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What policy makers can do

Policy makers who are committed to promoting women's health and rights can take the following actions:

1. Support reform of restrictive abortion laws and policies to make abortion safe, legal, accessible and affordable

Policy makers have a fundamental role to play in supporting reform of restrictive abortion laws. It is important to make people aware that equality for women will not be possible while denying women the means to terminate an unwanted pregnancy safely and legally. Some of the abortion laws worth looking at both as models and to see their limitations in practice are those of Bangladesh, Canada, Cuba, India, Sweden, South Africa, Tunisia and the UK.

Canada is the only country to date which has decriminalised abortion entirely *[35]*. In 1988, Canada's highest court struck down the federal law on abortion and the parliament did not replace it. Although there are abortion regulations at the state level, any re-criminalisation of abortion would be illegal. This represents the most complete form of normalisation and de-politicisation of abortion possible, bringing it in line with all other medical procedures, making good medical practice and quality of care in service provision the only "issues" involved. Any breaches of medical practice would be punishable under other existing laws. This has worked well in Canada and could work equally well elsewhere *[36]*.

Cuba is an early example of a developing country that legalised abortion on broad indications. In the context of sweeping changes in the country's health services in 1959, a 1936 law which had made abortion legal on grounds of serious risk to a woman's health was officially interpreted to encompass the WHO definition of "health" as a total state of well-being. Abortion services were extended to all obstetric-gynaecology hospitals. In 1979, when a new Penal Code was drafted, instead of specifying when abortion was legal, it specified when abortion was illegal. Under this Code, abortion was determined to be illegal if it was carried out without the woman's consent, or in other than hospital premises, or if the provider failed to comply with established norms, or if it was carried out for profit. As hospitals throughout the country provide abortions free, these conditions are enabling. Further, the law specified that menstrual regulation was not equivalent to abortion, as delay in menses may be due to causes other than pregnancy *[37]*.

In **Bangladesh**, although the law permits induced abortion only to save the life of the woman, menstrual regulation is legally available. As early as 1978, a large-scale menstrual regulation training programme was organized for government physicians and family welfare visitors *[38]*. Today, menstrual regulation using vacuum aspiration is widely available in Bangladesh through public, NGO and private sector facilities and is permitted at a woman's request up to 10 weeks of pregnancy (i.e. 12 weeks from first day of the last menstrual period). However, in spite of wide availability, barriers such as distance to health facilities and transportation costs, unofficial fees,

lack of privacy, confidentiality and cleanliness in public health facilities, and in some cases attitudes of service providers, are limiting access to MR services. Quality of care is compromised by inadequacies in infection control and in provider training and counseling *[39]*.

South Africa's 1996 law is an example of a progressive law with a number of conditions after the first trimester of pregnancy. Its passage was accompanied by efforts to develop good service provision nationwide. Up to 12 weeks of pregnancy, abortion is on the request of the woman. From 13-20 weeks of pregnancy, abortion is permitted if there is a risk to the woman's physical or mental health, there is a substantial risk of fetal abnormality, the pregnancy resulted from rape or incest, or the pregnancy would significantly affect the woman's social or economic circumstances; in addition, a termination must be approved by one medical practitioner. After the 20th week, abortion is permitted if continuing the pregnancy would endanger the woman's life, if there is a substantial risk of fetal abnormality; in addition, two medical practitioners, or one medical practitioner and a registered midwife, need to agree to the abortion *[40]*.

In **Sweden**, abortion is available at a woman's request up to 18 weeks of pregnancy and with the agreement of a medical board after that *[41]*. This allows almost all abortions to be the woman's decision alone, a facilitating policy which evolved based on experience and a growing awareness on the part of medical professionals and policy makers of women's needs .

2. Support government approval of mifepristone and misoprostol as essential medicines by your national drug regulatory agency and the availability of these drugs in your country

Medical abortion represents decades of medical research to develop and make available a safe alternative to surgical abortion. Misoprostol has also been shown to be valuable for other obstetric uses. The inclusion on the essential medicines list of mifepristone and misoprostol is an important goal. Since 1977, the World Health Organization (WHO) has been publishing a Model List of Essential Medicines which meets the priority health care needs of the population of developing countries. Medicines on this list are selected with regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Since mid-2005 WHO's Model List of Essential Medicines has included mifepristone and misoprostol *[21]*. National essential medicines lists are meant to serve as the main basis for public sector drug procurement and distribution in countries with those lists. Inclusion of mifepristone and misoprostol for medical abortion and other obstetric and gynaecological uses in national essential medicines lists would pave the way for their wider availability in public health services.

Women have the right to enjoy the fruits of scientific progress and to have the choice between surgical and medical abortion. ICMA believes the conditions exist to support the availability of mifepristone and misoprostol for medical abortion in every country where abortion is permitted for at least one indication.

Approval by national drug regulatory agencies for mifepristone has been complicated in some countries, however. ICMA's membership includes organisations with expertise in this area, who can advise and help with this process.

As part of this process, it is necessary to ensure that one or more pharmaceutical companies is

willing to make mifepristone and misoprostol available in the country. Misoprostol may already be available in the country for other indications. There was a recent instance in 2006, in Australia, where after successful advocacy to have medical abortion approved by the drug regulatory agency *[42]*, no pharmaceutical company applied to import and distribute mifepristone and it was left to individual doctors to apply to the Therapeutic Goods Administration for permission to import the drug to supply only to their own patients, which a few doctors had begun doing by mid-2006 *[42]*.

3. Ensure that abortion services, including medical abortion, are accessible to women who are legally eligible for an abortion

In countries where abortion is legal only under limited circumstances (e.g. rape, incest, risk to woman's life or health), women who are in such circumstances must be guaranteed safe legal abortions – including medical abortion. Oftentimes professionals at public health services feel unable to provide abortion even when it is legal, because they do not feel they have been authorised to do so, or they request women to produce a judicial authorisation. Sometimes, third parties (often conservative religious groups) try to take legal action to prevent the provision of abortion even though it is legal under the country's law. Policy makers are in a position to facilitate the necessary mechanisms to allow clinicians to carry out legal abortions. In both Mexico and Brazil, local and/or state-level governments have worked with hospitals to provide integrated services for women who have been raped, including counselling and support, treatment for sexually transmitted infection, emergency contraception and abortion if required *[43]*, *[44]*.

4. Remove barriers that make it difficult or impossible for women to access a legal abortion in a timely manner

Even in countries where abortion is permitted for a broad range of indications, there may exist barriers to accessing abortion services. These include, for example, mandatory as opposed to voluntary counseling, a waiting period that has no basis in good medical practice, the consent of a third part such as a husband or parent even though the (young) woman is able to give her own consent, allowing providers or others to refuse a legal abortion, and conscientious objection by service providers who are unwilling to refer the woman elsewhere *[45]*. These barriers only serve to make women have later abortions than is medical necessary (see Box 2). Many may seek an unsafe abortion instead, especially if they are poor, with all the risks to health and life that this may entail. It is important that these barriers be removed. This may require changes in regulations, but the result will be that many more abortions will be earlier and safer.

5. Invest in provider training

Access to abortion is constrained in many setting owing to a shortage of trained providers. Medical abortion training may be offered to providers already trained in vacuum aspiration abortion so that they are able to offer women a choice of abortion methods. In addition, training

on medical abortion can also be organised for general practitioners, midwives and other mid-level providers who may or may not also be skilled at vacuum aspiration abortion. This training can be included in both pre-service and in-service training for these cadres. Training should not only cover technical skills (including pain control) but also social, and ethical aspects of abortion, as well as counselling and contraceptive provision.

6. Improve quality of abortion care

Service delivery standards, protocols and guidelines need to be developed where these do not already exist. WHO's comprehensive guidance, Safe Abortion: Technical and Policy Guidance for Health Systems, is an excellent document for programme managers *[4]*. and for clinicians, there are the guidelines of the Royal College of Obstetricians and Gynaecologists *[49]*. Other guidance includes Providing Medical Abortion in Developing Countries: An Introductory Guidebook *[25]*. and in French, Prise en charge de l'interruption volontaire de grossesse jusqu'à 14 semaines *[50]*.

Quality of care is not only about technical quality but also about promoting women's autonomy in making the abortion decision and providing abortion services in a manner that respects women's dignity. Medical abortion services should include good quality counselling services. Protocols for service delivery should include mechanisms for redress for women who experience ill-treatment or abuse when seeking abortion services.

7. Promote research and documentation on abortion service delivery

Documentation of information on abortion availability and changes subsequent to efforts to expand access could prove to be an important tool to inform further policy changes. This includes improvements through making medical abortion available. Investment is also needed in operations research to track the quality of abortion services, both vacuum aspiration and medical abortion, from the perspective both of the providers and women. Documentation of the logistical, administrative and organisational challenges involved in introducing vacuum aspiration and medical abortion services in the process of scaling up these services would help those working locally at the policy and programmatic level.

8. Support public health funding to make abortion services, including medical abortion, affordable for all women who need it.

The cost of mifepristone tablets is one of the biggest components of the cost of providing medical abortion. Misoprostol, on the other hand, is affordable in most countries where it is available. Indeed, in many countries, misoprostol is being used alone for medical abortion because of its lower cost.

Adopting a 200mg regimen of mifepristone, as recommended by WHO, rather than the outdated 600mg regimen in the labelling information for mifepristone, as most countries have done,

means a substantial cost reduction. This dosage change was recommended by WHO early on *[4]*. Moreover, there are several efforts in the pipeline at this writing to produce low-cost 200mg mifepristone pills. There are also efforts to negotiate a public sector price for both drugs now that they are on the WHO List of Essential Medicines.

The other major cost factor is to do with the type of facility where medical abortion is offered and type of provider. It costs far more for a gynaecologist to provide medical abortion in a hospital-based clinic. Putting mid-level providers in charge of providing medical abortion in a primary care setting reduces the cost of medical abortion considerably. If women who are up to nine weeks pregnant can use misoprostol at home (whether following mifepristone or alone) – an option confirmed by many studies to be safe and efficacious, including in developing countries *[25]* – costs are further reduced.

Finally, health insurance schemes aimed at low-income groups need to provide coverage for abortion services, including medical abortion. In the absence of such schemes, public sector facilities with low or no fees are critical for supporting the access of poor women to abortion. This is another reason why it is important to provide medical abortion at primary care level.

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