Initiatives exemplifying effective practices in eliminating preventable maternal mortality and morbidity

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Unsafe abortion: a preventable cause of maternal morbidity and mortality

Women and girls, some as young as 9-13 years, suffer unwanted pregnancies for multiple reasons, including pregnancies resulting from sexual assault and non-use of or failed contraception.

Sexual violence against women is a major public health and human rights concern. WHO has reported that many women's first sexual experience was non- consensual, with percentages ranging from 24% in rural Peru to 40% in South Africa [1]. Moreover, women living in conflict areas often fall pregnant, sometimes more than once, as victims of rape used as a weapon of war [2].

No contraceptive method is 100% effective; each year about 33 million women become pregnant despite their efforts to prevent or delay pregnancy by using contraception [3]. In some cases, women are prevented from using contraceptives, for example, by parents or partners [4].

Provision of emergency contraception (EC) can prevent unwanted pregnancies and subsequent unsafe abortions. Assertions are made that EC is abortifacient and misinformation has been disseminated about its safety, resulting in prohibitions and restrictions on provision of EC in various countries [5]. Nevertheless, WHO has affirmed that EC pills do not interrupt established pregnancies or harm developing embryos [6]. Reviews of EC provision further indicate that it does not lead to more sexual risk behaviors or affect women's use of other contraception [6, 7].

WHO estimates that there were 21.6 million unsafe abortions worldwide in 2008, 98% occurring in developing countries [3]. An estimated 47,000 women worldwide die due to complications from unsafe abortion [3], accounting for approximately 13% of global maternal deaths, with the highest proportions in developing countries (e.g., Argentina 20%) [8]. Women younger than 24 years account for almost 46% of these deaths worldwide [9], with rates as high as 59% for women 25 years and younger in Namibia [10].

A further five million women and girls suffer short- and long-term injuries due to unsafe abortions, including hemorrhage; sepsis; trauma to the vagina, uterus and abdominal organs; cervical tearing; peritonitis; reproductive tract infections; pelvic inflammatory disease and chronic pelvic pain; shock and infertility [11, 12]. A 2009 study estimated the health system costs of postabortion care in Africa and Latin America to range from $159 million to $333 million per year [13].

Human rights, unwanted pregnancy and abortion

When women are denied emergency contraception by health-care providers due to their age, marital status or on the basis of moralistic arguments, they may suffer unwanted pregnancies and unsafe abortions in countries with severe restrictions on abortion. Not only are their rights to health and life then denied; refusals to provide or fund EC and safe abortion for women in humanitarian situations also constitute discriminatory treatment of persons protected under the Geneva Convention [14].

The African Union's Protocol to the Charter on People's and Human Rights on the Rights of Women in Africa specifically notes that women have a right to abortion care. As Ngwena has pointed out: "the Protocol has the potential to contribute toward transforming abortion law from a crime and punishment model… to a reproductive health model that complements the objects of CEDAW and the broader philosophy of the International Conference on Population and Development (ICPD)" [15].

Treaty Monitoring Committees for the following conventions have all called upon governments to revise their abortion laws to safeguard women's health, reduce maternal mortality and morbidity, and to remove punitive provisions for women who undergo abortions: International Covenant on Political and Civil Rights, Convention on the Rights of the Child, International Covenant on Cultural, Economic and Social Rights, Convention on the Elimination of All Forms of Discrimination Against Women, Convention against Torture, Inhumane and Degrading Treatment [16-18].

The Inter-American Commission on Human Rights has stated that maternal mortality due to abortion is preventable, and in commenting on a case in Mexico where a 13-year-old girl was denied a legal abortion, they stated: "it is impossible to achieve women's full enjoyment of human rights unless they have timely access to comprehensive health care services as well as information and education on the subject" [19].

At the 2009 UN Commission on Population and Development, the concluding resolution urged Governments and development partners to prioritize universal access to sexual and reproductive information and health-care services, including family planning, services to manage abortion complications and safe and accessible abortion care where permitted by law in order to reduce maternal mortality and improve maternal health [20].

Guidance on interventions needed to improve maternal and child health, drawn up by WHO with inputs from UNICEF, UNFPA and the World Bank, include safe abortion care [21] and the UN Secretary General's Global Strategy for Women's and Child Health states that the universal package of guaranteed benefits should include family-planning information and services, as well as safe abortion services as permitted by law [22].

Initiatives to expand access to emergency contraception

Some governments have ensured that female survivors of sexual violence can receive comprehensive post-rape care that includes measures to prevent unwanted pregnancies.

In Brazil, the 1998 Protocol on Immediate Assistance for Female Victims of Sexual Violence mandated that women who suffer sexual assault should be provided with psychological

assistance, EC and prophylaxis for sexually transmitted infections; this resulted in an increase in the number of health facilities providing such services (from 3 facilities in 1997 to 85 by 2003) [23]. In Bolivia, the government has included EC for women who have suffered rape in its list of essential resources for maternal and child care (Seguro Universal Materno Infantil) [24].

In 2010, the Supreme Court of Mexico reaffirmed the right of women survivors of sexual assault throughout the country to services including provision of emergency contraception and safe abortion care [25].

Initiatives to expand access to safe abortion care

Mexico: in 2007, the Mexico City Federal District reformed its Penal Code to permit legal abortion in the first trimester of pregnancy [26]. Whereas previously adolescent and adult women had sought expensive clandestine abortions in the District, today public hospitals and clinics provide women residing in the District with free and safe legal abortion care; women from other parts of the country can also receive services according to a sliding payment scale.

In response to legal challenges, the Mexican Supreme Court affirmed the constitutionality of the law reform in August 2008, stating: "the measure used by the Legislator turned out to be… ideal to protect women's rights, because the *counterpart of the non-criminalization of pregnancy termination is women's freedom to decide on their body, their physical and mental health, and even their life*..." [27-29]. Salazar Ugarte further notes that the law fulfills Article 4 of the Mexican Federal Constitution, which stipulates that every person has the right to decide freely and in an informed and responsible way on the number and spacing of their children; he adds that the law also fulfills the requirements of action of a secular, democratic State by providing services to all persons without discrimination [30].

Ethiopia: In 2005, the government of Ethiopia reformed its Penal Code to provide access to safe, legal abortion care in cases of rape or incest, to preserve a woman's life or health, to protect girls who are physically or mentally unprepared for childbirth because of age and for women with physical or mental disabilities [31]. Technical guidelines for implementing safe abortion care were issued in 2006 by the Ministry of Health [32].

A two-year monitoring project to assess services at 50 public sector facilities in Tigray showed notable improvements over time in almost all aspects of safe abortion care: availability, distribution, use and quality of services and improvement in post-abortion contraceptive uptake [31]. In March 2007, slightly more than 30% of all women who received abortion services left the facility with a contraceptive method. This increased to almost 80% in two years. The evidence also suggests that the complementary interventions (training of clinical providers, equipment and infrastructure support, supervisory and monitoring visits) contributed to these improvements. By the end of the monitoring exercise, 38 of 50 facilities met the criteria for comprehensive safe abortion care, thus achieving 86% of the recommended level of coverage.

The distribution of services also improved substantially from 2007 to 2009. About half of all health facilities in Ethiopia provide induced abortion services. However, the proportion is

much higher for public hospitals (76%) and private or nongovernmental organization (NGO) facilities (63%) than for public health centers (41%). These proportions are changing as efforts are being made to expand abortion services in public facilities [33].

India: despite provisions for legal abortion in India, almost 10% of maternal deaths result from unsafe abortions [34]. The Government of Uttarakhand therefore partnered with Ipas India to increase women's access to safe services, especially in rural and remote areas. The intervention included a baseline assessment, establishment of training centers for comprehensive abortion care and post-training follow-up to ensure provision of high-quality services.

Rural health facilities with all equipment essential for providing medical termination of pregnancy (MTP) increased significantly from 15% at baseline to 47% at follow-up, while in urban hospitals, essential MTP equipment was in place at 71% of facilities at follow-up versus only 35% at baseline. The improvement in availability of MTP service options also helped reduce unsafe abortion in the state. In early 2007, only one-third (33%) of abortions in the state were performed at public sector health facilities, whereas the follow-up assessment in 2009 showed that this figure had increased to almost one-half (48%). In addition, safer methods for abortion were used, with dilatation and curettage (D&C) being replaced with uterine evacuation and medical abortion. The percentage of women who received MTP services with appropriate technology increased significantly from 32% to 91% in rural health centers and from 26% to 78% in urban hospitals at baseline and follow-up assessments, respectively.

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

Conflict areas: NGOs and multilateral agencies also have taken measures to assist survivors of rape in conflict areas. Doctors without Borders has provided post-exposure prophylaxis, emergency contraception and safe abortion care to survivors of rape in Congo [35]. A new field guide produced by the International Inter-agency Working Group on Reproductive Health in Crises covers comprehensive sexual and reproductive health in humanitarian situations, including contraception and safe abortion care [36].

Action by medical professionals: in 2007, the International Federation of Gynecology and Obstetrics (FIGO) launched an initiative to prevent unsafe abortion and its consequences; 43 of its member associations produced country-specific action plans with national government and other collaborators [37]. The project aims to contribute to reduced maternal mortality and morbidity associated with unsafe abortion by reducing unintended/unwanted pregnancies, improving access to safe legal abortion services and improving access to and the quality of postabortion care; the plans are currently being implemented with assistance from international NGOs working on reproductive health [38].

Conclusion

The examples of interventions cited above demonstrate that rescinding laws prohibiting or impeding the availability of emergency contraception and legal abortion can increase women's access to reproductive health services and thereby reduce preventable maternal morbidity and mortality. There is a growing consensus that unsafe abortion and laws criminalizing abortion affect women's and girls' rights to health, life, privacy, integrity and security of the person, non-discrimination, the benefits of scientific progress and freedom from cruel and inhumane treatment. Revision of restrictive laws is a step towards promoting and fulfilling those rights.

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