

Young and Vulnerable: The Reality of Unsafe Abortion among Adolescent and Young Women

The Asia-Pacific is home to over a billion people between the ages of 10-24 but data on the incidence of induced abortion among this group are sparse, unrepresentative and incomplete, especially with respect to unmarried women. Estimates in Asia using national/subnational data range from 1-15% of all abortions¹; micro studies indicate much higher proportions.^{1,2} On the other hand, except for Australia and New Zealand, Pacific data are unavailable.^{3,4}

In most parts of the Asia-Pacific, the majority of young abortion seekers are unmarried. In South Asia, where 32% of 15-19 year olds are married and almost all women are married by age 24,⁵ however, most unwanted pregnancies occur within marriage in the context of delaying a first birth or spacing a subsequent one. However, even in this subregion, incidence of pregnancies among unmarried teenagers is on the rise, especially in urban areas.¹

Contraceptive use among sexually active unmarried girls is negligible and even among married 15-19 year olds, use is lower than amongst older women.⁵ Lack of accurate knowledge of contraception, difficulties in access (especially for unmarried girls), gender inequalities, family planning programmes ignoring the needs of newly weds and unmarried girls and the commonality of non-consensual sex are all factors to this low use.

Unsafe Abortion among Young People. Shah and Ahman⁶ estimate that 9% of all unsafe abortions in Asia are among girls aged 15-19 and a further 23% among young women aged 20-24. These proportions are lower than in Africa or Latin America; nevertheless, the sheer size of Asia's population means that the region accounts for just under half (45.7%) of the 7.2 million unsafe abortions among women aged 15-24 that occur each year in the developing world. In the Pacific, there is little information and official records on any aspect of induced abortion. Interviews with key persons and micro studies, however,



Photo Illustration by Libham

point to young women self-inducing abortion and going to hospitals for treatment of complications, or travelling overseas for services (e.g., to Australia).^{3,4}

Micro studies and hospital data consistently show that deaths from abortion-related complications are higher among adolescents, particularly if unmarried.^{1,7} This is primarily because (1) they are more likely to have second trimester abortions which even in the safest of settings carry greater risk than earlier abortions; (2) they are more likely to access services of an unskilled provider or self induce; and (3) they are less likely to seek early care for complications. What then causes young women to face these additional risks?

Legal Barriers. Unsafe abortion is almost unknown where laws are liberal and access widespread, as in East Asia. Where access is limited despite less restrictive laws as in India or where abortion is severely restricted, young, unmarried, poor women are impacted disproportionately.¹ Even liberal laws may contain ambiguity around the rights of unmarried women,⁸ impose age restrictions or require parental/guardian authorisation. Even where not mandated by law, hospitals may insist on the presence of the parent at the time of the procedure.⁹ The signature of the husband may be required for married girls as either part of law (e.g. South Korea) or practice.¹

Social Stigma, Lack of Support, Lack of Information. Premarital sex is stigmatised in most parts of Asia-Pacific. In parts of South Asia, any pregnancy in an unmarried girl is referred to as 'illegal' and women often believe that abortion in these circumstances is illegal even when it may not be.¹ Stigma imposes a need for confidentiality, which coupled with lack of partner and/or family support and economic vulnerability, may make it hard for some young women to access medically safe services¹ and even clandestine safe services may charge a high financial premium. Unskilled providers may be the only option even in settings where safer, legal alternatives exist.¹ Self-

induction using misoprostol is also becoming increasingly common in some parts (e.g., China and India).¹ In certain contexts (e.g. the Philippines), religious prohibitions and cultural taboos against abortion are also very strong. Women still have abortions despite these barriers, but these limit even further options that are already limited by restrictive laws. Poor knowledge of reproductive physiology may delay recognition of the pregnancy; fear and psychological denial may also add to the delay. Safe second trimester services even in liberal legal environments are fewer, urban-based, may have additional legal requirements (e.g. a second physician opinion), the abortion takes longer and may involve a hospital stay—all these factors also increase the delay in seeking care or drive women to more easily available but less safe options.^{1,9} Moreover many unmarried girls face judgemental attitudes and rude behaviour from providers. Even compassionate providers may be reluctant to acknowledge the realities of premarital sex and focus post-abortion counselling efforts on the need to avoid sex rather than these women's contraceptive needs.¹⁰

Barriers Faced by Married Adolescents. Married adolescents do not face the same social stigma that their unmarried counterparts do. Nevertheless, their status in the family, decisionmaking powers, financial independence and mobility may be more limited than older women,¹ leading to delays or the use of less skilled providers.^{1,11}

Ultimately, the barriers can be so strong that accessing any form of abortion care becomes impossible. Young women may carry on with such pregnancies, may abandon or sell their babies or resort to infanticide. The pregnant adolescent may be killed in order to preserve the family honour or be driven to suicide.^{1,12}

How Can Access Be Increased? While abortion data are always difficult to obtain, governments and researchers should make every effort to obtain and make accessible age-disaggregated information about the incidence of, morbidity and mortality from unsafe abortion. This is key to having appropriate information for advocacy. We need to learn more about young unmarried women's pathways to abortion care-seeking and their informal information and support networks, and academics and researchers should make this a research priority. Understanding these is a key step to finding appropriate community-based resources to making information accessible to women, whatever the legal circumstances. Where possible, policies that have blanket age of consent requirements need to be modified to include the concept of the evolving capacity of the adolescent and the capabilities of young women to make their own decisions, as well as of reproductive and sexual rights.

Where services exist, providers should be encouraged not to add barriers that do not exist in law and women need to be aware of what the law allows. Care should be taken to see that young women are treated confidentially and not singled out for undue attention. Values clarification and awareness-raising on young people's reproductive rights

may help providers to interact with these young women in non-judgemental ways.

Family planning programmes—whether of the state, the private sector, or of non-government organisations—must have policies that not just provide comprehensive sexuality education and information but also make contraceptives accessible to young women. Post-abortion care must include contraceptive counselling and links to effective contraception even for unmarried young women. The potential for medical abortion—such as misoprostol and mifepristone—in making access to safe abortion a reality is immense. Yet much more information and work is needed to understand how medical abortion can best meet adolescent needs in diverse settings in the Asia-Pacific without compromising safety.

Youth is a time of promise and hope. No young woman should have to lose her life, health, future and dignity to the hopelessness, desperation, stigma and the judgement of societies unwilling to recognise her choices, rights and humanity.

Endnotes

- 1 Ganatra, Bela. 2006. "Unsafe abortion in South and South-East Asia: A review of evidence," in Warriner, I.K. & Shab, I.H. (eds.). *Preventing Unsafe Abortion and Its Consequences: Priorities for Research and Action*. New York & Washington: Guttmacher Institute. pp. 151-186.
- 2 Warakamin S.; Boonthai, N.; Tangcharoensathien, V. 2004. "Induced abortion in Thailand: Current situation in public hospitals and legal perspectives." *Reproductive Health Matters (RHM)*. Vol. 12, No. 24 (supplement). pp. 147-56.
- 3 UNFPA Office for the Pacific. 2005. *Before It's Too Late: Pacific Experiences Addressing Adolescent Reproductive Health*. Suva, Fiji: UNFPA Office for the Pacific. 48p. Available at <Pacific.unfpa.org/pubs/pub_asrb.htm>.
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- 5 Population Reference Bureau (PRB). 2006. "The world's youth: 2006 data sheet." Washington, DC: PRB. pp. 9-11.
- 6 Shab, I.; Abman, E. 2004. "Age patterns of unsafe abortion in developing country regions." *RHM*. Vol. 12, No. 24 (supplement). pp. 9-17.
- 7 Olukeya, A. [et al.]. 2001. "Unsafe abortion in adolescents." *International Journal of Obstetrics and Gynecology*. Vol. 75, No. 2. pp. 137-147.
- 8 Hirve, Siddhivinayak S. 2004. "Abortion law, policies and services in India: A critical review." *RHM*. Vol. 12, No. 24 (supplement). pp. 114-121.
- 9 Gallo, M.; Nghia, N.C. "Real life is different: a qualitative study of why women delay abortion until the second trimester in Vietnam." *Social Science & Medicine*. Available online 13 March 2007.
- 10 Klingberg-Allvin, M. [et al.]. 2006. "Perspectives of midwives and doctors on adolescent sexuality and abortion care in Vietnam." *Scand J Public Health*. Vol. 34, No. 4. pp. 414-21.
- 11 Kapil Ahmed, M.; van Ginneken, J.; Razzaque, A. 2005. "Factors associated with adolescent abortion in a rural area of Bangladesh." *Trop Med Int Health*. Vol. 10, No. 2. pp. 198-205.
- 12 Puri, M.; Ingham, R.; Matthews, Z. "Factors affecting abortion decisions among young couples in Nepal." *Journal of Adolescent Health*. Article in Press.

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Demystifying Abortion for Young Women in the Philippines

In the Philippines, punitive laws and puritanical views make access to safe abortion services very difficult for adult women.¹ This difficulty is even greater for young women, most of whom are financially dependent on their parents or not accorded adult privileges even when contributing to family income. Lack of funds (a surgical abortion in a clinic costs US\$73–273²), practically no information on safe methods and where to get them, and worrying about family reaction if found to have undergone abortion are more than enough reasons for most young women to continue the pregnancy.

Despite these impediments, induced abortions are common. The Guttmacher Institute estimates that 473,000 induced abortions are done every year.² A nationwide survey of women of reproductive age also revealed that almost half of abortion attempts occur among young women: 16% among teenagers and 30% among women aged 20–24.² Because of the abovementioned obstacles, however, most young women resort to dangerous and unsafe abortion procedures. The Guttmacher Institute reports that 78,000 women are treated in hospitals yearly for complications due to abortion. Others are less fortunate—800 deaths due to abortion complications are estimated yearly.² Abortion is rarely discussed in the Philippines, even in the private realm, and the stigma associated with abortion is so strong that a young woman facing an unintended and unwanted pregnancy is still more likely to keep this to herself and settle for harmful and ineffective methods. Mainstream public discourse, on the other hand, tend to see abortions as ‘killing babies.’ Frames that feature the perspectives and realities of women who have abortions, argue for abortion as a woman’s right, or raise unsafe abortion as a public health concern, are rarely used.

Demystifying Abortion. Given this context, some women’s groups like Likhaan are focusing their efforts on creating and nurturing safe public spaces for discussing abortion. In doing this, Likhaan hopes that more women will break the silence and their isolation around the issue, share their situation with the organisations’ health workers and learn about available options. Aside from speaking at schools, at events of other groups and in the media upon request, Likhaan conducts education sessions and film showings on abortion in various communities. Likhaan also reaches out to young women through its tie-up with PiLaKK Youth, an urban poor federation advocating for health rights of young women, gays and lesbians, and which also stages short plays featuring abortion and other related topics for grassroots communities. Providing initial input helps open young women’s hearts and minds to know themselves better. This eventually helps them to make informed decisions during critical situations, as when

unintended pregnancy occurs. Other creative formats, such as plays and pocketbooks, are also combined with the information activities. The play “*Buhay Namin*” (Our Lives) presents the different situations women face and their varying feelings toward abortion. Based on Likhaan’s research on women’s abortion experiences, the play has been video-recorded and is used in the youth education sessions. The pocketbook series on abortion, which are written by feminist writers, feature situations and heroines that are based on real life and real women’s perspectives.

Beyond Information. For young women who are in the critical situation of facing an unintended pregnancy, Likhaan offers counselling. Eventually, these young women are referred to trained professionals who can counsel them better on their situation. Contraceptive provision for the youth—which is a crucial complementary service that would help prevent unintended pregnancies—is in the same problematic spectrum as abortion services. Likhaan and PiLaKK encourage sexually active youth to use contraceptives. As sex outside of marriage is considered a taboo (especially for young women), many prefer not to be seen in Likhaan clinics despite assurance of confidential and non-judgemental services for fear that this will reach the knowledge of parents. Likhaan and PiLaKK address this problem through covert contraceptive counselling, wherein youth leaders explain easier-to-use methods like condoms. Youth members may also consult community clinicians in various places like a peer’s house or the mall, and clinicians come during meetings to provide counselling and services.

Advocacies are started from the search for solutions to real-life problems. Information may be far from access, but it brings young women a step nearer to safety. Eventually, Likhaan hopes that information dissemination, combined with counselling and contraceptive provision, will encourage more young women to advocate for wider access to safe abortion services that can help save other lives.

Endnotes

- ¹ *The Philippine law can be interpreted as permitting abortion to save a pregnant woman’s life, but very few doctors would risk doing abortions openly if at all. Abortion is also seen as immoral in this predominantly Roman Catholic country.*
- ² Singh, S. [et al.]. 2006. *Unintended Pregnancy and Induced Abortion in the Philippines: Causes and Consequences*. New York: Guttmacher Institute. 40p.

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Providing Safe, Clandestine Abortion Services in Pakistan

Editor's Note: Names of organisations operating clinics and locations have been withheld upon their request.

Harsh Realities. In countries like Pakistan where the procedure is restricted and accessing safe services is problematic, the decision to have an abortion is often a difficult and stressful one for women. Despite this, some 890,000 unwanted pregnancies (or one in six pregnancies) end in induced abortion per year in Pakistan.¹

In the absence of accessible, safe and officially authorised abortion services, most rural poor women opt for traditional methods or go to *dais* (traditional birth attendants),¹ who use a range of methods including insertion of knitting needles or pouches containing arsenic into the uterus.² Urban women, on the other hand, often approach *safias* or backstreet clinics where environments are unsterile.² It is no surprise that many women's health and lives are put at risk—some 197,000 women are treated annually for post-abortion complications in public sector facilities and private teaching hospitals.¹ Complications from unsafe abortions factor for a large portion of the maternal mortality rate of Pakistan, although the exact number cannot be determined due to the secrecy that shrouds the issue.²

Research reveals that 65% of women who had induced abortions were aged 30 or above, while 80% had three or

more living children (i.e., abortion is being widely used as a family planning method).¹ It also indicates a fairly high level of acceptance of induced abortion, with 80% of women having discussed with their husband the possibility of terminating the pregnancy, 89% indicating that the husband was aware of the induced abortion, and in 66a% of cases, husband and wife had taken the decision jointly.

But what about younger women? While the Population Council research revealed that “almost certainly a small minority of aborted pregnancies occurred outside of marriage,”¹ it must also be noted that 21% of young women aged 15-19 are already married.³ Moreover, while the number of Pakistani young women having abortions is unknown due to the unavailability of age-disaggregated data, it is certain that they seek abortions. Shirkat Gah cites that NGO field workers say that young unmarried girls are the more frequent abortion seekers in rural areas.² On the other hand, smaller urban hospital and clinic-based studies found that young women comprise 3.3% to 20% of those who sought abortions or were treated for complications.⁴ It must be noted that young women may be overrepresented in such urban studies because they face an increased risk of complications, possibly caused by

delays in seeking medical care. Conversely, the dearth of rural-based health services and the difficulty of accessing urban-based ones mean that an undetermined number of women do not access medical treatment for post-abortion complications. This difficulty is even greater for young women, especially the unmarried, due to their limited decision-making power and severely restricted physical mobility in the Pakistan context.⁴

Some Relief. Set apart from backstreet clinics and *dais* are a few non-governmental organisations that provide safe abortion services because they believe in a woman's right to decide for herself about her body and reproduction. These "no-loss, no-profit" organisations provide a range of sexual and reproductive health (SRH) services, including information, referrals and safe abortion services up to 12 weeks of gestation. These organisations are well-established in the communities they serve and have earned credibility through an unwavering client-centred and needs-based approach, which considers communities' needs in the location and timings of facilities as well as in their service fees. In addition, their strict adherence to quality, protocols and professionalism instil comfort and trust in clients.

A woman seeking safe abortion or treatment of an incomplete abortion is provided services through the Manual Vacuum Aspiration (MVA) method. MVA is better known as menstrual regulation and is legally provided in Bangladesh, India and other countries. More recently, some facilities have piloted providing medical abortions that use pharmacological drugs, increasing client choices. Medical abortion has certain advantages as it is non-invasive, prevents surgery and anaesthesia, allows treatment of pregnancy in its very early stages, and is safe and effective. To the client, it permits greater privacy and a degree of personal control. For women who might face personal barriers in accessing MVA at a busy clinic—such as those who are young and unmarried, and who might otherwise be at risk of resorting to unsafe methods—the introduction of medical abortion could save lives.

Challenges. Despite being established in a society where SRH discussions are considered taboo, these facilities seldom face opposition from the community, local key decision makers, religious leaders or officials. In fact, the latter apparently refer clients to the facilities. What these facilities have experienced—though rarely—are protests from angry husbands, local influentials whose recommendations to hire staff have not been met by the organisations, or ex-staff members who have been asked to resign due to their negligence in following protocols and other reasons. Some negative media campaigns have also been initiated due to ulterior motives. In such situations, the facilities' staff faced stigmatisation, threatening phone calls and even police raids. The organisations have always been strategically sound in providing support and protection and in undertaking legal recourse in cases of police involvement.

Service providers themselves at times pose challenges. Only those who believe in a woman's right to choose and have control over her own body are hired, but there have been instances where after training and starting work, they find that they are unable to continue.

Pakistan is also witnessing the current surge of extremism that is happening worldwide. In the northern areas of the country, there are moves towards a cosmetic show of Islamisation, such as closing down of barber shops so that men may grow beards, coercing CD/DVD shops to close business, attacks on NGOs for being 'agents of western agendas' and on field workers of government health and population welfare programmes, and threats to close down girls' schools. This trend has begun to have a negative impact on reproductive health services and will further push back provision of contraceptive methods with the resultant increase in the incidence of unsafe abortions.

Way Forward. Growing extremism and women's low status need to be addressed. Abortion's restricted (rather than illegal) status in the country needs to be widely disseminated, and silence on the realities of unsafe abortions due to lack of access to safe services needs to be broken. Age-disaggregated research on abortion and contraceptive use are crucial towards understanding young women's different needs and creating programmes for them. Comprehensive sexual and reproductive health and rights information and services need to be made available to all women, including unmarried girls, to prevent unwanted pregnancies. Men's understanding of the abortion issue and its reality in women's lives, as well as sense of responsibility in preventing unwanted pregnancy, should also be increased. Finally, all those closely involved in the reproductive health sector need to take up the above initiatives, advocate for removal of legal restrictions on abortion as a matter of women's right, and effectively implement the provisions that already exist for safe, humane abortion services and post-abortion care for women of all ages.

Doing all these may stir the opposition, but failing to do so will continue to sentence countless women—both young and older—to an early grave.

Endnotes

- 1 Population Council. 2004. *Unwanted Pregnancy and Post-Abortion Complications in Pakistan: Findings from a National Study*. Pakistan: Population Council. 57p.
- 2 *Women Living Under Muslim Laws, Shirkat Gab*. 1996. *Time to Speak Out: Illegal Abortion and Women's Health in Pakistan*. Special Bulletin. December 1996. 34p.
- 3 Population Reference Bureau (PRB). 2006. "The world's youth: 2006 data sheet." USA: PRB.
- 4 POLICY Project. 2003. *Adolescent and Youth Reproductive Health in Pakistan: Status, Issues, Policies and Programmes*. USA: Futures Group International. 48p.

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International

Ipas, an international reproductive rights organisation based in the United States, organised 50 organisations worldwide (including ARROW, the Network of Asia-Pacific Youth and Sisters in Islam) to sign a letter expressing support for Amnesty International's (AI) adoption of a policy on abortion. The letter was sent in March 2007 to Larry Cox, Executive Director of Amnesty International U.S.A. The draft policy under consideration by AI would establish its position on access to health care for the management of complications arising from abortion; on access to abortion in cases of rape, incest or risk to a woman's life; and on the removal of criminal penalties for those who seek or provide abortions. Ipas supports AI's adoption of a policy on abortion but believes a stronger policy in line with human rights principles would promote a woman's right to abortion unconditionally and without restrictions.

The United Nations Special Rapporteur on the Right to Health, the African Union, and the United Nations Treaty Monitoring Committee have identified the human rights implications of unsafe abortion. Without access to safe services, nearly 70,000 women die and an estimated five million are hospitalised annually due to complications. The overwhelming burden of these deaths and injuries falls on poor women.

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NOTE FROM THE EDITORS:

ARROW was likewise invited to provide a feminist and woman-centred analysis of the draft policy at the AI Malaysia Annual General Meeting on 15 April 2007 in Kuala Lumpur. AI has subsequently adopted the policy, incorporating selected aspects of abortion into its broader policy on sexual and reproductive rights. AI's 6/14/07 press release states that the policy "support(s) decriminalisation of abortion, to ensure women have access to health care when complications arise from abortion, and to defend women's access to abortion, within reasonable gestational limits, when their health or human rights are in danger."

Sex-selective abortion became one of the centrally-debated issues at the 51st session of the Commission on

the Status of Women (CSW), which was held from 26 February to 9 March 2007 in New York City, USA and was attended by 91 member states, 2,000 civil society groups, and an estimated 4,000 people. This year's theme, "the Elimination of All Forms of Discrimination and Violence against the Girl Child," ought to have been a perfectly "safe" issue, but right-wing groups used the forum to try to push for their anti-choice agenda. A resolution on sex-selective abortion was introduced by the United States and was supported by anti-choice organisations. The resolution was seen by SRHR activists as a sly attempt to put language into international documents that can be used to limit women's access to abortion and other reproductive health services worldwide.¹

Elisha Dunn-Georgio of the Sexuality Information and Education Council of the United States (SIECUS)

explains: *Media attention to practices in India and China, where preference for male children has resulted in the use of ultrasounds to determine foetal sex, has been a boon for the right-wing. Instead of focusing on the root societal causes of gender inequality that have given rise to disproportionate value placed on males, right-wing groups instead use this situation to try and assert arguments of foetal personhood and foetal rights... The presence of [these] groups at the U.N. is alarming to say the least. But more alarming perhaps is the growing influence they wield and their ability to have their ultra-conservative voices heard when it comes to making policies on sexual and reproductive health rights (SRHR) internationally. To argue against sex-selective abortion on a platform based on a 'right to be born' is of course a sneaky right-wing way to whittle away at the sexual and reproductive rights of women and girls.*

Without access to safe services, nearly 70,000 women die and an estimated five million are hospitalised annually due to complications. The overwhelming burden of these deaths and injuries falls on poor women.

Boy preference and sex-selective abortion is without a doubt one form of discrimination against girls and women. But, as Yakin Erturk, the U.N. Special Rapporteur on Violence against Women, repeatedly pointed out at various presentations, this form of discrimination has the same root causes such as poverty, economics and gender inequality that underlie all other forms of violence against women. And it is not until we address these issues that we will be able to truly meet the CSW objective of ending all discrimination and violence against the girl-child.²

United States Ambassador Patricia Brister, in explaining why the U.S. ended up having to withdraw the resolution due to lack of support, expressed the U.S. delegation's displeasure that the final Agreed Conclusions

actually extended SRHR to girls by including “multiple references to programmes and activities to help girls understand their sexuality.”¹

In the end, the agreed CSW conclusions only had one reference to prenatal sex selection, as follows: “Eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection, which may have significant repercussions on society as a whole (14.9 h).”³

Sources: (1) SIECUS. March 2007. *International Right Wing Watch (IRWW)*. (2) Dunn-Georgiou, Elisha. “Right-wingers at the Commission on the Status of Women.” Available at: www.rhrealitycheck.org/blog/2007/03/06/right-wingers-at-the-commission-on-the-status-of-women SIECUS, 1706 R Street, NW Washington, DC 20009. Tel.: +1-202-265-2405. Fax.: 202-462-2340, (3) *CSW Agreed Conclusions*, available at: www.un.org/womenwatch/daw/csw/51sess.htm#outcomes



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Malaysia

Unwanted pregnancies and women’s reproductive choices and rights, including access to contraception and safe abortion services, were the key issues taken up in the *Kehamilan yang tidak diingini: Pilihan wanita dan hak-hak reproduktif ke atas kontrasepsi dan pengguguran* session at the Fiesta Feminista-Malaysia on 17 June 2007 in Kuala Lumpur. Organised by the Reproductive Rights Advocacy Alliance of Malaysia (RRAAM), the 2-hour parallel session was attended by about 30 participants—mostly coming from women’s organisations all over the country and a few media practitioners.

Rashidah Abdullah, RRAAM co-coordinator, ARROW co-founder and long-time reproductive rights activist, discussed Malaysian women’s sexual and reproductive realities vis-à-vis the government’s poor family planning programme, which result in women’s low use of contraceptives and high rates of unwanted pregnancies. She outlined various choices women make in dealing with unwanted pregnancies, discussed the issues surrounding access to safe abortion services (e.g., quality and legal issues, economic and social barriers, availability of post-abortion counselling, and others) and ended with a discussion on women’s reproductive rights. Mr. S. Radhakrishnan, lawyer and former President of

the Medico Legal Society, discussed women’s legal rights for abortion. He pointed out that contrary to common understanding, the law allows a doctor to decide on termination of a pregnancy for physical and mental health reasons. Finally, factual statistics on the abortion situation in Malaysia, as well as the elements of women-centred abortion services and challenges to abortion access were discussed by Dr. S.P. Choong, RRAAM co-coordinator and the director of a clinic providing women-centred

reproductive health services for over 20 years. The floor discussion that followed further clarified abortion’s legal status and emphasised the necessity of networking among various groups across the country to be able to increase women’s access to safe abortion.

The Reproductive Rights Advocacy Alliance of Malaysia was set up in 2007 as an alliance of individuals and NGOs committed to increasing access to the right to safe, legal and affordable abortion and contraceptive services through information, education and evidence-based advocacy. The Fiesta Feminista session was RRAAM’s first

public education activity; this will be followed by a seminar for 200 doctors and nurses in Seremban on 3 July 2007.

Source: *Reproductive Rights Advocacy Alliance Malaysia (RRAAM)*, Email: rraamalaysia@yahoo.com

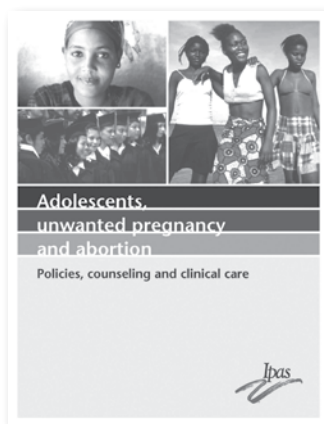
...contrary to common understanding, the law [in Malaysia] allows a doctor to decide on termination of a pregnancy for physical and mental health reasons.

Center for Reproductive Rights (CRR). 2005. "Adolescents need safe and legal abortion." New York: CRR. 5p. Available at www.crlp.org/pdf/pub_bp_tk_adolescents.pdf Tel.: +917-637-3600. Fax.: +917-637-3666.

This compact briefing paper is an excellent resource for policymakers, as well as for advocates and programmers working on adolescents' sexual and reproductive health and rights (SRHR). By providing evidence that young people are more at risk for unwanted pregnancies, are more likely to go through unsafe abortions and have particular reproductive health needs separate from adults, the brief puts forward strong rights-based arguments for governments to remove all barriers to safe abortion services for adolescents. It also cites some concerns and recommendations on the issue by the United Nations Committee on the Rights of the Child.

Cook, R. & Dickens, B.M. 2000. "Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive health care." *International Journal of Gynecology & Obstetrics*. Vol. 70, Issue 1, pp.13-21. Contact: rebecca.cook@utoronto.ca and bernard.dickens@utoronto.ca

This article tackles the thorny issue of parental rights vis-à-vis adolescent rights with regard to adolescent sexual and reproductive health (SRH). It looks at the UN Convention on the Rights of the Child (CRC), which all governments except for Somalia and the USA have signed, and which puts forward the concept of adolescents' "evolving capacities" to exercise choice in reproductive health care, thereby setting a legal limit on parental power to deny capable adolescents SRH services. Using the CRC, Cook and Dickens examine the specific duties of government and health service providers to implement adolescent rights regarding their SRH needs. The article concludes with a short case study of Profamilia, a Columbian non-government organisation which runs youth centres and provides some services for adolescents, and can serve as a model for accommodating adolescents' evolving capacities.



De Bruyn, M.; Packer, S. 2004. *Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical Care*. Chapel Hill NC, USA: Ipas. 50p. Available at www.ipas.org/english/publications/adolescents.asp Tel.: +919-967-7052. Fax.: +919-929-0258. Many resources on young people's SRHR tend to neglect abortion, while

abortion literature often fail to consider in length young people's needs. This publication fills this gap, providing available data and recommendations on addressing the consequences of unwanted adolescent pregnancies, particularly on abortion-related policies, counselling and clinical care. Intended to help policymakers and programme implementers ensure that girls and young women who choose to terminate unwanted pregnancies can readily obtain high-quality, comprehensive health care, *Adolescents* is divided into four sections. The "Introduction" provides an overview the issue, discussing pregnancy and induced abortion among adolescents and their reproductive rights, as well as abortion laws pertaining to adolescents in selected countries. The "Policy Framework" section describes measures that can be taken to prevent unwanted pregnancies among adolescents, provide adolescents with information on abortion, make comprehensive post-abortion care available, and enable adolescents to access safe, legal induced abortion services. The "Counseling and Clinical Care" section presents recommendations on psychosocial and clinical care collected from various sexual and reproductive health sources. The "Appendices" include citations from human rights documents on adolescent reproductive health, summaries of national-level laws pertaining to adolescent abortion, and training and counselling tools. A final section provides a list of useful resources for policymakers, researchers, counsellors, care providers and adolescents themselves.

A briefing paper by Sarah Packer, "Danger ahead: How restricting teens' access to safe abortion threatens their lives and health," was also produced by Ipas in 2005 based on this *Adolescents* document.

Faundes, A.; Barzelatto, J.S. 2006. *The Human Drama of Abortion: A Global Search for Consensus*. Nashville, USA: Vanderbilt University Press. 200p. For purchase details go to: www.VanderbiltUniversityPress.com Tel.: +615-322-3585. Fax.: +615-343-8823.

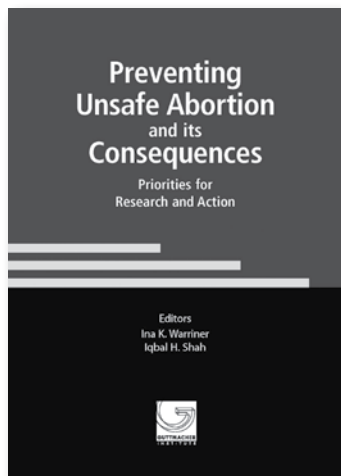
As medical students and physicians, both authors witnessed the death and disability associated with unsafe abortion. Their experiences resulted in a book that offers a clear framework for dialogue to replace the polarisation that presently exists on the abortion issue. Divided into four parts, the first part, "The Human Drama of Abortion," covers the main aspects of the complex personal and social problem of abortion. Part two describes the conflicting values faced by health professionals who deal with abortions. The third part, on improving the situation, reviews the interventions that have proven effective in decreasing the number of abortions and in reducing the human, social and economic costs; and the fourth part analyses the need for societies to reach a political consensus on the issue. Overall, it suggests that most people believe that a world without abortion would be a better place, but that the vast majority

accepts that under certain circumstances an induced abortion can be an acceptable choice. They put forth that if both sides of the heated debate recognised the lesser degree of their differences, it would open the door to constructive dialogue that could lead to consensus on vital points that could save lives. They equally believe that once the silent majority is better informed, the cultural shifts necessary to reach a political consensus will become increasingly feasible.

Shah, I.; Ahman, E. 2004. "Age patterns of unsafe abortion in developing country regions." *Reproductive Health Matters*. Vol. 12, No. 24 (supplement), pp. 9-17. Contact: shahi@who.int

Age patterns of unsafe abortion are critical for tailoring effective interventions to prevent unsafe abortion and for providing post-abortion care. This paper analyses the extent of unsafe abortion by age and region in developing countries using some 300 studies published from 1985 to 2002. It provides age-disaggregated data on the incidence and the rate of induced abortion in the Africa, Asia, and Latin America/Caribbean regions, and reveals that 9% of unsafe abortions in Asia occur among 15-19 year-old women, and a further 23% occur among 20-24 year-olds.

Shah and Ahman's analysis shows that the focus of interventions in Africa should be on women below age 25, whereas in Asia it should be on women over 25 years of age, and in Latin America and the Caribbean it should be on women aged 20-35.

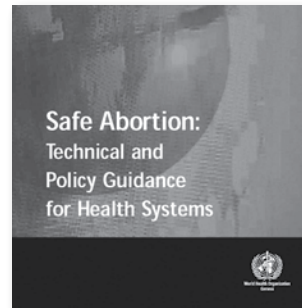


Warriner, I.K.; Shah, I.H. (Eds.). 2006. *Preventing Unsafe Abortion and Its Consequences: Priorities for Research and Action*. New York & Washington: Guttmacher Institute. 243p. Available at: www.guttmacher.com/pubs/2006/07/10PreventingUnsafeAbortion.pdf Tel.: +212-248-1111. Fax.: +212-248-1951.

This excellent report brings together the papers submitted to a WHO-convened interdisciplinary consultation, which assessed the global and regional problem of unsafe abortion and identified a research agenda aimed at reducing unintended pregnancy, unsafe abortion and the resultant burden on women, their families and public health systems. At the meeting, experts reviewed the available evidence on unsafe abortion, examined the factors that perpetuate the problem and identified both opportunities for preventing unsafe abortion and constraints on prevention.

Participants addressed the theoretical and medical issues relating to research on unsafe abortion and outlined regional priorities for the prevention of unsafe abortion. The volume identifies critical topics for future research and action on preventing unsafe abortion. Of particular interest to Asian-Pacific readers is Bela Ganatra's article, "Unsafe abortion in South and South-East Asia: A review of the evidence," which examines the available evidence on access to safe abortion in the region, identifies critical gaps in existing information, and outlines key priorities for research and programmes.

Other articles include "Abortion, human rights and the International Conference on Population and Development (ICPD)" by Rebecca J. Cook; "The incidence of unsafe abortion: A global review" by Susheela Singh; and "Reducing the complications of unsafe abortion: The role of medical technology" by David A. Grimes.



World Health Organization (WHO). 2003. *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva, Switzerland: WHO. 106p. Available at: www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf Tel.: +4122-791-2111. Fax.: +4122-791-3111.

This invaluable resource was developed by WHO to address the challenge of making safe abortion services available, given that nearly 20 million induced abortions (almost half of 46 million induced abortions that occur yearly) are estimated to be unsafe, and that 13% of pregnancy-related deaths can be attributed to complications resulting from unsafe abortion. This publication recognises that, in almost all countries in the world, abortion is legal to save the woman's life; in more than three-fifths of countries, it is allowed to preserve women's physical and mental health; and in about 40 percent, it is permitted in cases of rape or incest or fetal impairment.

The technical and policy guidance publication was developed with input from numerous international experts on law, medicine, ethics, social science and public health. It is a comprehensive overview of actions that health professionals and others both inside and outside of government can take to ensure the provision of safe, good-quality abortion services as allowed by law. Specifically, it offers an overview of the public health challenge of unsafe abortion, goes into the details of various clinical aspects of safe abortion care, health system issues in putting services in place, and legal, regulatory and policy considerations for improving both quality and accessibility of care.

Other Resources

Bearinger, L.H. [et al.]. 2007. "Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention, and potential." 12p. *The Lancet Early Online Publication*.

Boonstra, H.D. [et al.]. 2006. *Abortion in Women's Lives. Washington, DC, USA: Guttmacher Institute.* 44p. Available at www.guttmacher.org/pubs/2006/05/04/AiWL.pdf

Bott, S. [et al.]. [Eds.]. 2003. *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia.* Geneva: World Health Organization. 244p.

Family Care International & Ipas. 2005. *Improving Access to Safe Abortion: Guidance on Making High Quality Services Available, A Presentation Package for Advocates.* [CD-ROM].

Grimes, D.A. [et al.]. 2006. "Unsafe abortion: The preventable epidemic." *Lancet SRHR Series.* 12p. Available at www.who.int/reproductive-health/publications/articles/article4.pdf

PATH, Ipas. 2005. *Sparking Dialogue: Initiating Community Conversations on Safe Abortion.* PATH and Ipas. 12p. Available at: www.ipas.org/publications/en/SPARKDIA_E05_en.pdf

Sjödahl, Silvia. (Ed.). 2004. *Respect Choice: Safe Abortion, A Prerequisite for Safe Motherhood.* Stockholm, Sweden: *The Swedish Association for Sexuality Education (RFSU).* 114 pp. Available at www.rfsu.se/upload/PDF-Material/respect%20choice.PDF

Tylee, A. [et al.]. 2007. "Youth-friendly primary-care services: how are we doing and what more needs to be done?" *The Lancet Early Online Publication.* 9p.

Westley, Elizabeth. 2005. *Saving Women's Lives: The Health Impact of Unsafe Abortion, Report of a Conference Held in Kuala Lumpur, Malaysia, 29 September - 2 October 2003.* Montreal: Family Care International. 52p.

Websites with Resources on Abortion and Youth Center for Reproductive Rights

www.reproductiverights.org/pub_bp.html#adolescents

Guttmacher Institute

www.guttmacher.org/sections/adolescents.php

International Planned Parenthood Federation

www.ippfwbcr.org/publications/serial_issue_e.asp?PubID=31&SerialIssuesID=148

Ipas

www.ipas.org/english/publications/adolescents.asp

Youth Coalition

www.youthcoalition.org/DEV/mambo2/index.php?option=content&task=view&id=68&Itemid=92

ARROW's Publications

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights - Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project.* Kuala Lumpur: ARROW. 216p. Price: US\$ 10.00

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports.* Kuala Lumpur: ARROW. 384p. Price: US\$ 10.00

ARROW, CRR. 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia.* New York: Center for Reproductive Rights. 235p. Price: US\$ 10.00

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* Kuala Lumpur: ARROW. 147p. Price: US\$ 10.00

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report.* Kuala Lumpur: ARROW. 39p. Price: US\$ 10.00

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* Kuala Lumpur: ARROW. 30p. Price: US\$ 10.00

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1-4 June 1998, Kuala Lumpur, Malaysia.* Kuala Lumpur: ARROW. 65p. Price: US\$ 10.00

ARROW. 1999. *Taking up the Cairo Challenge: Country Studies in Asia-Pacific.* Kuala Lumpur: ARROW. 288p. Price: US\$ 10.00

ARROW. 1997. *Gender and Women's Health: Information Package No. 2.* Kuala Lumpur: ARROW. v.p. Price: US\$ 10.00

ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific. Health Resource Kit.* Kuala Lumpur: ARROW. v.p.
Differential Pricing. Contact ARROW for details.

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p. Price: US\$ 10.00

Payments accepted in bank draft form. Please add US\$3.00 for postal charge. For more details, please email arrow@arrow.org.my

Definitions

Parental Rights

This term is used by conservative forces to deny young people access to contraception, information and counselling, sexuality education and abortion. They argue that parents have the ultimate decision-making power concerning young people's sexual and reproductive health and rights (SRHR). At the International Conference on Population and Development (ICPD), they strongly opposed recognition of adolescent SRHR and partially succeeded in clipping these rights. The language adopted in the final ICPD document was a compromise—ICPD recognises the “rights, duties and responsibilities of parents” in providing guidance to adolescents on sexual and reproductive health matters even as it requires the promotion and protection of “the rights of adolescents to reproductive health education, information and care” (para 7.46), and that access to such services is not restricted.¹ Why can such a seemingly benign term as “parental rights” be so harmful? Instead of protecting adolescents, it often has the opposite effect. “Parental rights” has been used to restrict adolescents' SRHR at the national and local levels, such as in laws or hospital policies requiring parental consent or prior notification for obtaining abortions. While adolescents may want to include their parents in their decision-making, governments and health providers should not mandate that they do so. Indeed, many young women involve a parent when they make a decision to terminate their pregnancy, even without these laws. Those who do not often fear negative consequences, such as abuse, being thrown out of the house or pressure to carry the pregnancy to term. Legislations and procedures that require parental involvement place adolescents suffering from abuse or incest in further risk. These laws or policies may also cause delay in seeking an abortion, increasing the physical risks of the procedure with each week of delay, or drive adolescents to have abortion procedures which are unsafe but where confidentiality would be assured.²

Evolving Capacities of Adolescents

The Convention on the Rights of the Child (CRC) recognises that adolescents are capable of making decisions about their lives and that these decisions should be respected. It also recognises their right to privacy.¹ Under the CRC, governments are required to “respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.” The CRC, thus, limits parental role as the adolescent become capable of making independent decisions. A general rule is young people capable of being sexually active without parental control are equally capable of receiving SRH counseling and care without parental control.³ Among others, the CRC legally binds governments to remove legal, regulatory and social barriers to adolescents accessing essential reproductive health information and care; and ensure that health care providers are trained to assess the capability of adolescents

to make reasonable, independent, and confidential decisions regarding their reproductive health.³

Endnotes

- 1 Bergman, Ylva. (Ed.). 2004. *Breaking Through: A Guide to Sexual and Reproductive Health and Rights. Sweden: The Swedish Association for Sexuality Education (RFSU)*. 64 pp. Available at www.rfsu.org/upload/PDF-Material/breaking.pdf
- 2 Center for Reproductive Rights (CRR). 2005. “Adolescents need safe and legal abortion.” New York: CRR. 5p. Available at www.crrp.org/pdf/pub_bp_tk_adolescents.pdf
- 3 Cook, R. & Dickens, B.M. 2000. “Recognizing adolescents' evolving capacities' to exercise choice in reproductive health care.” *International Journal of Gynecology & Obstetrics*. Vol. 70, Issue 1, pp.13-21.

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The Other Half of the Coin: Increasing Access to Contraceptive Services

Nine percent of all unsafe abortions in Asia occur among girls aged 15-19 and 23% are among young women aged 20-24.¹ Clearly, such data discussed in the Editorial indicate that overcoming the barriers girls and young women face in accessing safe abortion services should be a priority for governments, non-government groups and donor agencies. To be able to fully address young women's needs and enable them to realise their reproductive rights, however, preventing unintended and unwanted pregnancies should also be a main concern.² Aside from provision of comprehensive sexuality education, increasing young women's access to contraceptive services is key to this.

Contraceptive use tends to be low among young women compared to adults, even among those who are married (see Table 1). Moreover, difference further exists within this age group—married adolescent girls in Asia are also less likely than married young women to use modern contraceptives (no data was available for the Pacific). Modern contraceptive use among those aged 15-19 ranges from a mere 2% in Pakistan to 47% in Indonesia (compared to 20% and 57% usage among all married women in Pakistan and Indonesia, respectively). For all seven

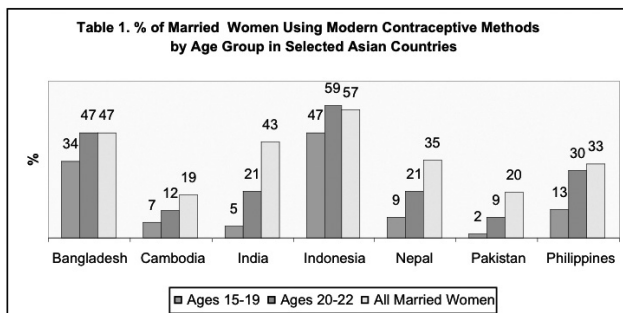
by ARROW to monitor ICPD, only in China can unmarried youth access contraceptives in primary health care facilities. Cambodia reportedly does not prohibit providing contraceptives to unmarried youth, but health providers were reported to be reluctant to provide these services.⁶ The same culture and policy environment that hinder unmarried young women's access to safe abortion services impede their access to contraceptives.

Considering that the youth aged 10-24 comprise one-third to one-half of the total population in Asian-Pacific countries, and a significant percent of young women aged 15-19 are married or in consensual unions,⁷ they are an important target group both from rights-based and public health perspectives. Married young women's low contraceptive use and the lack of data for unmarried women raise critical questions for policy makers, sexual and reproductive health and rights (SRHR) activists and programme implementors.

Are young people really seen as an important target group? Do policies and programmes for youth consider differential needs within various groups of young people? Do these address reasons for low contraceptive use, including structural ones, such as gender differences, young married girls' low status and limited income and mobility, and societal expectations to have a first child immediately after marriage? Is programming guided by evidence, and are strategies to overcome barriers critically assessed to show what works with whom and when? For example, do 'well-proven' strategies—such as the "Abstinence, Be Faithful, Use Condom" model—really work or do they further drive young people to risky behaviors? Do youth programmes accept adolescent sexuality or do they just pay lip service, stopping at information? When providing contraceptive (and abortion) services, are they really available, accessible, acceptable and appropriate for young people? Lastly, do young women have a say in how these policies and programmes are crafted and implemented?

Endnotes

- 1 Shab, I.; Ahman, E. 2004. "Age patterns of unsafe abortion in developing country regions." *Reproductive Health Matters*. Vol. 12, No. 24 (supplement), pp. 9-17.
- 2 Note, however, that there will always be a need for terminating pregnancies for various reasons, including contraceptive failure and sexual coercion.
- 3 Such sexuality education should provide adolescents and young people accurate, scientific and comprehensive information on body functions, sex, reproduction and safer sex, as well as build life skills for interpersonal communication and decision-making. It should also be rights-based and take into account gender relation issues, as well as other concerns such as abortion, diverse sexualities, and sexual coercion.
- 4 Population Reference Bureau (PRB). 2006. "The world's youth: 2006 data sheet." Washington, DC: PRB. Available at www.prb.org
- 5 Although child marriage is still widespread, particularly in South Asia. In PRB.
- 6 ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015—Asian Country Reports*. Kuala Lumpur: ARROW. 384p. The research covered Cambodia, China, India, Indonesia, Malaysia, Nepal, Pakistan and the Philippines.
- 7 9% of young women in the Philippines are married, 13% in Cambodia, 15% in Indonesia, 21% in Pakistan, 34% in India, 42% in Nepal, and 48% in Bangladesh. In PRB.



Sources: Population Reference Bureau (PRB). 2006. "The world's youth: 2006 data sheet." Washington, DC: PRB Available at www.prb.org & United Nations Department of Economic and Social Affairs Population Division. 2006. *World Population Policies 2005*. New York: UN. Available at: www.un.org/esa/population/publications/WPP2005/Publication_index.htm

countries with available data, use increased in the 20-24 age group, with the highest increase occurring in the Philippines, India and Bangladesh.⁴ On the other hand, data on contraceptive use and sexual activity among unmarried youth are not captured in national health statistics systems and demographic surveys. There are few privately funded national studies as well, although it is known that sexual activity among young people is increasing even as women are marrying at a later age compared to their mothers' generation.⁵ Given this lack of full understanding and acceptance of youth sexuality outside of marriage in Asian-Pacific societies, it is not surprising that of the eight countries studied

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