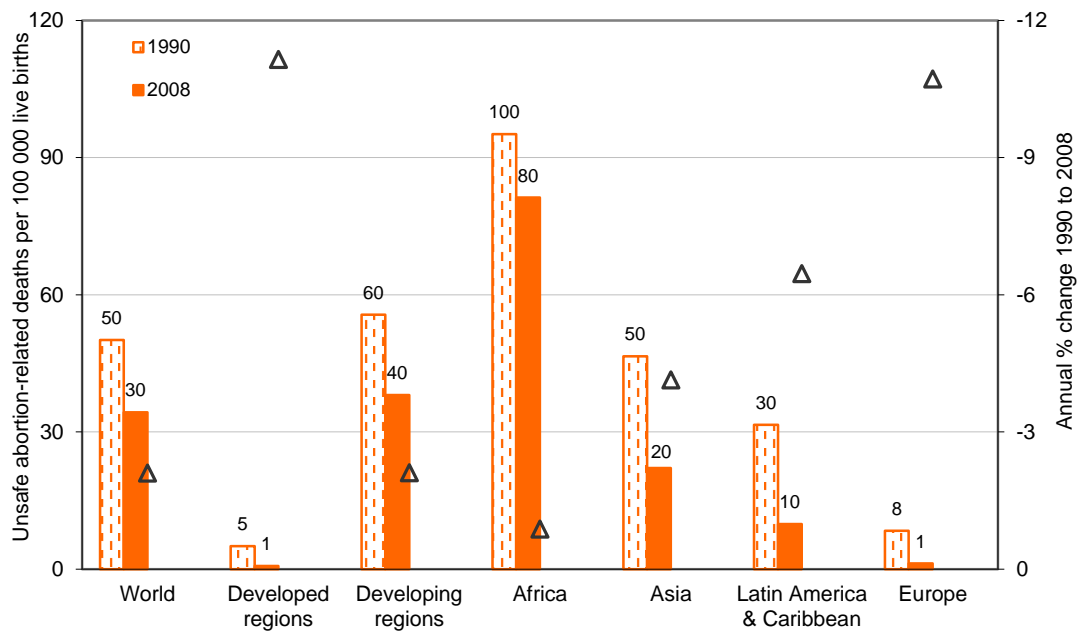
Globally and for developing countries the case fatality rate associated with unsafe abortion is estimated at 220 per 100 000 procedures, ranging from a high of 520 in Sub-Saharan Africa to a low of 30 in the Latin America region (Annex 5). These rates are approximately 450 and over 1000 times higher than the rate associated with safe and legal induced abortion in developed countries (0.1-0.7 per 100 000 procedures) where safe induced abortion is widely available and accessible. Even in developed countries, the case-fatality rate for unsafe abortion is about 40 times higher than that for legal induced abortion.

### ***Trends in mortality associated with unsafe abortion from 1990 to 2008***

The global, regional, and subregional unsafe abortion mortality ratios have also gradually decreased over time as seen in Figure 5.1 and in Annex 6. There is also substantial differences in reduction of unsafe abortion mortality among regions - the reduction in the unsafe abortion mortality ratio between 1990 and 2008 for the Africa region of less than 20% is visibly slower than that in other regions.

The case fatality rate, which captures the number of unsafe abortion-related deaths per 100 000 unsafe abortions (Figure 5.2), shows more distinct improvements between 1990 and 2008 than seen for the unsafe abortion mortality ratio (Figure 5.1). This points to less risky unsafe abortion procedures being used, better care, and increased access to care in more recent periods than in the beginning of the period: the Asia and the Latin America regions show a drop of over 60% and nearly 70%, respectively, while the Africa region reduced by over 30%.

**Figure 5.1** Number of unsafe abortion-related deaths per 100 000 live births and annual percent change, globally and by major regions, from 1990 to 2008.<sup>a</sup>



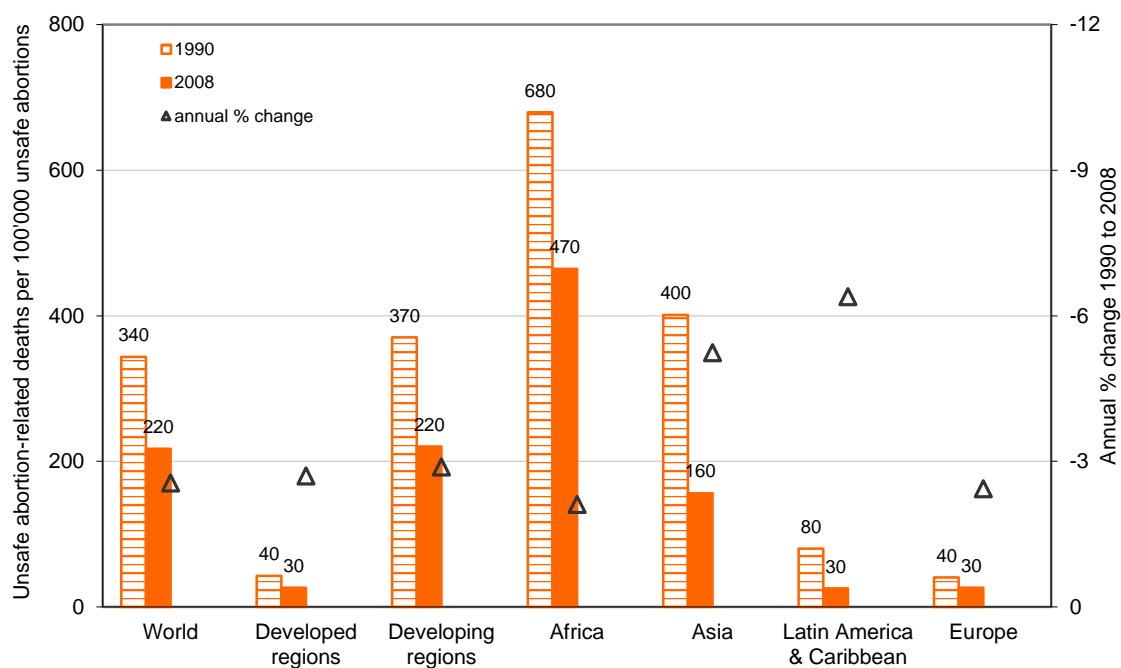
Numbers are rounded

<sup>a</sup> Japan, Australia, and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries

Source: Åhman and Shah, 2011<sup>26</sup>



**Figure 5.2** Number of unsafe abortion-related deaths per 100 000 unsafe abortions (case fatality) and annual percent change, globally and by major regions, from 1990 to 2008.<sup>a</sup>



Numbers are rounded

<sup>a</sup> Japan, Australia, and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.

Source: Åhman and Shah, 2011<sup>26</sup>

## 6. Improving women's health by increasing access to safe abortion: case studies

Nepal and South Africa have made major strides in improving women's health by legal reforms and other measures that have expanded access to safe abortion services. The efforts of women's health advocates and others in Turkey effectively halted the attempt to curtail access to safe abortion. Each of these three cases is described below.

### ***Nepal: Reforming restrictive laws***

Before 2002, Nepal's 1963 legal code known as the *Muluki Ain*, prohibited abortion and characterized abortion as an offence against life, making no exception even when pregnancy threatened a woman's life. The reproductive rights impetus of ICPD galvanized the women's health advocates and others to reform abortion laws in Nepal. The 2002 reform permits abortion: (a) on request up to 12 weeks of pregnancy; (b) up to 18 weeks if the pregnancy is the result of rape or incest; and (c) at any time during the pregnancy if the life, physical or mental health of the woman is at risk or if the fetus is deformed. The law does not require consent from anybody, including husband or partner, except the adult woman to ensure that she is not forced or deceived into having an abortion against her will or choice. Young women under 16 years require consent of the guardian or a near relative. Sex-selective abortion is illegal. Soon after the law was passed, a Task Force was established to develop and implement plans for the provision of safe abortion services. Providers (doctors and midwives) were trained and facilities were upgraded and both providers and facilities were accredited for the provision of safe abortion. Medical abortion was introduced and expanded to 75 districts. Eight guidelines, standards and tools were developed: (1) Safe abortion procedural order (2003); (2) National safe abortion policy (2004); (3) Comprehensive abortion care training manuals (2004); (4) National reproductive health clinical protocol (2008); (5) Medical abortion training manuals (2008); (6) National medical abortion scale up activities (2009); (7) Second trimester implementation guidelines (2010); and (8) Safe abortion implementation guidelines (2011).

By June 2011, over 500 000 women had accessed safe abortion services since the legal reforms. The maternal mortality ratio (MMR) declined from 539 in 1996 to 229 per 100 000 live births in 2009.<sup>42</sup> Abortion complications decreased from 41% in 1998 to 26% in 2008. A recent hospital-based study shows a significant downward trend in the proportion of serious infection, injury, and a decline in the risk of serious complications.<sup>43</sup> Comprehensive abortion care services were expanded by strengthening post-abortion counseling and services, resulting in 80-85% of women adopting contraception following abortion during 2008-2011. MVA was introduced and training was provided.

The success in expanding safe abortion services can be attributed to strong government leadership and commitment; applying evidence-based policies, protocols and standards; permitting trained mid-level health care providers (nurses, nurse-midwives, and auxiliary nurse-midwives) to provide comprehensive abortion care; major donor support; active involvement of international NGOs and a strong presence of women's health advocacy groups.

Despite the impressive progress in the availability of and access to safe abortion services, unsafe abortion has not yet disappeared. The access in remote and rural areas remains a challenge and the awareness of the legal provision of abortion continues to be poor among women (38%).<sup>44</sup> The need for PAC services therefore continues to exist. The first PAC service facility was established in 1995. By 2011, 500 facilities were providing safe abortion, 78 facilities were providing PAC 24 hours a day, seven days a week as an emergency obstetric care (EmOC) service and over 1300 service providers had been trained. The number of women obtaining safe abortion each year rose from 2,686 in 2004 to 11,369 in 2011. Yet, the reported number of women admitted for complications continued to rise from 3,429 in 2002/2003 and 3,779 in 2003/2004 to 3,877 in 2005/2006. Despite a significant decrease in 2010, still 527 women were admitted to four public hospitals with complications from unsafe abortion. A majority of these women (65%) took unsafe, ineffective or unknown methods from uncertified sources. Nearly half of them (47%) attempted to self-induce abortion and one in two women (56%) did not know that abortion was legally permitted in Nepal.

The Nepal example proves that safe abortion services can be extended to women by reforming abortion laws accompanied by political commitment, support, training and improvements in the health system. This is especially noteworthy because Nepal is among the poor countries with largely rural population (81%), difficult terrain and low literacy rate.

### ***South Africa: Recognizing women's right to abortion***

In South Africa, the Choice of Termination of Pregnancy (CTOP) Act No. 92 was passed in 1996 and went into effect in 1997. The CTOP Act permitted abortion on request during the first 12 weeks of pregnancy and from 13<sup>th</sup> up to and including 20<sup>th</sup> week for a number of broad conditions. Abortion after the 20<sup>th</sup> week of pregnancy was permitted to save the woman's life and if the pregnancy would result in a severe malformation of the fetus or posed a risk of injury to the fetus. CTOP recognized a woman's right to abortion and was exceptional in allowing trained nurse-midwives, in addition to doctors, to provide first-trimester abortion. Abortion service is provided free at public hospitals and clinics.

The national guidelines were developed in 1997 and the National Abortion Care Programme provided training in MVA and for comprehensive abortion care. Medical abortion was subsequently approved.

The abortion law reforms were attributed for a 91% decline in abortion related mortality between 1994 and 1998-2001.<sup>45,46,47</sup> A decline in the number and severity of complications was also observed.<sup>48</sup>

Despite the major headway in providing safe abortion and reducing unsafe abortion and related mortality and morbidity, obstacles remain. The knowledge of the time limit for abortion on request is not widely known, resulting in delays to seek abortion to a time beyond the limit set by the law. There is also a critical shortage of providers and less than 50% of public facilities are able to provide abortion. Moreover, abortion providers face stigma and disapproval.<sup>49</sup> Thus, the remnants of unsafe abortion continue to exist in South Africa.

### ***Turkey: Defending women's right to safe abortion***

In Turkey, abortion on request up to 10 weeks of pregnancy was legalized in 1983. The 1983 Demographic and Health Survey (DHS) showed that 78.5% of married women of reproductive age wanted to avoid pregnancy yet only 27% used modern contraceptives and nearly half of all births during the previous five years were reported to be unintended. Despite being legally restricted, abortion was widely practiced, 12.1% of pregnancies in 1982 were reported to have ended in induced abortions. Unsafe abortion related deaths were estimated to constitute a large part of maternal mortality and treatment of complications burdened the health system.<sup>50</sup>

The 1983 Law not only legalized abortion (upto 10 weeks, and with spousal consent if woman is married), but also voluntary sterilization for men and women. It also pioneered task-shifting by authorising general practitioners to perform abortions using MVA and midwives and nurses to insert Intrauterine Devices (IUDs). During the following decade uptake of modern contraceptives, especially IUDs, increased dramatically especially in underserved rural areas and in Eastern Turkey.<sup>51</sup> As seen in other countries, abortion rates also increased during the decade following legalization (24 per 100 pregnancies in 1987)<sup>52</sup> but declined subsequently.

During 1990s, following recommendations of ICPD PoA, Ministry of Health focused on improving the quality of services by introducing family planning counseling, and increasing the method mix. Integration of safe abortion services with contraception counseling and immediate provision of contraceptives was also promoted.<sup>53,54,55</sup> Contraceptive prevalence reached 73% in 2008 and the gap between desired family size and total fertility rate was narrowed (2.2 vs 2.5 children per woman) and the abortion rate fell to 10 per 100 pregnancies.<sup>56</sup>

In the same year the government started to voice a change in the five-decade old anti-natalist policy; with a call for at least three children per woman, on World Women's Day.<sup>57</sup> Four years later the Prime Minister made a statement equating abortion to *murder* followed by the announcement of a bill that would ban abortion/lower the limit to four weeks of pregnancy.<sup>58</sup>

This attempt commenced a heated public debate and was met with strong reaction from women's rights groups which organized street protests across the country. Professional organizations such as the Turkish Medical Association, the Turkish Association of Gynecology and Obstetrics, and the Turkish Association of Public Health called upon the government to respect reproductive and human rights of women and to withdraw the bill, stating that a ban on abortion could not stop abortions but only make them unsafe with serious consequences on women's health. The Government withdrew anti-abortion bill.<sup>59</sup> However discussion around the ban caused several women and providers to get confused and/or intimidated about abortion. There are ongoing complaints that many public hospitals refuse to provide these services limiting access of women from rural areas or in disadvantaged economic conditions.<sup>60</sup>

## 7. Reproductive rights and safe abortion

Health and human rights reinforce each other. The legal reforms in Nepal and South Africa referred both to the public health and human rights imperatives for safe abortion. Yet, the reproductive right to safe abortion continues to be hotly disputed globally, regionally and nationally while the public health rationale for providing access to safe abortion is universally accepted.

Human rights are universal and overarching. The discourse on human rights has evolved over time since the Universal Declaration of Human Rights in 1948 that proclaimed, among others, that *"Everyone has the right to life, liberty and security of person"* (article 3).<sup>61</sup> During the same year, WHO Constitution stated: *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"*.<sup>62</sup> UN International Conference on Human Rights, held in Tehran in 1968,<sup>63</sup> proclaimed reproductive rights as subset of human rights: *"Parents have a basic human right to determine freely and responsibly the number and spacing of their children"* (proclamation number 16). Later conferences, conventions and resolutions strengthened the case for reproductive rights and for the right to safe abortion, the latter being mostly a derivative of other rights.

The concept of reproductive rights was further refined, defined and accepted at the ICPD.<sup>10</sup> ICPD para 7.3 states: *"These [reproductive] rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health."* ICPD para 7.2 addresses rights to fertility regulating methods: *"Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples the best chance of having a healthy infant"*. Abortion was covered in para 8.25: *"In circumstances where abortion is not against the law such abortion should be safe."* In 1999, the UN General Assembly agreed upon a set of Key actions for the further implementation of the Programme of Action of ICPD<sup>11</sup> and stated: *"In recognizing and implementing the above, and 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"* (para 63iii).

The Resolution 2012/1 on Adolescents and youth by the Commission on Population and Development at its Fifty-Fifth Session, 23-27 April, 2012,<sup>64</sup> reiterated what was agreed at the ICPD in 1994. It stated: *"Recognizing that reproductive rights embrace certain human rights that*

*are already recognized in national laws, international human rights documents and other consensus documents and rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, the right to attain the highest standard of sexual and reproductive health, the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents, and the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”* The Commission: *“Urges Governments to protect and promote human rights and fundamental freedoms regardless of age and marital status, including, inter alia, by eliminating all forms of discrimination against girls and women, by working more effectively to achieve equality between women and men in all areas of family responsibility, in sexual and reproductive life, and in education at all levels, and by protecting the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health”*”.

The Commission on the Status of Women at its Fifty-Seventh session held from 4 to 15 March 2013 concluded,<sup>65</sup> among others, “ ... and adopt and accelerate the implementation of laws, policies and programmes which protect and enable the enjoyment of all human rights and fundamental freedoms, including their reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and their review outcomes”.

The Report (A/66/254) of the Special Rapporteur [Anand Grover] on *the Right of every one to the enjoyment of the highest attainable standard of physical and mental health*, presented to the UN General Assembly at the Sixty-sixth session, on 3 August 2011<sup>66</sup>, deals explicitly with the sexual and reproductive rights and on the right to safe abortion. Paragraph 16 states: *“Criminal laws and other legal restrictions affecting sexual and reproductive health may amount to violations of the right to health”*. It further states: *“Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women’s right to health and must be eliminated. These laws infringe women’s dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health”* (paragraph 21). Using right-to-health approach, the report makes bold yet obvious recommendations to the UN Member States:

*“States must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality”* (§29);

*“Decriminalize abortion, including related laws, such as those concerning abetment of abortions”* (§65h);

*“Consider, as an interim measure, the formulation of policies and protocols by responsible authorities imposing moratorium on the application of criminal laws concerning abortion, including legal duties on medical professionals to report women to law enforcement authorities”* (§65i);

*“Ensure safe, good quality health services, including abortion, using services, in line with WHO protocols”* (§65j).

These and the progress in national laws since 1994 provide the foundation for prioritizing and accelerating access to safe abortion.

## 8. Recommendations

Globally, the unsafe abortion mortality ratio and case fatality rate have declined from 1990 to 2008. Even if the decline accelerates, the Millennium Development Goal 5 target to reduce the maternal mortality ratio by three-quarters between 1990 and 2015 is unlikely to be attained. At the ICPD, a commitment was made to make postabortion care available to women experiencing complications. Simply meeting this commitment could save the lives of many and improve the health of millions of women, especially in developing country regions. Despite notable gains made in expanding access to safe abortion, several recommendations for intensified efforts emerge from this review of evidence:

1. While we must do more to ensure that all women have access to safe, acceptable and affordable contraception that reduces the need for abortion, some need will always exist and, therefore, must be addressed in programmes and policies.
2. WHO has provided technical and policy guidance for safe abortion which, if followed by most countries, would vastly improve the health of women.
3. Advocacy to implement existing liberal laws and to change other restrictive laws is essential, using both public health and human rights arguments.
4. Grounds under which abortion is permitted, providers and facilities authorized to provide safe abortion should be made universally known to policy makers, health care providers, women and population at large and health services should be made available to meet the full extent of the law.
5. Authorize trained mid-level health care providers (nurses, midwives, auxiliary nurse-midwives, and physician assistants) to provide PAC and safe abortion.
6. As recommended by ICPD PoA, all women should have access to quality post-abortion care (PAC) promptly. Countries need to provide PAC as part of Emergency Obstetric Care and Primary Health Care.
7. Women should have access to contraceptive counseling and services at the same delivery point they receive both safe abortion services, and postabortion care.
8. Data on abortion should be collected through HMIS in all countries and should be used for appropriate policy development and decision making.
9. Countries can move forward quickly through public/private partnerships for advocacy, public education, and access to services.

Access to safe and legal abortion improves women's health and wellbeing and those of their children and families. Therefore, provisions should be made for the availability of and access to safe abortion for all women who need it. The returns for women's health, and the benefits for families, for public health and for countries, will be very high.

## References

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- <sup>1</sup> WHO. *Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003, 5<sup>th</sup> edition*. Geneva, World Health Organization, 2007. [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/9789241596121/en/index.html](http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241596121/en/index.html).

- 2 Joffe C. Abortion and medicine: a sociopolitical history. In: Paul M, Lichtenberg ES, Borgatta  
L, Grimes DA, Stubblefield PG, Creinin MR, eds. *Management of unintended and abnormal*  
3 *pregnancy: comprehensive abortion care*. Oxford, Wiley-Blackwell, 2009.
- 4 World Health Organization. *The prevention and management of unsafe abortion. Report of a*  
5 *Technical Working Group*. (WHO/MSM/92.5). Geneva, World Health Organization, 1992.
- 6 Sedgh G, Singh S, Shah IH, Åhman E, Henshaw SK, Bankole A. Induced abortion: incidence  
and trends worldwide from 1995 to 2008. *Lancet*, 2012, 379(9816):625-632.
- 7 World Health Organization. *Safe abortion: technical and policy guidance for health systems*.  
Second Edition. Geneva: World Health Organization, 2012.
- 8 World Health Organization. *Unsafe abortion: global and regional estimates of the incidence*  
9 *of unsafe abortion and associated mortality in 2008, 6<sup>th</sup> edition*. Geneva, World Health  
Organization, 2011.  
[http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/9789241501118/en/index.html](http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/index.html).
- 10 United Nations Population Division. Department of Economic and Social Affairs. *World*  
11 *abortion policies 2013 (Wallchart)*. New York, United Nations, 2013.  
[www.un.org/en/development/Desa/Population/publications/pdf/policy/WorldAbortionPolicies](http://www.un.org/en/development/Desa/Population/publications/pdf/policy/WorldAbortionPolicies2013/WorldAbortionPolicies2013_Wallchart.pdf)  
12 [2013/WorldAbortionPolicies2013\\_Wallchart.pdf](http://www.un.org/en/development/Desa/Population/publications/pdf/policy/WorldAbortionPolicies2013/WorldAbortionPolicies2013_Wallchart.pdf)
- 13 Center for Reproductive Rights. *The World's abortion laws*. Fact sheet. New York, CRR,  
2009.
- 14 Singh S, Wulf D, Hussain R, Bankole A, Sedgh G. *Abortion Worldwide: A decade of uneven*  
15 *progress*. New York, Guttmacher Institute, 2009.
- 16 United Nations Population Fund. *International Conference on Population and Development -*  
17 *ICPD - Programme of Action*. New York: United Nations Population Fund, 1995  
(A/CONF171/13/Rev.1)  
[http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd\\_eng.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf),  
18 accessed on 20 March 2013).
- 19 United Nations General Assembly, 1999. *Key actions for the further implementation of the*  
20 *Programme of Action of the International Conference on Population and Development*.  
*Resolution adopted by the General Assembly. A/RES/S-21/2*; accessed on 23 March 2013at  
URL:  
[http://www.unfpa.org/webdav/site/global/shared/documents/publications/1999/key\\_actions](http://www.unfpa.org/webdav/site/global/shared/documents/publications/1999/key_actions_en.pdf)  
21 [en.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/1999/key_actions_en.pdf).
- 22 Ministry of Health & Family Welfare (India). *Annual report 2006-2007*. New Delhi, Ministry  
of Health & Family Welfare, Government of India, 2008.
- 23 Centre for Enquiry into Health and Allied Themes (CEHAT). *Abortion assessment project –*  
*India*. Jaipur and Mumbai (India), HealthWatch Trust and CEHAT, 2005.
- 24 United Nations Department for Economic and Social Information and Policy Analysis. *World*  
25 *population prospects: the 2008 revision*. New York, United Nations, 2009.
- 26 United Nations Department for Economic and Social Information and Policy Analysis.  
Population Division. *World abortion policies 1994 (wall chart)*. New York, United Nations,  
1994.
- 27 United Nations Department for Economic and Social Affairs. Population Division. *World*  
28 *contraceptive use 2011 (wallchart)*, (ST/ESA/SER.A/301). New York, United Nations, 2011.
- 29 World Health Organization. *The world health report 2008: primary health care now more*  
30 *than ever*. Geneva, World Health Organization, 2008.
- 31 Shah IH and Åhman E. Unsafe abortion differentials in 2008 by age and developing country  
region: high burden among young women, *Reproductive Health Matters* 2012, 20(39): 169-  
173.
- 32 Sedgh G, Bankole A, Singh S, Eilers M. Legal abortion levels and trends by woman's age at  
termination. *International Perspectives on Sexual and Reproductive health* 38(3):143-153,  
2012.
- 33 World Health Organization. *Abortion. A tabulation of available data on the frequency and*  
34 *mortality of unsafe abortion, 2nd edition*. Geneva, World Health Organization, 1993.

- 21 World Health Organization. Resolution WHA20.41. Health aspects of population dynamics. In: *Twentieth World Health Assembly, Geneva, 23 May 1967*. Geneva: World Health Organization, 1967 (WHA20/1967/REC/1).
- 22 UNESCO, *Beijing Declaration and Platform for Action: Fourth World Conference on Women*. Accessed on 15 March 2013 at [http://www.unesco.org/education/nfsunesco/pdf/BEIJIN\\_E.PDF](http://www.unesco.org/education/nfsunesco/pdf/BEIJIN_E.PDF).
- 23 The Population Council, *Meeting women's health care needs after abortion*. Program Brief No. 1, September 2000.
- 24 USAID. High Impact Practices (HIP). *Postabortion Family Planning: Strengthening the family planning component of postabortion care*. Accessed November 2012 at <http://www.fphighimpactpractices.org/resources/postabortion-family-planning-strengthening-family-planning-component-postabortion-care>.
- 25 Singh S. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet* 368(9550): 1887-1892, 2006.
- 26 Åhman E. and Shah IH. New estimates and trends regarding unsafe abortion mortality, *International Journal of Gynecology and Obstetrics*, 2011, 115(2):121-126.
- 27 AbouZahr C. Maternal mortality overview. In: Murray CJL, Lopez AD, eds. *Health dimensions of sex and reproduction*. Boston and Geneva. World Health Organization, Harvard School of Public Health, World Bank, 1998.
- 28 World Health Organization. *The global burden of disease, 2004 update*. Geneva, World Health Organization, 2008.  
[http://www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/index.html](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html).
- 29 World Health Organization, UNICEF, UNFPA, The World Bank. *Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva, World Health Organization, 2010.
- 30 Grimes D, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, Shah I. Unsafe abortion: the preventable pandemic. *Lancet*, 2006, 368:1908-1919.
- 31 Gold RB. *Abortion and women's health. A turning point for America?* New York and Washington, DC, Alan Guttmacher Institute, 1990.
- 32 Bartlett LA, Berg CJ, Shulman HB et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics and Gynecology*, 2004, 103(4):729-737.
- 33 Department of Health. *Abortion statistics, England and Wales: 2011*. London, Department of Health, 2012.
- 34 O'Herlithy (on behalf of the Centre for Maternal and Child Enquiries). Deaths in early pregnancy. *British Journal of Obstetrics and Gynecology*, 2011, 118(Suppl.1), 81-.
- 35 Socialstyrelsen. *Induced abortion 2009*. Official Statistics of Sweden. 2010.
- 36 Inserm. *Report of the national Expert Committee on Maternal Mortality (CNEMM)*, France, 2001-2006. Accessed 09/04/2013 at [http://www.invs.sante.fr/publications/2010/mortalite\\_maternelle/rapport\\_mortalite\\_maternelle\\_anglais.pdf](http://www.invs.sante.fr/publications/2010/mortalite_maternelle/rapport_mortalite_maternelle_anglais.pdf).
- 37 Vilain A. *Les interruptions volontaires de grossesse en 2007*. Direction de la recherche, des études, de évaluation et des statistiques (DREES) N° 713, 2009. Accessed 09/05/2013 at <http://www.avortementivg.com/sites/default/files/rapport%20DRESS%202007.pdf>.
- 38 Institut national d'études démographiques (INED). *Avortements 2002 -2010*. Accessed 09/05/2013 at [http://www.ined.fr/fr/france/avortements\\_contraception/avortements/](http://www.ined.fr/fr/france/avortements_contraception/avortements/).
- 39 Lichtenberg ES, Grimes DA. Surgical complications: prevention and management. In: Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield PG, Creinin MD, eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Oxford, Wiley-Blackwell, 2009.
- 40 Costa SH, Vessey MP. Misoprostol and illegal abortion in Rio de Janeiro, Brazil. *Lancet*, 1993, 341(8855):1258-61.
- 41 Miller S, Lehman T, Campbell M, Hemmerling A, Anderson SB, Rodriguez H, Gonzalez WV, Cordero M, Calderon V. Misoprostol and declining abortion-related morbidity in Santo Domingo, Dominican Republic: a temporal association. *BJOG*, 2005, 112(9):291-1296.



42 Upadhyaya T. *Progress in the Implementation of the Abortion law in Nepal, 10th Anniversary of Abortion Law Reform in Nepal. Presentation at the National Conference “Looking back 10 years, how much have we achieved in preventing unsafe abortion in Nepal”*, Kathmandu, 26 September 2012.

43 Henderson JT, Puri M, Blum M, Harper CC, Rana A, Gurung G, Pradhan N, Regmi K, Malla K, Sharma S, Grossman D, Bajracharya L, Satyal I, Acharya S, Lamichhane P, Darney P. Effects of Abortion Legalization in Nepal, 2001-2010, *PlosONE*, [www.plosone.org/article/info%3Ado1%2F10.1371%2Fjournal.pone.0064775](http://www.plosone.org/article/info%3Ado1%2F10.1371%2Fjournal.pone.0064775); accessed on 20 May 2013.

44 Ministry of Health and Population (MOHP) [Nepal], New ERA, and ICF International Inc. *Nepal, Demographic and Health Survey 2011*. Kathmandu, Nepal, Ministry of Health and Population, New ERA, and ICF International, Calverton, Maryland, 2012.

45 Jewkes R and Rees H, Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act, *South African Medical Journal*, 2005, 95(4):250.

46 Hoffman M, Moodley J, Cooper D, Harries J, Morroni C, Orner P, Constant D, Mathews C. The status of legal termination of pregnancy in South Africa. *South African Medical Journal*, 2006, 96(10), 1056.

47 Mbele, AM. Impact of the Choice on Termination of Pregnancy Act on maternal morbidity and mortality in the west of Pretoria. *South African Medical Journal*, 2006, 96(11), 1196-1198.

48 Jewkes RK, Rees H, Dickson K, Brown H, Levin J. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change, *BJOG*, 2005, 112(3):355–359.

49 World Health Organization. Providing abortion care in Cape Town, South Africa: findings from a qualitative study. *Social Science Policy Brief*, 2010.

50 Akin A. Unpublished data.

51 Ortayli N, Cagatay L. Contraception and induced abortion: two indispensable pieces of a whole [In Turkish]. *Turkish Journal of Public Health*, 2012, 10 (Special Issue 1): 61-74.

52 Hacettepe University Institute of Population Studies. *1988 Turkish Population and Health Survey*. Accessed on August 23, 2013, at [http://www.hips.hacettepe.edu.tr/eng/dokumanlar/1988\\_TPHS.pdf](http://www.hips.hacettepe.edu.tr/eng/dokumanlar/1988_TPHS.pdf)

53 Senlet P, Cagatay L, Ergin J, Mathis J. Bridging the gap: Integrating Family Planning with Abortion Services in Turkey. *International Family Planning Perspectives*, 2000, 27(2):90-95.

54 Bulut A, Toubia N. Abortion services in two of public sector hospitals in Istanbul, Turkey: How well do they meet women’s needs? In: Mundigo A.I, Indriso C. (eds). *Abortion in the Developing World*. London, England, Zed Books, 1999:259-78.

55 Ortayli N, Bulut A, Nalbant H. The effectiveness of preabortion contraception counseling. *International Journal of Gynecology and Obstetrics*, 2001, 74(3):281-285.

56 Hacettepe Institute of Population Studies. *Turkey Demographic and Health Survey, 2008*. Accessed on August 23, 2013, at [http://www.hips.hacettepe.edu.tr/eng/tdhs08/TDHS-2008\\_Main\\_Report.pdf](http://www.hips.hacettepe.edu.tr/eng/tdhs08/TDHS-2008_Main_Report.pdf).

57 Hurriyet Daily. Erdogan: En az uc cocuk dogurun. *Hurriyet Daily*. March 7, 2008. Accessed on August 24, 2013 at <http://www.hurriyet.com.tr/gundem/8401981.asp>

58 BBC World. Turkey PM Erdogan sparks row over abortion. *BBC World*. June 1, 2012. Accessed on August 24, 2013 at <http://www.bbc.co.uk/news/world-europe-18297760>

59 Aljazeera. Turkey drops anti-abortion legislation. *Aljazeera*. June 22, 2008. Accessed on August 24, 2013 at <http://www.aljazeera.com/news/europe/2012/06/2012622811474159.html>

60 Eurasianet. Turkey: Trying to Impose an Abortion Ban in Fact, if Not in Name? *Eurasinet*. Accessed on August 24, 2013 at <http://www.eurasianet.org/node/66550>

61 United Nations. *The Universal Declaration of Human Rights*. United Nations. Accessed on 27 May 2013 at <http://www.un.org/en/documents/udhr/index.shtml#a3>.

62 World Health Organization. *Constitution of the World Health Organization, Basic Documents*. Accessed on 27 May 2013 at [http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf).

- 
- 63 International Conference on Human Rights, Tehran, 1968. Accessed on 20 June 2013 at [http://web.archive.org/web/20071017025912/http://www.unhchr.ch/html/menu3/b/b\\_tehern.htm](http://web.archive.org/web/20071017025912/http://www.unhchr.ch/html/menu3/b/b_tehern.htm).
- 64 United Nations Department of Economic and Social Affairs. Commission on Population and Development, Forty-Fifth Session, 23-27 April 2012, *Resolution 2012/1, E/2012/25 and E/CN.9/2012/8*.  
[http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012\\_1\\_Adolescents%20and%20Youth.pdf](http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf). Accessed on 27 May 2013.
- 65 United Nations Economic and Social Council. Commission on the Status of Women: *Follow-up to the Fourth World Conference on Women and to the twenty-third special session of the General Assembly, entitled "Women 2000: gender equality, development and peace for the twenty-first century"*. Report E/CN.6/2013/L.5. Fifty-seventh session, 4-15 March 2013.  
[http://www.un.org/ga/search/view\\_doc.asp?symbol=E/CN.6/2013/L.5](http://www.un.org/ga/search/view_doc.asp?symbol=E/CN.6/2013/L.5), Accessed on 26 May 2013.
- 66 United Nations General Assembly. *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Report A/66/254, 3 August 2011.  
[http://www.un.org/ga/search/view\\_doc.asp?symbol=A/66/254](http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254). Accessed 5 January 2013.