RECLAIMING REDEFINING RIGHTS

ICPD+25:
Status of SRHR in Asia and the Pacific

ACCESS *to* SAFE ABORTION *in* ASIA *and the* PACIFIC REGION

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asian-pacific resource & research centre for women

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ABOUT THIS BRIEF

This brief is part of ARROW's State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25), developed as a result of monitoring of 25 years of implementing the ICPD programme of Action in the region by ARROW and our partners. This is the fifth five-yearly review, research and monitoring report contributing to insights on progress, gaps and challenges to ICPD PoA implementation in the region. This brief provides an overview of the status of SRHR in Asia and the Pacific region with a focus on 19 countries. The monitoring series also includes country level research findings around the status of ICPD implementation in 13 countries in the region.

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Introduction to Abortion and References to POA

Safe abortion is a necessary component of reproductive health services, though some parties continue to contest the issue. In the ICPD, Paragraph 8.25 speaks of the need to reduce the recourse to abortion through contraception; pre-and-post abortion counselling; where abortion is not against the law, such abortion should be safe; and that at the very least, all countries should have access to services for the management of complications arising from abortion.

As the ICPD PoA was negotiated between countries, some compromises with regards to abortion appear within the ICPD PoA itself. The compromises can be located in the following paragraphs on abortion:

- 7.24 which does not recognise the role of abortion in limiting births;
- 7.6 which limits service provision to the prevention and management of abortion complications;
- 8.19 which discusses abortion prevention but not the provision of safe abortion services;
- 8.22 which again only considers service provision to treat abortion complications.

All of these compromises, in 1994, led to safe abortion being caveated at different policy levels, and led to limited access for women. These compromises continue to haunt us in all inter-governmental negotiations till today.

The U.S government in particular has affected the way in which abortion issues continue to be politicised outside of the United States. Since 1994, women's health and safety has been compromised through the different enactments of the Global Gag Rule, from the periods 2001-2009, and again 2017 till the present day. The most recent Global Gag Rule of the Trump-Pence administration affects not only family planning clinics but all organisations which receive any US government funding from its global health budget. The global gag rule has devastating consequences on women's lives as evidence notes: there was symmetric reduction in use of modern contraception, increase in pregnancies, and a rise in abortion rates.[1]

Safe Abortion and Human Rights Framework

In 1995, in Beijing, the women's movement was able to take it one step further in the Beijing Platform for Action, in which Paragraph 107 (j) and (k) adopted Paragraph 8.25 in full, with the addition of "consider[ing] reviewing laws containing punitive measures against women who have undergone illegal abortions." This helped mitigate the caveat that abortion should be primarily viewed within the existing legal frameworks of countries, and that there was an onus on States to review and change laws on abortion. This shift also helped position abortion not only as a public health issue but also one of women's rights: because only women need abortions, legislation that limits or makes abortion inaccessible harms women and is construed as gender discrimination.

This legal shift also enabled further work on abortion as a human rights issue.

The CEDAW committee noted that: "Unsafe abortion is a leading cause of maternal mortality and morbidity. As such, States parties should legalize abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe foetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. States parties should also remove punitive measures for women who undergo abortion."[2]

Furthermore, General Recommendation 35 by the CEDAW committee frames a denial of safe abortion services as a form of gender-based violence in paragraph 18: "Violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[3]

The Committee on Economic, Social and Cultural Rights noted in its General Comment 22 that: "The realization of the rights of women and gender equality, both in law and in practice, requires repealing or reforming discriminatory laws, policies and practices in the area of

sexual and reproductive health. Removal of all barriers interfering with access by women to comprehensive sexual and reproductive health services, goods, education and information is required. To lower rates of maternal mortality and morbidity requires emergency obstetric care and skilled birth attendance, including in rural and remote areas, and prevention of unsafe abortions. Preventing unintended pregnancies and unsafe abortions requires States to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health."[4]

However, despite the work at the global level, there has been a gap in establishing reproductive rights, in particular, the right to safe and legal abortion, as an indicator of gender equality at the country level.

The Committee on Economic, Social and Cultural Rights also noted that: "There exists a wide range of laws, policies and practices that undermine autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example criminalization of abortion or restrictive abortion laws. States parties should also ensure that all individuals and groups have equal access to the full range of sexual and reproductive health information, goods and services, including by removing all barriers that particular groups may face." The General Comment 22 puts the onus on state parties to respect, protect and fulfil these rights.

In the General Comment on Adolescents (GC20), the Committee on the Rights of the Child also urged "States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that pregnant adolescents' views are always heard and respected in abortion-related decisions."[5]

What is a common thread in the deliberations of all the different committees is that governments are called to legalise abortion in specific circumstances, decriminalise in all cases, and guarantee access to safe abortion services for all women and girls.

The work of the Committee against Torture also framed a denial of abortion services as a form of torture, and this is noted in the reviews and recommendations at country level with a particular emphasis on Latin-American countries.

The UN Committee against Torture also saw the denial of abortion services as a form of torture. In 2006 and 2012, when reviewing Peru, the Committee noted the case of LC vs Peru, and that Peru's restrictive abortion law leads to "grave consequences, including the unnecessary deaths of women." The Committee also called upon Peru to "take whatever legal and other measures ... necessary to effectively prevent acts that put women's health at grave risk, by providing the required medical treatment." In 2011, when reviewing Paraguay, the Committee against Torture strongly noted the long-standing psychological consequences of banning abortion in cases of sexual violence, incest, or when the foetus is not viable. The Committee's review of Nicaragua in 2009, stated that the country's laws that deny abortion to even victims of sexual violence is "constant exposure to the violation ... and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression," and recommended that Nicaragua relieve the trauma of forcing victims of sexual violence to carry pregnancies to term by liberalising its abortion laws.

The work of the Human Rights Committees helped push the envelope on one of the key shortcomings of the ICPD PoA: "access to safe, legal abortion [is] not recognized as part of reproductive health and rights; [in] deference to national laws; where illegal, [requiring] treatment of complications only."[6]

However, despite the work at the global level, there has been a gap in establishing reproductive rights, in particular, the right to safe and legal abortion, as an indicator of gender equality at the country level. The caveats of ICPD continue to be an obstacle to us on this quest. Legality in the context of each country indicates public acceptance of fertility control, women's need for abortion, the limitations of contraception and contraceptive use, and women's right to decide the number and spacing of their children as well as

public respect for and acknowledgement of women's responsibility as mothers.[7]

National laws, protected by the national sovereignty clause in all UN documents, are not easy to change. The deference to national laws, when restrictive, frames abortion with illegality. In addition, laws governing abortion may be covered under different sections; may be difficult to interpret; may be contradictory; and may be obfuscatory. In countries where abortion is broadly legal, time frames are tied to legality, along with parental or spousal consent.

We cannot also doubt that there is a very real attempt to recriminalise abortion. These attempts, which help limit access to safe abortion services, are discussed at the end of this chapter.

It is imperative that we view access to abortion in a humane and just way: "Women have abortions for only one reason —because they cannot cope with a particular pregnancy at a particular time. This can never be said enough. They may regret the reasons, but this does not alter the fact that abortion is the correct decision for them and necessary in the circumstances of their lives."[8] Furthermore, it is important to create policies, laws and procedures which enable and empower women to make these choices.

In this section, we examine the legal status of abortion in the countries; changes in the law since ICPD; the extent to which the abortion law is known and acted upon; the incidence of unsafe abortion; and percentages of maternal deaths attributed to unsafe abortion.

1. Legal Status of Abortion

There are different levels of permissibility with regards to abortion in the 19 countries studied. National laws create or restrict legal access to abortion. The grounds upon which abortion is legally permitted are usually 'additive' – when abortion is permitted for a more liberal condition, it is generally also permitted for the more restrictive conditions as shown in the table above.

There is adequate evidence to show that restrictive legislation on access to abortion is associated with a high incidence of unsafe abortion. There may also be discrepancies between the wording of the law and its application[9] and this is shown by differing term limits, and the requirement of parental and spousal consent.

The aspects of abortion being legal and safe are intertwined because "[m]aking abortion legal is an essential component of making abortion safe.... Legal changes need to take place if safety is to be sustained for all women. Safety is not only a question of safe medical procedures being used by individual providers. It is also about removing the risk of exposure and the fear of imprisonment and other punitive measures for both women and providers, even where illegal abortion is tolerated."[10] And these aspects apply in both situations where abortion is unavailable or available under certain conditions, and also with regards to second trimester abortions in countries where abortion is already legal within certain time frames.

Government commitment to making abortion accessible to women must also be followed up in programme implementation through the provision of services, facilities and personnel trained on procedures. In some Asian countries, notably Cambodia, India and Nepal, abortion laws are liberal, but many pregnancy terminations are performed in substandard conditions.[11]

2. Changes in Abortion Law After ICPD

Many countries, only in recent years, have been addressing abortion in laws and policies. Since ICPD in 1994, the following countries in the region have changed their laws on abortion.

In Cambodia, in 1997, concerned with the high MMR brought about by the unsafe conditions in which illegal abortions were generally being performed, the government decided to introduce abortion legislation to regulate the procedure formally. The government hoped that the legislation would reduce the MMR by one half by 2010. Moreover, the proposed legislation was depicted as a measure designed to improve the social welfare of the population. Despite some opposition from those who argued that the country's Buddhist traditions do not allow the legalisation of abortion, the proposed legislation was enacted in early October 1997.[12]

In Vietnam, abortion and menstrual regulations have been officially allowed by the Vietnamese Government since 1989 when it approved the Law on Protection of People's Health. Women's rights to gynaecological check-ups and treatments, and abortion and menstrual regulation, as stipulated in Chapter 8 (Family Planning and Mother and Child Health) Item 1, Article 44, reads: "Women have the right to abortion and menstrual

TABLE 1: LEGAL STATUS OF ABORTION IN THE REGION

	To Save a Woman's Life	To Preserve Physical Health	To Preserve Mental Health	Pregnancy Resulting from Rape or Incest	Foetal Impairment	For Economic or Social Reasons	No Restriction as to Reason (With Gestational and Other Requirements)
EAST ASIA							
China ***	●	●	●	●	●	●	●
Mongolia ■	●	●	●	●	●	●	●
SOUTH ASIA							
Bangladesh	●						
India **	●	●	●	●	●	●	
Maldives *	●	●					
Nepal	●	●	●	●	●	●	●
Pakistan [2]	●	●	●				
Sri Lanka	●						
SOUTH EAST ASIA							
Cambodia **■■	●	●	●	●	●	●	●
Indonesia *	●			●	●		
Lao PDR	●	●					
Malaysia	●	●	●				
Myanmar	●						
Philippines [1]	●						
Thailand	●	●	●	●	●		
Vietnam ***	●	●	●	●	●	●	●
PACIFIC							
Fiji [3] **	●	●	●	●	●	●	
Papua New Guinea	●						
Samoa [3]	●	●	●				

Sources:
Department of Economic and Social Affairs, *World Abortion Policies 2013.*
Guttmacher, *Abortion Worldwide 2017: Uneven Progress and Unequal Access.*

Legend:
1 - *Laws on abortion do not expressly allow abortion to be performed to save the life of a woman, but general principles of criminal legislation allow abortion to be performed for that reason on the ground of necessity.* **2 -** *The law allows abortion to be performed in order to save the life of a woman or to provide necessary treatment. The law does not indicate which abortions constitute necessary treatment.* **3 -** *Laws on abortion either expressly allow abortion to be performed only to save the life of a woman or are governed by general principles of criminal legislation which allow abortion to be performed for that reason on the ground of necessity. In addition, the British case of R. v. Bourne or local application of that decision apply. Under that decision, the ground of necessity was interpreted to encompass abortion performed on grounds of preserving physical and mental health.*

* - *Spousal authority required*
** - *Parental authorization/notification required*
*** - *Law does not indicate gestational-age limit*
■ - *Gestational-age limit through 90 days/three months*
■■ - *Gestational age limit through 14th week.*

regulation at their will and to gynaecological check-ups and treatment and health check-ups during pregnancy and child delivery services at health facilities."[13]

In 2002, India adopted legislation aimed at improving access to safe abortion facilities by moving authority to approve facilities from the state level to the district level. The law, which is intended to simplify the approval process for new facilities, also increases criminal penalties for providers and facility owners who operate without approval.

In Nepal, it was only in 2002 that "abortion [was made] legal without restriction as to reason during the first 12 weeks of pregnancy, and thereafter on specific grounds. Under the [previous] law, abortion was prohibited altogether."[14]

In Thailand, it was only in 2005, that the Medical Council amended a regulation governing the medical profession's conduct in regard to abortion. "The regulation provides a standard interpretation of the criminal law provision on abortion, which permits the procedure when a woman's life or health is in danger and in cases of rape. According to the new regulation, "health" is defined to include mental health as well as physical health. The regulation clarifies that abortion may be performed in public or private health facilities not only to protect a woman's life and physical health and in cases of rape, but also when a pregnancy causes harm to a woman's mental health and in cases of foetal impairment."[15]

In Indonesia, it was only in September 2009 that the law was amended again recently, and stipulates that only women whose lives are in danger or those that have been raped can have an abortion, but the time limit is woefully inadequate.[16]

In Fiji, in 2009, abortion was permitted on socioeconomic grounds or in cases of rape, incest or foetal impairment. Previously, although abortion was authorised on socioeconomic grounds, the penal code did not explicitly permit abortion in cases of rape, incest or foetal impairment.

3. Extent to Which Abortion Law is Known, Accepted, and Acted Upon by Health Care Providers and the Public

Health providers play an important role in the provision of abortion services. In the region, however, both the shortage of health providers, and unwillingness or bias of service providers, can make it difficult for women to access services, and this further stigmatises those services. At the same time, women's knowledge of the legality and availability of abortion services also ensures that women seek services, and from the right providers. Incorrect knowledge of laws may affect how women enter the health system or seek services, and it likely contributes to the disconnect between official laws and practical applications of the laws that influence women's access to safe, legal abortion services.[17]

In Southeast Asia, health care providers have moral, social and gender-based reservations about induced abortion. These reservations influence attitudes towards induced abortions and subsequently affect the relationship between the health care provider and the pregnant woman who wishes to have an abortion. Health care providers often persist in viewing induced abortion as immoral, rather than recognising the legal status of abortion in their country and supporting women who seek to obtain the services.[18] Evidence at ground level lends support to this view.

Health providers play an important role in the provision of abortion services. In the region, however, both the shortage of health providers, and unwillingness or bias of service providers, can make it difficult for women to access services, and this further stigmatises those services.

In Nepal where abortion has been legal since 2002, and the government began providing comprehensive abortion care services in March 2004.[19] Overall, two in five (41%) women age 15-49 were aware that abortion is legal in Nepal. Those living in urban areas (43%) were more likely to be aware that abortion is legal than those living in rural areas (36%). Furthermore, those in the highest wealth quintile (50%) were more likely to be aware than those in the lowest quintile (30%), and those residing

in Province 1 (46%) had a higher level of awareness than those residing in the other provinces. Women, who thought that abortion is legal, were further asked about the circumstances allowing legal abortion. Most women were aware that abortion is legal for pregnancies up to 18 weeks gestation in the case of rape or incest (29%) and pregnancies up to 12 weeks gestation for any woman (23%). This awareness of the legality of abortion in the early gestational period expands with increasing education. However, women were least aware of the circumstances related to legal abortion at later stages of pregnancy. Apart from that, 48% of women age 15-49 reported knowing a place where safe abortion services can be obtained. Knowledge of this source for a safe abortion is higher among urban, educated, and wealthy women compared to their counterparts. In addition, knowledge of a safe abortion location is slightly higher in the terai zone than in the hill or mountain zone, and higher in Province 6 than in the other provinces. Women who report knowing places for safe abortion practices are more likely to mention the government sector (79%) than the private (46%) or the non-government sectors (18%).

In Bangladesh, even though the MR programme has been supported by the government of Bangladesh since 1979, many women are unaware of its services—more than half of ever-married women in Bangladesh had never heard of MR.[20] This was reiterated in another study, which showed that women, especially from rural areas, had poor knowledge of MRM (menstrual regulation with medication). The study identified female sex workers as an especially marginalised group with a high need but they lacked knowledge.[21] However, the impact of menstrual regulation services in reducing maternal mortality and abortion related deaths has been significant in Bangladesh, although determining and understanding the extent of this impact has been difficult due to the scarcity of data on abortions.

In India, studies in two areas show gaps in women's knowledge on the legality and availability of abortion. While the majority of women (77%) were aware of at least one situation in which abortion is legal in India, an equal proportion (73%) held one or more misconceptions about women's right to abortion. Half of all women believed that abortion is not legally available to unmarried women (49%) or to those who have experienced contraceptive failure (50%), and 30–34% believed that abortion is not legally available to women whose health is at risk due to their pregnancy or women who have a strong chance of foetal malformation.

Furthermore, a considerable proportion (88%) of women believed that it is mandatory for women undergoing abortion to have their husband's consent.

In Southeast Asia, health care providers have moral, social and gender-based reservations about induced abortion. These reservations influence attitudes towards induced abortions and subsequently affect the relationship between the health care provider and the pregnant woman who wishes to have an abortion.

Awareness of the location of abortion facilities and providers was also limited. For example, 27% of all women were unaware that abortion services were available at public or private sector facilities in their district, and at the same time, an almost equal proportion (one-quarter) reported that abortion services were currently available from providers outside the provisions of the Act. Besides that, awareness that abortion is conducted in a public sector facility was also limited: just 38% of women reported such awareness, compared to 62% reporting awareness that abortions are conducted in private sector facilities.[22] Unfortunately, in Madya Pradesh, India,[23] most women in rural parts of Madhya Pradesh (MP) lack awareness about the legality of abortion, and are unsure who an eligible provider is. They frequently get confused between rural practitioners and registered medical practitioners, therefore, often ending up in the hands of illegal providers. Moreover, as per one study, only 12% of the community in MP know that abortion is legal—this is the major issue why women hesitate to access a government facility for abortion.

Confusion among providers arises in the background of other laws which often tend to be linked with the MTP Act. For instance, in case of rape, there is the confusion regarding informing the police and about giving consent for abortion. For young women, there is confusion on the services offered in the light of the Protection of Children from Sexual Offences Act, 2012 (POCSO). Most importantly, confusion arising due to the mis-linkages with the PCPNDT Act, and every second trimester abortion being looked as a sex-selective abortion, is also evident among these women.

Malaysia has an abortion law, which permits termination of pregnancy to save a woman's life and to preserve her physical and mental health (Penal Code Section 312, amended in 1989). However, the lack of a clear interpretation and understanding of the law results in women facing difficulties in accessing abortion information and services. Some health care providers, moreover, were unaware of the legalities of abortion in Malaysia and influenced by their personal beliefs regarding the provision of abortion services.[24]

In the Philippines, the moral judgment of providers, and the lack of knowledge among providers and the general population regarding the legality of post abortion-care services, significantly affects the methods used to manage complications and the prompt and humane treatment of patients seeking these services.[25]

One of the key ways in which service providers may recuse themselves from providing abortion services is through the practice of conscientious objection (CO). Conscientious objections are considered indefensible by some,[26] that 'CO' in reproductive health care should not be considered a right, but an unethical refusal to treat. Refusals to treat are based on non-verifiable personal beliefs, usually religious beliefs, but introducing religion into medicine undermines best practices that depend on scientific evidence and medical ethics. Conscientious objection, therefore, represents an abandonment of professional obligations to patients.

Unsafe abortion is a major factor contributing to maternal mortality. Legalising and decriminalising abortion is one of the first steps that can be taken to ensuring access to safe abortions for women as seen in Eastern Asia.

In the Philippines, the Supreme Court ruling recognises conscientious objections, Section 23(3) mentions: "(3) [Refusal] to extend quality health care services and information on account of the person's marital status, gender, age, religious convictions, personal circumstances, or nature of work: Provided, that the conscientious objection of a health care service provider based on his/her ethical or religious beliefs shall be respected; however, the conscientious objector shall immediately refer the person seeking such care and services to another health care service provider within the same facility or one which is conveniently accessible ..." The rules and regulations for implementing this provision elaborate on penal provision. The rules make a distinction between "Private Skilled Health Professionals" who are conscientious objectors and "Public Skilled Health Professionals," i.e., private practitioners and government employees.[27]

4. Unsafe Abortion and Percentage of Maternal Deaths Attributed to Unsafe Abortion

The onus on governments to reduce unsafe abortion is mentioned in the ICPD PoA and reiterated as a state obligation through various human rights instruments.

Overall, there has been a reduction in the abortion rate especially with the increase of access to contraceptives in the region, and with more women exercising greater fertility control.

It is estimated that about 35.5 million abortions that occur within the region,[28] this number contributes significantly to the number of worldwide abortions (55.9 million), due to the sheer size of the population of the region.

The rates, ratios and percentages show the relative health burden of unsafe abortion in the specified regions. Unsafe abortion is negligible in Eastern Asia, where abortion is legal and relatively accessible, for example, China and Vietnam. Hence, in these countries, all procedures are safe, and correspondingly, 88.9% of all abortions are considered safe, and only 0.04% abortions are considered unsafe. The small percentage of unsafe abortions taking place in Eastern Asia is comparable to numbers of unsafe abortion in Northern and Western Europe, and Northern America. In the same way, in the Pacific region, though the number of abortions occurring are small, 25.9% of these abortions, however, are unsafe.

In Southeastern and Western Asia, the proportion of safe abortions exceeded 50%. In Southern Asia, the number of safe and less safe abortions are equally distributed, which means that around 1 in 2 abortions are less safe or least safe. Though countries such as India and Nepal have legalised abortions, this also has to translate into the provision of quality services for women.

TABLE 2: REGIONAL ESTIMATES OF UNSAFE ABORTION

	Abortion Rate (1990-1994)	Abortion Rate (2010-2014)	Percentage Distribution of Abortion (2010-2014)		
REGION			Safe	Less Safe	Least Safe
ASIA	41 (37-50)	36 (31-46)	62.1 (54.8-67.2)	29.7 (23.5 – 36.6)	8.3 (4.9-13.3)
- Central	54	42	—	—	—
- Eastern	43	36	88.9	11.1	0.04
- Southeastern	46	35	59.6	26.9	13.5
- Southern	35	37	42.2	44.9	12.9
- Western	42	34	51.5	36.3	12.3
OCEANIA	20 (18-27)	19 (15-28)	66.3	7.8	25.9

Source:
Guttmacher, *Abortion Worldwide 2017: Uneven Progress and Unequal Access.*

Unsafe abortion is a major factor contributing to maternal mortality. Legalising and decriminalising abortion is one of the first steps that can be taken to ensuring access to safe abortions for women as seen in Eastern Asia.

Unsafe abortion continues to be a major factor in maternal deaths in the region. Mortality due to unsafe abortion for Southeast Asia is estimated at 14% of all maternal deaths,[29] and South Asia, at 13%.[30]
WHO conceptualises abortion safety into three categories: safe, less safe, and least safe. The less-safe and least-safe categories constitute unsafe abortions. Abortions as categorised as safe if done with a WHO recommended method (medical abortion, vacuum aspiration, or dilatation and evacuation) that was appropriate to the pregnancy duration and if the person providing the abortion was trained. Abortions are categorised as less safe if only one of the two criteria were met that is if the women either received services by a trained provider or received safe abortion methods. Abortions are categorised as least safe if provided by untrained individuals using dangerous methods, such as ingestion of caustic substances, insertion of foreign bodies, or use of traditional concoctions.

Common unsafe abortion methods used include inserting sticks, herbs, roots, and foreign bodies into the uterus. Other vaginal methods include pins, laminaria tents and fetex paste. Rural Medical Providers have been known to sell medicines for oral use to induce abortion. Apart from that, ANMs use intra-amniotic saline and intra-amniotic glycerine with iodine. In terms of orally ingested abortifacients, these include, indigenous and homeopathic medicines, chloroquine tablets, prostaglandins, high dose progesterone and oestrogens, liquor before distillation, and seeds of custard apples and carrots. Invasive or surgical methods are also tried by a minority of informal providers. The common instrument used is a curette, and occasionally a syringe, catheter or copper-T.[31]

5. Methods of Abortion

Abortion services are often equated with the earlier methods of abortion in medical settings for pregnancy termination which are dilation and curettage (D&C), and dilation and evacuation (D&E). From the 1970s, however, there has been a decrease in D&Cs, and manual vacuum aspiration (MVAs) became more popular. MVAs were safer, required no anaesthesia, no dilation of the cervix, and in low-resource settings, it could be utilised by midwives and trained nurses. The MVA method was also enhanced by innovation, and the utilisation of electric vacuum aspiration (EVA), which has also become popular. These methods are described as surgical abortion methods.

In recent years, medical/medication abortion utilising antiprogestogens and prostaglandin analogues (mifepristone and misoprostol) has become more widely available in the region, and are considered more effective than previous methods of abortion, especially in the early weeks, and allow for greater autonomy and control

by women. Medical/ medication abortion has also contributed to abortion safety, which is likely having an important positive impact on abortion-related morbidity and mortality. This is especially true when the pills are used properly, with adequate knowledge on how to use them, at the right time and dosage. Issues on receiving adequate information on dosage and timing and referral options have been highlighted and should be worked on.

As early as 1997, acceptability of medical abortion in the region has been noted especially in China and India, with women and service providers finding the procedure safe, less painful and more private.[32]

The availability and proliferation of a range of methods of abortion has enabled access to safe abortion services in a greater degree in recent years, post ICPD.

Two key areas—stigma and attempts to recriminalise abortion—have emerged in the last decade as deserving of our particular attention as the women's sexual and reproductive rights movement in the region.

Stigma

Abortion stigma is well-acknowledged though lesser researched and studied. Abortion stigma is contextual and ever-evolving and deeply relates to marks of shame and disgrace of women who have undergone abortions, abortion service providers and advocates of abortion. At the fundamental level, abortion is considered a violation of the ideals of female sexuality and motherhood which are culturally and religiously perpetrated.[33] Despite literature and data proving otherwise, abortion stigma is connected to sexual promiscuity, and unnatural womanhood—women who shed the sacrificial role of mothers within families and embark on routes of individual gratification. This in itself is a mark of a disvalued woman especially within Asian cultures where marriage and family are upheld as standards of achievement for women.

Cultures in the Asia-Pacific region continue to be more patriarchal, with a strong emphasis on family, including extended families. The role of women within families is strongly circumscribed by gender, social and domestic roles and ensuing limitations on freedom and autonomy of women. This is often reinforced by religious beliefs, cultural practices and social attitudes, through these institutions, and these serve as dominant sources of stigma, regardless of whether abortion is legal or not. Abortion stigma results in women keeping silent about their abortions for fear of social reprisals, feelings of guilt and inferiority for having had abortions, and justifications for abortions—being divided into good abortions (due to external circumstances) and bad abortions (due to personal choices). Stigma has both short-term, episodic impact as well as long-term impact.

Stigma continues to be a powerful tool to limit access to safe abortion services. The right-wing has continued to perpetrate stigma as a powerful tool in order to limit access, at both personal and political levels. Hence, the attempts to recriminalise abortion discussed at length above—frame abortion as a criminal, illegal, and inhumane activity to further drive stigma, without recognising that forced pregnancies are as criminal, illegal and inhumane as well.

While on the one hand legal abortion is equated with safe abortion, and illegal abortions equated with unsafe abortions, the situation is more complex. Even in circumstances where abortions are legal, abortion stigma can and does drive women to seek services from less trained providers. CommonHealth's study in India demonstrates that stigma continues to be powerful in deterring women from seeking services, and that stigma around abortion is higher amongst younger than older women.[34]

Abortion stigma should be considered, acknowledged, and addressed as a predictive factor in abortion safety and in reproductive morbidity and mortality risk.[35] Hence, understanding and unpacking abortion stigma is a critical intervention in ensuring access to safe abortion. Mortality risk from unsafe abortion has been enumerated and fairly well known, however reproductive morbidity is lesser explored. The complications include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs. The WHO estimates that about 20–30% of unsafe abortions result in reproductive tract infections and that about 20–40% of these result in upper-genital-tract infection and infertility. An estimated 2% of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections.[36]

In Asia, most studies point out that abortion-related stigma is lower in countries where abortion is legal. In South India, where public health services have wide coverage and utilisation, abortion is not as stigmatised. Despite this, women seek services from private, and

perhaps clandestine providers becauseaccess is more difficult in rural areas and a lack of widespread information about legal abortion services.[37] Interestingly though, in Bangladesh, abortion is illegal in almost all circumstances, yet menstrual regulation is easily available, and this is more accepted and a less-stigmatised means for women seeking safe abortion services. In Nepal, though abortion is legal and relatively safe, there is still an estimate of 20% of pregnancy-related deaths, as women may not know that abortion has been legalised, or there are free services availed by providers.[38] Beyond Beijing Committee's work shows that lack of comprehensive information and knowledge on abortion helps drive stigma, and despite abortion law reform, further work needs to be done on addressing and reducing stigma to ensure women access and receive the quality services they need and deserve.[39]

Abortion-related stigma, and the ways and means by which it is perpetrated on those who seek, support, procure, and provide abortion services can be regarded as an "insidious and destructive form of structural violence insofar as it threatens physical and emotional health, and status, and affects people already disproportionately vulnerable to physical and social suffering on biological, economic, political, social, and medical levels."[40]

Case Study - From an FGD with younger Dalit women

My first baby was young and suddenly I conceived [again]... when I went to the government hospital they told me that they cannot do it [perform and abortion]. So, we went to a private hospital. We only had Rs. 1,000, so my mother removed her earrings and other jewellery and handed them over to the doctor to pay for the abortion services. She requested the doctor to do the abortion and told her that she will come and discharge me the next day. The next day she paid Rs. 6,000 to the doctor, got back her jewellery from the doctor and took me home.

Source: Availability of Safe Abortion Services and the Perspectives of Actors on the Right to Safe Abortion in the States of Bihar and Tamil Nadu, India: A Rapid Assessment.

Attempts to Recriminalise Abortion

While we look at changes in laws and policies in regard to liberalising laws on abortion, we need to be cognisant of the deliberate work of groups to attempt to recriminalise abortion on certain grounds in order to limit access to safe abortion. Recriminalisation and stigma have a mutualistic relationship: both are built on the same thought platforms and works to strengthen and drive each other. The attempts to recriminalise abortion come from different angles but always as a matter of rights being pitted against each other. Different stakeholders gathered and momentum gained around the issues. It is undeniable that from 1994 till now, the Vatican continues to lead the conservative forces at inter-governmental sessions, to whittle down the paradigm of rights that support women's access to safe abortion services and overall sexual and reproductive rights of women, young people and LGBTIQ, in particular. In the Asia-Pacific region, governments who championed ICPD in 1994, have, now, more conservative governments in place who have reversed governmental positions and commitments to ICPD ideals of reproductive rights. These include Indonesia, Bangladesh, Pakistan, Malaysia, and Iran, who are influenced by the Middle Eastern nations like Qatar and Saudi Arabia, to join this grouping. This group of countries consistently join forces with the Vatican in limiting government commitment to gender equality and women's rights. The caveats in ICPD against abortion have been firmly and consistently held onto, without recognition of the advances in the human rights mechanisms.

This is a critical chasm between the consensus documents which determine development such as Rio, ICPD, Beijing, the MDGs, the SDGs and the human rights conventions which determine rights. Governments often keep these documents and these spaces separate, because building bridges between both of these paradigms—development and rights—are difficult.

At the same time, there are robust attempts at country levels to introduce discourses that frame the necessity to clamp down on abortion services. This has been, in some ways, introduced within the Asia-Pacific region by certain groups. This report aims to track some of the discourse which aims to whittle down women's rights to access safe abortion, and we rely on media sources mainly to do this as no mainstream studies have tackled this issue.

1. Life Begins at Conception, Foetus Having Personhood and Abortion Regarded as Murder

The idea of life beginning at conception is one specific to the Christian religion. In other religions, for example, in Islam—ensoulment is when 'life' and 'consciousness' begins, and this takes place circa 120 days. Anti-abortion advocates argue that the embryo and foetus have potential personhood, which means that if carried to term, the foetus will most likely grow into an adult with full social and political rights.

The argument is one that has crossed borders and recent events show that conservative groups within the region also employ the same framework.

In 2014, in the Philippines, the single Catholic country in the region, the Supreme Court sided with pro-life groups in affirming that life begins at fertilisation.[41] The court was of the "strong view" that life begins at the meeting of the sperm and the egg in the mother's womb or "fertilisation," which the court said should be taken as being synonymous with "conception." The decision written by Associate Justice Jose Catral Mendoza cited dictionaries, medical literature, court decisions, and records of the Constitutional Commission that drafted the 1987 Constitution. Article II, Section 12 of the Philippines constitution says the state shall "equally protect the life of the mother and the life of the unborn from conception."

In 2017, Buddhist, Muslim and Christian religious leaders united to oppose legalising abortion in Sri Lanka[42, 43] even in the cases of rape or for those with fatal foetal anomalies when the Cabinet approved presentation of a bill to parliament to legalise abortion when a pregnancy is due to rape or if a foetus is diagnosed with a lethal congenital malformation. Buddhist, Muslim, and Christian leaders have told the government they all believe life begins at conception.

China which has had a liberal abortion law, has also seen a burgeoning of pro-life Christian groups and Buddhists[44] who are introducing discourses on forced abortion, and abortion as a sin since life begins at conception which aim at dissuading women from choosing abortions rather than changing the law. "According to a July 26 article by *World*, a U.S.-based Christian magazine, one church in China formed a partnership with a local hospital to open a crisis pregnancy center, painted pink and yellow, where volunteers speak with abortion patients about alternative options. Another organisation in China provides financial assistance so that women can pay the fines that would otherwise push them towards abortion. Yet another, China Life Alliance, is U.S.-based but seeks change in China by helping to sponsor safe houses that serve Chinese women "at high risk for forced abortions," according to the organisation's website. It also helps mobilise "abortion rescue teams, "volunteers who walk into abortion clinics and speak directly with patients to try to convince them to pursue other options, as well as providing training seminars for local churches. According to a map posted on the CLA website, pro-life volunteers operate in 29 cities around China."

The efforts to limit and recriminalise abortion are built from the same thought platforms and have a symbiotic relationship with efforts to advance abortion-related stigma.

2. Sex-selective Abortion

In a number of countries with more liberal abortion laws – China, India and Vietnam, certain stakeholders including UN agencies have brought attention to unbalanced sex ratios at birth as evidence of sex-selective abortion. These three countries are known for their culture of preferences for sons, and strong population policies on the ground. There have been studies which posit that in countries where births are limited to one child or two children, the biological possibility that the first child is male, is high[45] which also contributes to the sex ratio imbalance but is never considered.

Sex-selective abortion is utilised by groups in order to create barriers and new laws, on the basis of gender discrimination. India has a national Pre-Conception and Pre-Natal Diagnostics Techniques (PNDT) Act of 1994, and groups call for stronger implementation of the law especially against abortion service providers. There have been calls in Vietnam for similar laws. In this discourse, the choice of sex selective abortion is considered as an individual decision, particularly by women, rather than the couple or the family preferences for male children. Hence, to reverse sex selection, laws and policies that favour parents and families with girl children are needed.

3. Foetal Abnormalities and the Rights of Persons With Disabilities

As recent as 2017, the UN Committee on the Rights of Persons with Disabilities has objected to "fatal foetal impairments" being used as a specific ground for abortion. The disability committee said that such an approach was risky given there was no guarantee as to whether or not a foetal abnormality was fatal. The recommendation to its sister human rights bodies was to exercise caution, when advocating for the right to abortion in these cases.[46]

This has also picked up momentum in India,[47] where counselling is suggested as a key intervention for women seeking abortions on the basis of foetal abnormalities.

4. Young People and Sexual Promiscuity

Abortions are often framed as the choice of promiscuous women and girls. In this instance, teenage pregnancies are analysed as the outcome of the low social morals of young women, who engage in premarital sex. This is a discourse reiterated in a number of countries where abortion is accessible. This has been noted in Thailand, where availability of legally safe and inexpensive abortions will aggravate the problem of teen pregnancy and abortion and encourage promiscuity amongst students.[48]

In Nepal, where the abortion laws have been liberalised since 2006, there has been an increase of 42% in abortions (which of course will occur as data could not be collected earlier) of which 70% of these cases involved young women under the age of 24. The data has been used as evidence that only promiscuous women and girls need abortion services, and this could be considered the premise for limiting access to safe abortion services and to amend the law accordingly.[49]

In Vietnam, another country with a liberal abortion law, have reported in 2016, that pregnant teenagers account for 70% of undisclosed abortions in the country, including repeated abortions.[50]

In Vietnam and Nepal, these stories of young women seeking abortions are often sensationalised, and the focus is on the morality of young, unmarried women engaging in premarital sex. In these countries, sensationalist news stories posit that young women engage in premarital sex as they can easily access safe abortion services (i.e. are free from the consequences of their actions—unintended pregnancies), and the solution touted is to limit access to safe abortion services in order to keep young women 'moral' and whole.

Younger women across all countries had higher unmet need for contraception. In India, the unmet need was 3% for women age 45-49, whilst a high 22% for women age 15-24.[51] In Pakistan, unmet need was a low 11% for women aged 40-49, whilst it was a high 20% for women aged 25-34.[52] In Samoa, unmet need was highest for women aged 15-19 (50%) and for women aged 20-24 (42%).[53]

Unmet need for contraception is higher amongst sexually active unmarried women in the Philippines, where half (49%) have an unmet need, 35% for spacing and 13% for limiting.[54] This is magnified and reiterated in Papua New Guinea where the total unmet need for contraception is at 25.9%, but amongst sexually active unmarried women, the unmet need is at 65%.[55]

So from our data on contraception we can note that across all countries – women aged 15-24 consistently demonstrate the largest unmet need, and the abortion-seeking behaviour amongst this age group is evidence of this large unmet need for fertility control. Age and marital status play an important determining role on whether or not women are able to access contraception. This is largely driven by social taboos which are prevalent in communities and amongst service providers on premarital sexual activity. Across all countries, minors were marginalised even when married and from receiving services due to age differentials, social taboos around premarital sexuality, and the expected pregnancy of the girl (to prove her fertility.) Hence to place the unintended pregnancy outcome within the context of need for contraceptive services is far more strategic and useful than placing it within the morality discourse.

From the evidence gathered, we can see that public discourse has been created in order to establish the rights of the unborn and pitting those rights against women's rights to access safe abortion services. Women's agency in obtaining safe abortion services has also been framed in a negative light and seen as the service sought by promiscuous young women. The efforts to limit and recriminalise abortion are built from the same thought platforms and have a symbiotic relationship with efforts to advance abortion-related stigma. The Women's Global Network on Reproductive

Rights study in the Philippines show how stigma and criminalisation of abortion are so closely intertwined, and it is not possible to move ahead on even partial legalisation without addressing the deep stigma prevalent in societies.[56]

Summary and Recommendations

Estimates of the incidence of unsafe abortion continue to be high in the region as does the percentage of maternal deaths attributed to unsafe abortion. Although access to safe abortion services has been proven to be linked to a lower incidence of unsafe abortion (and lower percentages of maternal deaths due to unsafe abortion), progress on amending laws seems slow. In the region, five countries provide abortion on many grounds: China, Nepal, Vietnam, Cambodia and India. In countries where abortion laws are restrictive, it is important to look at how NGOs for women are working to amend these laws as mentioned clearly in the Beijing Platform for Action. It is also useful to note that abortion services for women are being provided safely through the private sector (as in Malaysia and Thailand), through the family-planning methods of menstrual regulation (as in Bangladesh) and through private provision of medical abortion (as in Southeast Asia).

In countries such as Lao PDR, the Philippines, Indonesia, Bangladesh and Pakistan, legal barriers continue to curb women's access to abortion, simply because there can be no services without laws.

In countries such as Malaysia, there are non-legal barriers such as hospital administration policies, which continue to curb women's access.

There is still a challenge in shifting the paradigm to provide abortion upon request, within the public health system in the countries with restrictive laws, although most countries have made some provisions for post-abortion care after ICPD. In countries where abortion is legal, this is mainly for the duration of the first trimester with the exception of China, where the government permits abortion to be performed up till six months of gestation.[57] In these countries, second trimester abortions still prove to be a challenge in terms of legality, political support, balancing between women's rights and pregnancy advancement, as well as empathy for both women and service providers.[58]

In countries with liberal policies on abortion, such as Cambodia, India and Nepal, there are service barriers to accessing safe abortion. In these countries, many abortions are performed in substandard conditions, and governments must follow through on their efforts to provide safe abortion services. In Cambodia, the study done by the Reproductive Health Association of Cambodia (RHAC) showed low levels of knowledge about the availability of abortion services, and how cost, distance, time and quality of care concerns are still significant barriers to overcome, in ensuring women realise the right to safe abortion.[59]

Countries with liberal abortion policies may see a rise in anti-abortion discourse framed within issues of girls' rights, disability rights, young women's rights. In this we need to be able to reach out and work with human rights groups across the divide and create common ground early enough—to ensure that this does not impact a reduction in the way that laws and policies are interpreted and enacted, and above all reinforce the rights of women to be able to choose whether or not they continue with the pregnancy.

Recommendations

1. Policymakers need to ensure that safe abortion services are fully integrated to reduce preventable maternal deaths and maternal morbidities in line with ICPD commitments and human rights standards as well WHO technical guidelines.
2. Service providers need to ensure that a range of abortion methods are available to women and girls and services are offered without judgement and respecting patient privacy and confidentiality.
3. Service provision agencies (both public and private) need to address denial of services to women through conscientious objection clauses and ensure that these women are receive referrals to access quality and safe services.
4. Health NGOs and service providers must actively work on removing the issues of stigma which continue to hamper women from seeking services.
5. Donor governments and private donors need to respect laws (already in place) which affirm the right to safe abortion and advocate to change regressive laws which deny the right to safe abortion.
6. UN agencies, health organisations and women's rights movement need to uphold the right to safe abortion in the work carried out at national levels to ensure women can access the necessary services in their time of need.

Unsafe abortion continues to be a major factor in maternal deaths in the region.

Mortality due to unsafe abortion for Southeast Asia is estimated at **14%** *of all maternal deaths, and South Asia at* **13%.**

DETERMINING THE QUALITY OF MRM SERVICES IN SOUTHERN AND CENTRAL BANGLADESH

CASE STUDY:
Claiming the Right to Safe Abortion Project in Asia, National Baseline Research – Bangladesh

PARTNER:
Naripokkho

ABORTION CONTEXT

In 1979, the Government of Bangladesh approved menstrual regulation (MR) as an "interim method of establishing non-pregnancy" regardless of whether women were actually pregnant. MR is widely available in the country and free of cost at Government health facilities. Unintended pregnancies and abortions in women aged 15-49 is common and in 2014, 58% of unintended pregnancies and 28% of all pregnancies ended in abortion and MR. Despite the wide availability of MR services, accessibility is often restricted due to reasons such as lack of women-friendly environment, failure of health providers to instill confidence in their clients about their services, additional costs for the services, unauthorized "brokers" who mislead clients to visit private and untrained providers. These barriers have made menstrual regulation with medication (MRM) very popular but has also resulted in its indiscriminate use. MRM is often not used correctly, leading to incomplete abortions and complications. This study was therefore undertaken to obtain a clearer understanding on MRM services, namely gaps in service, barriers to accessing and receiving services, and the needs of women who use MRM.

KEY FINDINGS

1. Easy Access to MRM
There is a great demand for MRM and the proportion of women seeking MRM has increased over the years, due to easy access, and maintenance of privacy and confidentiality. However, cost of services was a barrier for some women, for MRM as well as post-abortion care (PAC) services, which led many to buy part of the MRM kit or not completing their PAC.

Pharmacies are the most common source of MRM, but complications are most frequently reported in women who bought the MRM drugs from pharmacies than from clinics (NGO clinics, etc.). MRM medicines are currently not available in Government health facilities.

2. Quality of Service
Service providers in clinics, both public and private, were more likely to provide comprehensive services whereas services at pharmacies were mostly related to selling the MRM drug, with little counseling or information given. The presence of male pharmacists and service providers posed a barrier for women, who felt inhibited to talk about their reproductive health with men.

3. Awareness About MRM
General awareness about MRM was poor amongst women, especially rural women. If they were aware, many were unclear about the dosage and how to take the medicine, often not heeding instructions (including female sex workers, who often ignored precautions such as avoiding sexual intercourse after taking MRM drugs, due to the need to return to earning money as soon as possible).

4. Untrained Service Providers
A large proportion of service providers in clinics are not trained in MRM or have not recently received training, and the vast majority of pharmacists have no formal training either. Counseling was also found to be poor.
Service Provider Attitude and Behaviour About MRM
Some health service providers were against MRM due to personal or religious reasons, but nevertheless felt it was their duty to provide services. Many women believed that they were often treated with disrespect when seeking MRM or post-abortion care services, which deterred them from seeking services or speaking openly to service providers.

In general, a lot of service providers were against providing services to young, unmarried women because they believed them to be engaging in sinful behavior (i.e. engaging in sex before marriage) and that selling them MRM medicine meant encouraging promiscuity.

RECOMMENDATIONS

- Ensure availability of MRM medicines at Government health facilities. MRM medicines must be included in the annual procurement plan of the Government.
- Regulate the sale of MRM medicines through pharmacies. It is important for regulations to balance the rampant sale of MRM medicines which may endanger women's health, and at the same time provide women with improved services, easy access and comprehensive services.
- Train or re-train all service providers engaged in providing MRM services, including pharmacists that sell MRM medicines. Guidelines on MRM, and counseling tools must be provided to all service providers providing MRM.
- Raise awareness among women and young girls, including female sex workers, about MRM through electronic and print media and other campaigns.
- Work with human rights groups, women's groups and CSOs to advocate and hold policy makers and service providers accountable towards women's reproductive and sexual health needs and rights, keeping it central to all service provision.

ABORTION RELATED STIGMA AND DISCRIMINATION IN CAMBODIA

CASE STUDY:
Claiming the Right to Safe Abortion Project in Asia, National Baseline Research – Cambodia

PARTNER:
Reproductive Health Association Cambodia (RHAC)

ABORTION CONTEXT

As in many developing countries, there is limited data on abortion in Cambodia. Part of this is cultural – the majority of Cambodians are Buddhist, and people tend to consider it sinful to have an abortion. Talking about abortion is still a taboo issue, and available data sources for health, such as the Cambodia Demographic Health Survey (CDHS) tend to avoid the topic or provide only limited information due to the sensitive nature of the subject, and the highly charged socio-political environment around abortion. Sex before marriage remains a taboo subject and activity, and so women are often reluctant to openly discuss reproductive health issues before marriage, fearing discrimination. Partly due to the difficulties in collecting accurate data in this environment, no comprehensive study on abortion has been made in Cambodia.

Lack of information about how women and their communities understand and perceive abortions, women that have abortions, and abortion service providers has resulted in limited knowledge on women's access to safe abortion services and how women's lives change after an abortion. Despite the fact abortion was legalized in Cambodia in 1997, available information demonstrates that women greatly hesitate to access safe abortion services, and even when they access them, they are strongly stigmatized within their community after having an abortion. Therefore, a new study on perceptions and awareness of abortion can contribute to identifying why women do not access abortions, or why people avoid talking about the subject. This can directly contribute to policymaking discussions on increasing public awareness of women's right for access to abortion information and services, and assist in the design of projects intended to improve access to abortion services and empower women in their sexual and reproductive health rights.

KEY FINDINGS

1. Awareness of Abortion and Related Issues
Awareness of the legal protections around abortion is very low, with most women not fully understand the legality of abortion; only 2.7% of women correctly knew all aspects of abortion legality. However, around half of the community leaders surveyed knew that abortion was legal and were able to name the circumstances when it was permitted. In addition, around half of all women knew that it was legal for medical staff and hospitals/ clinics to perform abortions, and around half were able to identify safe abortion providers. From the qualitative discussions on abortion legality, there is also a clear

conflation between the national law and the moral code of Buddhism – Cambodia's dominant religion. This affects women's understanding of their right to an abortion, and their right to safe abortion services in a medical facility, and may increase their fear of stigma, isolation and self-judgment.

2. Perceptions on Abortion

Based on the international scales used to measure stigma and discrimination towards women that have abortions, Cambodian communities show a low to moderate level of stigma towards abortion. Community leaders demonstrate a less discriminatory attitude toward women that have abortions than people in their communities. But, abortion stigma is ever-present in these conservative communities; all IDI and FGD respondents reported stigma or discrimination towards women that have abortions and/or abortion providers. This stigma is greater towards unmarried women that have abortions. While communities can understand the justifications for married women to have abortions (poverty, multiparity, etc.), unmarried women carry the double stigma of having sex outside of marriage and terminating a pregnancy (abortion).

Individual Level Abortion Stigma Scale (ILAS) Of the 57 women that reported having an abortion, all completed this section. Women that had an abortion had average ILAS scores of 1.57 (on a Likert scale of 0-3 or 0-4 depending on the question); slightly below mid-value. In the different sub-categories, women were most worried about community condemnation and self-judgment, and least worried about individual judgment.

3. Barriers to Safe Abortion Access

Most women do not have full control over their healthcare, and decision-making for abortion follows a similar trend; only around one-third of women reported that they could decide to have an abortion by themselves. The other barriers which were raised by the qualitative respondents pertained to the difficulty accessing abortions. These primarily included cost, distance, time, and quality of care concerns. For women in vulnerable groups, including the poor and those living in remote areas, these barriers were seen as a greater obstacle to abortion access than for other women. Illiterate or uneducated women were also seen as having barriers to receiving a safe abortion, as they may not be aware of safe abortion providers, and may not fully understand medical instructions or advice.

4. Women's Experience of Abortion

Fifty-seven women (18.2% of the weighted sample) reported that they had an abortion before, with an average of one abortion per woman. The most common reasons for having their last abortion were a lack of money, not wanting children at this time, and abnormal fetal development. Around half of abortions were considered safe abortions; conducted in recognized health facilities using medical abortion techniques. Concerningly, over one-third of abortions were initiated in an unsafe location; usually a pharmacy, drug store, or the respondent's home. Nearly all abortions had to be paid for, with average costs of around US$ 47.51.

RECOMMENDATIONS

- Increase awareness around the legality of abortion and safe abortion providers, especially among the most vulnerable groups.
- Separately address the circumstances of unmarried and married women in campaigns to reduce abortion stigma.
- Include husbands and community leaders in the target audience for awareness raising campaigns.
- Ensure equal access for all women to program materials.

AVAILABILITY OF SAFE ABORTION SERVICES AND THE PERSPECTIVE OF ACTORS ON THE RIGHT TO SAFE ABROTION IN THE STATES OF BIHAR AND TAMIL NADU, INDIA

CASE STUDY:
Claiming the Right to Safe Abortion Project in Asia, National Baseline Research – India

PARTNER:
CommonHealth

ABORTION CONTEXT

As early as 1971, India passed the Medical Termination of Pregnancy Act, making safe abortion services available to women for a wide range of indications, including grave danger to their physical and mental health, rape, severe foetal abnormalities, and contraceptive failure in married women. And yet, unsafe abortions still accounted for 8 per cent of all maternal deaths in 2006 (RGI and CGHR 2006). According to the most recent (2015) national estimates, about three out of four abortions in India were medication abortions performed outside a health facility (Singh et al. 2018). What are the circumstances surrounding this extraordinary situation of abortions being 'legal yet out of reach' for Indian women after almost five decades of the MTP Act being passed? And, what can advocates for sexual and reproductive health and rights do to change this situation? These are the concerns that motivated this study, which was undertaken by CommonHealth (Coalition for Maternal-Neonatal Health and Safe Abortion) India.

The states of Bihar and Tamil Nadu are very different in terms of their socio-demographic and health profiles. Bihar is among the poorest states, with poor health indicators, weak public health infrastructure and few personnel trained to provide safe abortion services. In contrast, Tamil Nadu is among the states with relatively high per capita income levels, good health indicators, and a good network of public health facilities with a high utilisation rate, including primary health centres (PHCs) for pregnancy and delivery-related services. Despite these differences, the state's share many common features in terms of support for and availability of abortion services.

Both states had some government initiatives aimed at improving access to safe abortion services, but in neither was it a priority health issue. Neither was it a priority for CSOs, including those working on maternal health and adolescent sexual and reproductive health. From CSO leaders in Bihar we learnt that none of the CSOs working on maternal health made attempts to promote safe abortions. Four of five CSO leaders did not think abortion was a priority issue. In Tamil Nadu, only two of the five CSOs involved with women's issues worked on health, and neither of these dealt with safe abortions. Several CSOs in Bihar focussed on preventing gender-biased sex-selection; Tamil Nadu had a strong presence of groups advocating the restriction of second-trimester abortions to prevent gender-biased sex-selection and protect the rights of the unborn child. Thus, the milieu did not appear to strongly support safe abortion as a women's right.

In both states, fewer than 5 per cent of the estimated abortions were recorded in the official Health Management Information System. Further, there was only one abortion facility for 370,000 people in Nawada, Bihar, while Kancheepuram, Tamil Nadu had one abortion facility per 70,000, far lower than the recommended norm of one facility per 20,000.

KEY FINDINGS

Overall the results show that even after five decades of legalising abortion, access to safe abortion remains a major challenge for women, not only in a low-resource settings such as Nawada, Bihar, but also in the relatively privileged setting of Kancheepuram in Tamil Nadu.

The baseline study also found that there was a low level of awareness on the legal status of abortion in the sample districts of both states. A significant proportion of women in the community believed that abortion was illegal, and there was confusion between the illegality of all abortions or only those that take place after sex-determination.

In terms of attitudes, abortion appears to be strongly stigmatised. While opinion was divided on the circumstances in which abortion was justified, the

general perception was that women seeking abortions were likely to be humiliated, gossiped about, considered immoral, and unlikely to receive any support from peers and family members. Respondents reported that people viewed an unintended pregnancy as completely within the power of the woman to avoid, and an abortion to terminate an unintended pregnancy as not justifiable.

RECOMMENDATIONS

Based on our findings we identified priority issues for advocacy to promote access to safe abortion services as a women's right. One of the key priorities would be to advocate for the availability of abortion services in all designated public facilities. Enhancing the levels of knowledge and awareness about the legality, public health importance, availability and various abortion methods was a second key priority. A third priority would be addressing the stigma associated with abortion through the creation of champions for women's right to safe abortion among key constituencies, local, state and national. A special area of focus would be to sensitise the public on the gendered reasons why women seek abortions and to promote support for safe abortion services among health professionals and students training to be health professionals.

ABORTION STIGMATIZATION ATTITUDES AND BELIEFS AND ITS EFFECT ON ACCESSING SAFE ABORTION SERVICE

CASE STUDY:
Claiming the Right to Safe Abortion Project in Asia, National Baseline Research – Nepal

PARTNER:
Beyond Beijing Committee (BBC)

ABORTION CONTEXT

Nepal has promulgated progressive abortion laws, provisioning for free safe abortion services (SAS) through listed government health facilities. In recent years, the country has expanded SAS to be nationwide. In 2018, the Government has formulated Safe Motherhood and Reproductive Health Right (SMRHR) act to ensure the right to safe abortion. However, more than half of those pregnancies is unwanted and more than 50% of abortion is conducted through clandestine procedure. Unsafe abortion practices do not only contribute to higher maternal mortality and morbidity rate, but they are also incidences of violence of the sexual and reproductive rights of women. Throughout the world, women still do not have the right to make one of the most important and life-transformative decisions; whether to continue with their pregnancies or terminate them owing to different barriers, including the accessibility and availability of quality SAS.

Abortion stigma is one of the major barriers to SAS which not only prevail in the developing countries, but also in developed countries. Abortion stigma is a shared understanding that it is morally wrong and/or socially unacceptable to abort the foetus. Stigma is a complex issue because it is both a cause and a consequence of inequality. Abortion stigma persists at different levels: individual, community, institution, law enforcement, mass media and culture. Stigma manifests negative image of post-abortive women (PAW); and those who are directly involved in abortion such as PAW and ASPs, are considered as wrong-doers. Disapproving and prejudiced stereotyping of women who have undergone abortions is the most common form of abortion stigma.

The women participants who practiced abortion expressed that they themselves felt some sense of guilt and anguish when they had undergone through abortion procedure. Two out of three women having abortion anticipated stigma if others knew about it. Fifty-eight percent of them explained they required keeping their abortion secret from friends and family members. Hence, self-induced abortion is a way-out that a woman can keep her abortion a secret. Deeply ingrained prejudice among ASPs regarding abortion, especially towards unmarried women, is a barrier for them to access SAS. They often witness the denial or unwillingness of the service providers while requesting for the services. The stigma attached to it has also adversely affected the implementation of country's reproductive law and policy. It is evident that the practice of unsafe abortion is higher in those countries where there are restrictive abortion laws.

The global gag rule that came into action in 2017, which limits the access to information and services of abortion, not only produces undesirable implications on the right to life of pregnant women, but also can fuel stigma and discrimination. Likewise, abortion stigma prevails depending on how it is portrayed by the media. News coverage are crucial to frame the attitude and perception of public policy makers, decisively resulting in what and how they think and what should be done about it.

KEY FINDINGS

The qualitative findings show that not many participants had clarity of the legal provision of safe abortion. PAW, who exercised unsafe abortion, did not know that abortion is legalized in Nepal; and that free safe abortion services are available at the recognized health facilities. Most of the participants viewed abortion as a right of all women. However, they had contradicting opinion on decision making for abortion. The male as well as female participants stated that abortion without the consent of their husbands is the misuse of the right provided to women. Due to high patriarchal values and norms, the practice of exercising the rights to safe abortion is still under the control of male members in the community.

There were also a few participants who argued that abortion services are often misused by unmarried women. Some of the participants of FGD and the participants at the policy level in IDI also stated that free safe abortion services should be provided to the poor and marginalized population along with the provision of transportation and other indirect cost rather than providing the free services to all in through a blanket approach. Almost all of the participants of the FGD and IDI among the PAW believed that abortion is an act of immorality and sin. Different negative connotations were used to denote abortion in the community that has been stigmatizing women in different contexts. The interviewed PAW reflected having bad experiences when they were perceived as characterless by the community, and being an embarrassment for their family as well. In the context of PAW, they also felt like they had committed a murder as they believe the foetus develops to be human being, and abortion as a sin attributing it to religious and cultural aspects.

RECOMMENDATIONS

1. Repeal abortion from the country criminal code to ensure the rights to safe abortion fully;
2. Develop non stigmatizing abortion related policy, regulation and guidelines;
3. Include the VCAT training in the curriculum of the abortion service training and provide VCAT to trained service providers to reduce the stigmatizing attitude towards abortion and the women seeking abortion irrespective of the marital status of the women;
4. Develop and implement laws against any discrimination toward the PAW;
5. Ensure the reach of complete, accurate and pragmatic information relating to safe abortion in the community in a massive way to reduce the myths on abortion through behaviour change communication material and using non stigmatizing language;
6. Sensitize and mobilize religious leaders to impart information on safe abortion and reduce the traditional and religious notion on abortion;
7. Apply multi-sectoral approach to increase the access to SAS and reduce abortion stigma. Sectors such as health, human rights, population, education, religion and media should be integrated together to leverage knowledge, expertise, reach and resources, to ensure the right to safe abortion;
8. Ensure proper counselling on all aspects of SAS to help the abortion service seeker deal with emotions and with any practical issues such as methods of abortion, its procedure, confidentiality, post abortion contraceptive and more;
9. Promote generating evidence with regard to abortion stigma and implement evidence-based practices to reduce stigma and increase access to SAS.

EXPLORING MEDICAL, NURSING, AND MIDWIFERY STUDENTS KNOWLEDGE AND ATTITUDES TO ABORTION IN THE PHILIPPINES

CASE STUDY:
Claiming the Right to Safe Abortion Project in Asia, National Baseline Research – Philippines

PARTNER:
Women's Global Network for Reproductive Rights (WGNRR)

ABORTION CONTEXT

The Philippines is one of the remaining countries that criminalize abortion without clear exceptions on any grounds. The penal law however, can also be interpreted to allow abortion under the general provisions of "justification" and "necessity" when performed to save the life of a woman. But with such ambiguity, healthcare providers have remained afraid of criminal liability and women are forced to undergo unsafe abortions that lead to life-threatening complications and contribute to high maternal mortality. Since abortion is highly stigmatized, even women who had spontaneous abortion and need post-abortion care experience abuse and discrimination.

Healthcare professionals are critical in this regard, since women need skilled and empathetic service providers to address their SRH needs. Even where protecting a woman's life is the only justifiable reason for abortion, it is essential that there are trained providers of abortion services and that humane, compassionate, non-judgmental post-abortion care is widely available. Thus, building the knowledge and attitudes of health care professionals towards SRHR, including abortion and post-abortion care, are key to women's access to quality care and consequently to their attainment of full range of human rights. They are also a key sector in contributing to an open and rational discourse on safe abortion rights.

KEY FINDINGS

The results indicate that the participants were aware of the high prevalence of abortion, and many even personally knew women who had gone through an abortion. There was uncertainty on the legal status of abortion and whether healthcare providers are required to report women who had abortions. They had high awareness on the mistreatment and abuse of women seeking post-abortion care in facilities.

They understood abortion mainly as pregnancy complication, as taught in their medical, nursing, and midwifery education. The students' discussions about abortion revealed how the interplay of religious, moral, socio-cultural, and ethical norms, influence their attitudes toward the issue. While they acknowledged abortion as a medical issue, much of their discourse was grounded on their religious and moral beliefs. They generally recognized abortion is a necessary medical procedure for obstetric emergencies and that medical and professional ethics require them to give priority to the patient's life. However, there was still stigma towards abortion due to religious beliefs; beliefs on the roles of healthcare providers; ideals of womanhood; and concepts of responsibility. This creates ambivalence towards abortion service provision and abortion law reforms.

The students held a strong opinion on women's choice and access to reproductive health service. They also supported women's reproductive autonomy, but their concept of autonomy was limited to what was perceived as acceptable based on religious and gender norms. Thus, abortion as a right had more support among study participants when it is medically needed, and less so when it is for other reasons. There were students, however, who had pro-choice attitudes and believed that a woman has the right to decide over her body and based on her given circumstances. They also strongly believed on women's right to humane, non-judgmental, compassionate post-abortion care. These beliefs should be nurtured and reinforced in a supportive environment both in the healthcare education institutions, in health facilities where they train and will eventually work in, and in professional associations and organizations.

RECOMMENDATIONS

1. Inclusion of PAC education in the medical and nursing schools as first step towards making humane, non-judgmental, quality post-abortion care accessible for women.
2. Medical schools, POGS, WHO, DOH, public health NGOs and safe abortion advocacy groups to equip medical and nursing students with skills and knowledge of new methods of PAC such as the use of MVA and misoprostol.
3. To integrate PAC into other medical discipline or specialty such as Emergency Medicine.
4. SRHR and safe abortion discussions to be incorporated into existing courses along with family planning and reproductive health modules. Integration of safe abortion discussion/education in medical, nursing and midwifery courses/curriculum would result in improved quality of reproductive health services and information for women.
5. To ensure the implementation of a rights-based PAC Policy, medical associations, women and SRHR groups, and public health NGOs should be part of the formulation of the policy.
6. Discussions, trainings and workshops on gender equality, women's rights and SRHR to be implemented in medical, nursing , and midwifery schools. Focus on second year midwifery students rather than fourth year students. Second year students are already legible for licensure and practice service provision after.
7. Safe abortion advocacy groups to conduct special courses on abortion stigma reduction with medical and nursing students, faculty members and schools heads.
8. Examine how medical, nursing, and midwifery curriculum address contemporary issues of sexual and reproductive health and how educational environment influence prevailing gender norms and stigma on abortion.
9. Further studies on knowledge and attitudes with medical, nursing and midwifery students. Because of the difference in curriculum and length of study, it is recommended that each program studied separately.

time, and quality of care concerns.

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