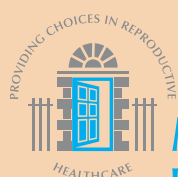




For Women's Lives and Health: Report of the Global Safe Abortion Conference

Whose Right? Whose Choice? Who Cares?

23-24 October 2007
London, England



**MARIE STOPES
INTERNATIONAL**

In association with

Abortion Rights
The national Pro-Choice campaign

Ipas Protecting women's health
Advancing women's reproductive rights

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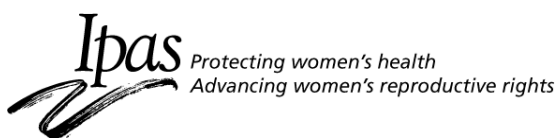
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The organisers' deepest thanks and appreciation go to the conference participants, many of whom travelled long distances to represent women in every region of the world whose voices are too often absent from global policy and programming discussions that directly affect them. In their daily work to protect women's health and rights, these women and men—and thousands of their colleagues who were not in London that week—inspire us every day.

ABOUT THE ORGANISERS



Founded in 1976, Marie Stopes International (MSI) works in 42 countries through a global partnership of locally registered nongovernmental organisations in Asia, Africa, the Middle East, Latin America and Europe. MSI provides comprehensive sexual and reproductive health care services to over five million couples annually, delivered via almost 550 static clinics and thousands of outreach projects and mobile clinics worldwide. MSI has also developed targeted programmes to address the needs of adolescents and marginalised groups such as refugees, internally displaced people and commercial sex workers. MSI is a global leader in providing safe abortion services in countries where abortion is permissible and postabortion care in countries where abortion is heavily proscribed. The agency also advocates on behalf of women who are denied access to safe abortion services at global, regional and national levels. MSI is the United Kingdom's largest independent provider of sexual and reproductive health services outside the National Health Service. Approximately 100,000 British women and men benefit from MSI services every year.



For more than three decades, Ipas has worked to stop needless deaths and injuries of women from unsafe abortion and to advance women's sexual and reproductive rights, believing that women everywhere must have the opportunity to determine their futures, care for their families and manage their fertility. Through local, national and global partnerships, Ipas works to ensure that women can obtain safe, respectful and comprehensive abortion care, including counselling and family planning to prevent future unwanted pregnancies. Ipas works on five continents, with offices and a multidisciplinary professional staff in 13 countries, to address unsafe abortion by training healthcare providers to improve health services; increasing the availability of appropriate reproductive health technologies; and working with policymakers and advocates to bring about positive changes in health policies and practices.



Abortion Rights is the national pro-choice campaign working to defend and extend women's abortion rights in the United Kingdom, leading the campaign to liberalise the current abortion law to make abortion available on request; oppose any restrictions in women's current legal rights and access to abortion; extend the 1967 Abortion Act (as amended) to Northern Ireland; and improve women's access to and experience of abortion. Abortion Rights is a membership-based grassroots organisation working with a broad coalition of supporters—including members of parliament, peers, medical professionals, journalists, women's and sexual health and rights organisations, students and trade unions—to build an active and vocal pro-choice movement.

Notes, video clips and copies of most presentations made
at the Global Safe Abortion Conference are available for free download at
www.globalsafeabortion.org

FOREWORD

In October 2007, almost 800 public health experts, government representatives and women's health advocates from more than 60 countries came together in London in an unprecedented show of support for making safe legal abortion widely available as an essential element of comprehensive reproductive health care. Held on the 40th anniversary of the UK Abortion Act, the conference also celebrated the British government's groundbreaking leadership in reducing unsafe abortion's appalling toll on women's health and lives and reviewed remaining needs and challenges.

The Global Safe Abortion Conference was the first time that a gathering of such magnitude and scope forthrightly addressed this critical issue, which the medical journal *The Lancet* has called one of the most neglected health issues of our time. Representing thousands of others fighting daily to ensure that women everywhere can safely exercise their reproductive rights, delegates declared that safe abortion saves lives and asked what more the global community can do to combat unsafe abortion.

While the conference frankly acknowledged the multiple challenges that confront those working to improve women's access to contraception and safe abortion, its mood was overwhelmingly positive. Abortion clearly remains a divisive issue, but recent medical, political, social and other advances are driving much-needed, long overdue progress. For example, effective methods of contraception are more available and more widely used than ever before. The revolutionary technology of medical abortion is making safe services accessible to even the most marginalised, vulnerable women. And more and more enlightened countries are liberalising their abortion laws, recognising that, rather than stopping abortion, restrictive laws serve only to make it more dangerous.

The Global Safe Abortion Conference offered an unparalleled opportunity to exchange ideas and experiences, to strengthen existing partnerships, and to form powerful new alliances and strategies. These alliances and strategies must and will enable us to end the preventable tragedy of unsafe abortion and expand access to safe, comprehensive abortion care, including contraception.

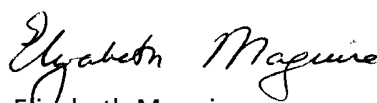
Participants joined in supporting the Global Call to Action for Women's Access to Safe Abortion, agreeing to:

- stop deaths and injuries from unsafe abortion;
- end the silence and hypocrisy that surround the issue of abortion;
- give voice to the voiceless women and girls who suffer most from this tragedy;
- ensure universal access to safe abortion care;
- erase the stigma that hinders progress on this issue;
- fight for social justice and for the health, well-being and equality of all women.

This historic event has created the foundation of a new global movement to turn women's right to safe abortion into reality. Now is the time to reclaim the moral high ground, to speak out loudly and to take bold action. The lives and health of millions of women are at stake.



Dana Hovig
Chief Executive
Marie Stopes International



Elizabeth Maguire
President
Ipas



Anne Quesney*
Director
Abortion Rights

**Since the conference, Anne Quesney has joined Marie Stopes International as Head of Advocacy.*

EXECUTIVE SUMMARY

Introduction

The Global Conference on Safe Abortion, held in London in October 2007, drew nearly 800 public health experts, women's health advocates, government representatives, researchers and others from every region. Its purpose was to share challenges and successes in ending preventable deaths and injuries from unsafe abortion and in helping women exercise their right to terminate an unwanted pregnancy safely. The conference coincided with the 40th anniversary of Britain's Abortion Act, which was among the first in the world to liberalise access to first-trimester abortion. The fact that this groundbreaking act was being hotly debated in the British Parliament the very week of the conference underscores the ongoing controversy surrounding the issue of abortion.

The Impact of Unsafe Abortion

Despite notable achievements in recent years, global progress in preventing and otherwise effectively addressing unsafe abortion has been too slow. **At least 66,500 women and girls, mostly in developing countries, die from unsafe abortion each year, and about five million more are hospitalised with serious complications.** The women and girls who are most affected are poor, young, rural, ill-educated and otherwise vulnerable. Poor African women face the highest risks of death and injury from unsafe abortion.

Unsafe abortion has severe economic and health consequences, imposing huge burdens on poor countries' already struggling public health systems and broader societal costs such as lost productivity, social stigmatisation, and children left motherless. Research shows that managing complications of unsafe abortion costs health systems much more than providing preventive contraceptive services or safe elective abortion.

Actions needed to reduce unsafe abortion and its health, economic and social consequences include improving the availability and quality of postabortion care, which includes emergency treatment for complications of unsafe abortion and contraceptive counselling and services to help women prevent repeat unintended pregnancy. **But postabortion care alone is insufficient**; from a health and human rights standpoint, **it is also necessary to make safe abortion accessible.** Also required are better data on the incidence and impact of unsafe abortion and on the needs of groups whom it disproportionately affects.

Abortion as a Human Right

Governments, international treaty-monitoring bodies and others increasingly recognise abortion as an intrinsic human right, integral to women's ability to make their own decisions about the number and spacing of their children:

- The United Nations Human Rights Council (UNHRC), the Committee on the Elimination of Discrimination against Women, the European Court on Human Rights, and Colombia's Constitutional Court are some examples of **global, regional and national bodies that have called for liberalisation of laws criminalising abortion on human rights grounds.**
- In Africa, the 2005 approval of the Protocol on the Rights of Women in Africa marked the first time that an international human rights agreement explicitly recognised abortion rights. In 2006, **Ministers of Health and delegates from 48 African countries approved the Maputo Plan of Action**, which identified reducing unsafe abortion as one of nine action areas essential for achieving the Millennium Development Goals.

- In 2007, the world's leading human rights advocacy organisation, **Amnesty International**, adopted a policy supporting women's right to information and services for safe legal abortion in cases of unwanted pregnancy resulting from rape or incest or posing serious risk to the woman's life or health.

Activists and others working to protect women from unsafe abortion need to make greater use of human rights treaty-monitoring bodies, national judicial systems and other mechanisms to hold governments accountable to citizens and to international human rights commitments. **Governments need to honour basic principles of human dignity by ratifying human rights instruments and treaties** and actively working to ensure that their citizens realise concrete benefits from their commitments.

Legal and Policy Influences

As evidence of growing consensus on the need for safe abortion, **between 1995 and 2007, 17 countries liberalised abortion laws**. Today, abortion is permitted on broad grounds or without restriction in 70 countries, where more than 60 percent of the world's population lives. A few countries have moved to further restrict access to safe pregnancy termination. In 2006, for example, despite vigorous objections from health professionals and women's groups, Nicaragua imposed a total ban on abortion, increasing women's risks related to unsafe abortion.

Restrictive laws do not stop abortions from occurring. The abortion rate in Europe, where most abortion laws are liberal, is almost the same as in Africa, where most are restrictive. But **restrictive laws are clearly associated with increased deaths and injuries of women from unsafe abortion, and more liberal laws unmistakably correlate to lower risks and better health outcomes**, including fewer deaths. More than half of the 66,500 deaths from unsafe abortion each year occur in Africa, where many countries retain obsolete abortion laws inherited from former colonial powers. In legally restricted environments, an important approach for improving women's access to safe abortion is to encourage broad interpretation of existing laws and policies. It is also essential to remove medically unnecessary requirements regarding provision of abortion imposed on women, providers and healthcare facilities.

Nor do liberal laws guarantee women's access to safe abortion or lower mortality or morbidity. Concerted planning and investment in making safe services accessible—by training providers, making appropriate technologies such as manual vacuum aspiration (MVA) and medical abortion available on a sustained basis, and issuing clear, evidence-based clinical and policy guidance—are also necessary, along with efforts to inform women of their legal rights and of service availability, and ongoing vigilance to protect legal gains.

Abortion Services: Access and Quality

Even where abortion is legally permitted, technical and policy barriers such as shortages of trained, authorised healthcare personnel or unavailability or inconsistent supply of required medical equipment and supplies commonly inhibit access to safe care. The prohibition of midlevel providers such as nurses and midwives—often the only healthcare workers accessible to women—from performing abortion is a common and especially detrimental barrier. With proper training and supervision, these essential personnel are fully competent to offer abortion care, especially medical abortion.

Ensuring that abortion-related services are safe and otherwise of high quality is equally important. Important steps include ensuring **use of appropriate technologies**; providing **confidential, client-focused counselling**; and **integrating postabortion contraceptive services with abortion care**. Adherence to international clinical standards to ensure technical competence is essential to ensuring service quality. Specifically,

the World Health Organization (WHO) recommends medical and aspiration methods for first-trimester abortion, in place of dilatation and curettage, or D&C. **Medical abortion has the potential to make safe first-trimester abortion accessible to women in even the most remote settings**, including the privacy of their own homes, is less costly and carries lower risk of infection than other methods. Currently, however, this important method is insufficiently available.

Primary actions needed to improve the quality of abortion care include **pre- and in-service training for all cadres of healthcare workers in aspiration and medical abortion** techniques and related clinical skills, with special emphasis on midlevel providers. While maintaining a focus on safety and efficacy and on improving availability of required drugs, the international community should continue to support adaptations in medical abortion regimens that respect women's needs for privacy, confidentiality and convenience. Second-trimester abortion services also need to be expanded, since some women will always need to terminate pregnancies later than the first trimester.

The Stigma of Abortion

The stigma surrounding the very common experiences of unintended pregnancy and abortion is one of the biggest obstacles in addressing unsafe abortion effectively. Within health systems, stigma manifests in some healthcare workers' negative attitudes toward—and even punitive treatment of—women seeking abortion-related care or refusal, often on grounds of conscientious objection, to provide or participate in such care.

Speaking out honestly and boldly about women's experiences, as participants in the Global Safe Abortion Conference did, is an essential first step in dismantling stigma and improving access to safe care. In addition, **qualitative research is needed** to illuminate the often complex personal, societal and health system factors influencing women's experiences. Abortion rights **advocates can also help de-stigmatise abortion by reclaiming the moral high ground** and adopting a pro-active, rather than defensive, stance that affirms women as rational, competent decision-makers and moral agents.

Conclusion

Reducing unsafe abortion and promoting women's access to safe abortion require multiple strategies and the active engagement of diverse audiences. **Key needs include stronger commitment and greater investment by governments and international donors**, particularly in the context of meeting the Millennium Development Goals. There clearly is growing demand worldwide for women to have full access to legal, voluntary, safe and affordable abortions as part of comprehensive sexual and reproductive health care, and **liberalising abortion laws is one of the most effective steps governments can take to save women's lives from unsafe abortion**.

The nearly 800 people who travelled from every corner of the globe to attend the Global Safe Abortion Conference included men and women of all ages and of every race, religion and region, representing multiple professions. In all their diversity, they were united by their vision of a world motivated by compassion and caring for women and by their desire to empower women to make the choices they know are right for themselves and their families, without risking their lives and health.

Their vision is shared by millions of people around the world. It is the hope of the conference organisers—Marie Stopes International, Ipas and Abortion Rights—that the Global Safe Abortion Conference has launched a global movement that will bring about and will settle for nothing less than the full realisation of that vision.

INTERNATIONAL PROGRAMME

Introduction

In October 2007, nearly 800 public health leaders, government representatives, researchers and women's health advocates from more than 60 countries made history by convening in London, England, for the world's first Global Conference on Safe Abortion. Never before had so many dedicated women and men—of all ages, from a wide variety of backgrounds, and from every part of the world—come together to declare publicly and unapologetically their commitment to making safe abortion accessible to every woman who needs it.

Marie Stopes International—one of the world's largest international family planning organisations and the leading private provider of safe abortion services—planned the Global Safe Abortion Conference in association with **Ipas**, an international nongovernmental organisation working to reduce deaths and injuries from unsafe abortion, and **Abortion Rights**, which leads efforts to defend and extend women's abortion rights in the United Kingdom. Together, the organisers designed a programme and invited experts from around the world to share their challenges and successes in ending deaths and injuries from unsafe abortion and in helping women exercise their reproductive rights, including their right to terminate unwanted pregnancies safely.

As one of the primary causes of maternal mortality and morbidity in the developing world, unsafe abortion is long overdue for the scale of attention that the Global Safe Abortion Conference mobilised. Organisers hoped that the thoughtful, passionate discussions that took place in London those two days in October 2007 would spark the creation of a new global movement to demand that women everywhere have full access to legal, voluntary, safe and affordable abortion as part of comprehensive sexual and reproductive health care.

October 2007 marked the 40th anniversary of Britain's groundbreaking Abortion Act of 1967, which was among the first in the world to liberalise access to first-trimester abortion. The very week of the conference, Parliament was considering revising the law. Public debate was lively, with strong voices arguing both for tightening the law (specifically, reducing the upper time limit for legal abortion) and for relaxing administrative restrictions that hinder women's access to care (particularly the requirement that two physicians authorise the procedure). The lead architect of the 1967 act, Lord David Steel, spoke eloquently at the Global Safe Abortion Conference about the act's impact in altering the "grisly picture" of unsafe abortion in Britain, expressing his wish that countries that still ban abortion could undergo such a reform.

"It is a time of great hope and possibility. With the wind at our back, we can do so much here, and hereafter."

Dana Hovig, Chief Executive,
Marie Stopes International



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International support has grown steadily in the last several decades for women's right to make their own reproductive decisions and to be free of the preventable risk of unsafe abortion—defined by the World Health Organization (WHO) as termination of unintended pregnancy by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.

Landmark international health and population conferences, including the United Nations International Conference on Population and Development in 1994 and Fourth World Conference on Women in 1996, have highlighted incontrovertible evidence of the needless death and injury that results from women's too-limited access to modern contraception and safe abortion, and the multiple personal, familial and societal tragedies that can follow. Important in its own right, achieving universal access to reproductive health is also increasingly recognised as essential to promoting social and economic development and has now been identified as a target for all nations to achieve within the framework of the UN's Millennium Development Goals. International treaties and recommendations from human rights treaty bodies increasingly recognise women's access to safe abortion as a human right.

“It is an outrage that in the years since the landmark UN conferences, close to one million women have died from complications of botched abortions and over 50 million women have suffered needlessly from injuries and disabilities caused by abortion complications.”

Elizabeth Maguire, President & CEO
Ipas

Increased visibility and acknowledgment of unsafe abortion has led to concrete progress in addressing it, in the form of advocacy, research, legal and policy reform, and programmatic interventions with proven effect in reducing unwanted pregnancy and unsafe abortion and their consequences. Perhaps most notably, more and more countries are liberalising abortion laws, and in many such countries, positive impact on women's health and lives is already evident.

On the whole, however, such progress has been too slow. The London conference took place shortly after the release of new data from the WHO and Guttmacher Institute showing that, while the number of abortions performed globally and the worldwide rate of unsafe abortion have both declined slightly in recent years, the proportion of unsafe abortions increased. Almost all unsafe abortions and related deaths occur in developing countries, and in Africa, the estimated number of deaths from unsafe abortions rose between 2000 and 2003, from 29,800 to 36,000. Worldwide, estimated deaths from unsafe abortion fell from 67,900 in 2000 to 66,500 in 2003; an estimated five million women are hospitalised each year for complications of unsafe abortion.

Formidable obstacles continue to impede efforts to ensure that women can safely control their own fertility. For example, a well-financed, increasingly global conservative movement that opposes abortion rights and often uses misleading or inaccurate arguments to convert others to their cause is challenging political victories around the world. In addition, insufficient investment by donors and governments inhibits implementation of technologies

and strategies that are known, effective and affordable. A fundamental cause of such opposition and inertia is the strong, persistent stigma that still surrounds abortion in most cultures.

Despite differences of geographical, cultural, economic and legal contexts, participants found the conference to be a unique opportunity to share information, challenges, and best practices on a number of critical themes:

1. the impact of unsafe abortion
2. abortion as a human right
3. legal and policy influences
4. accessibility and quality of abortion services
5. overcoming abortion stigma

This report synthesises and presents highlights of conference presentations, discussions and recommendations in each of these areas. Additional information, including presentation notes, video recordings, and PowerPoint slides, can be found at the conference website: www.globalsafeabortion.org.

THE IMPACT OF UNSAFE ABORTION

At the local, national, regional and global levels, unsafe abortion takes a tremendous toll on girls, women, families, communities, health systems and nations. The full extent of its impact is difficult to measure, both because unintended pregnancy and abortion remain taboo in most societies and because few health systems or countries effectively collect data on the subject.

The individual girls and women whose personal struggles and tragedies lie behind statistics on unsafe abortion disproportionately come from the ranks of the world's most vulnerable populations. By and large, they are poor, young, rural and ill-educated. They are the same girls and women who have least access to modern contraception and to safe abortion, and almost all live in poor countries of Africa, Asia and Latin America. As previously noted, African women and girls are at highest risk of death from unsafe abortion. The WHO estimates that 650 women die for every 100,000 unsafe abortions that occur on the African continent; this rate is nearly twice that for the developing world as a whole (350/100,000), more than twice that for Asia (300/100,000), more than 10 times the rate for Latin America (50/100,000), and 65 times the rate reported for developed countries as a whole (10/100,000).

Even with limited data, enough is known about the magnitude of unsafe abortion and about its impact—in terms of health, cost and other factors—to justify demands for immediate and more effective action to address it.

Health effects

Many women suffer serious injuries or die as a result of their desperate attempts to end unwanted pregnancies. Methods commonly used include the insertion of foreign (usually non-sterile) objects such as plant stalks, bicycle spokes, pencils or toothbrushes into the uterus; ingestion of toxic substances including herbal brews or bleaches; and infliction of physical trauma such as vigorous jumping or abdominal massage or beating. Common medical complications of unsafe abortion include incomplete abortion, uterine perforation or other trauma, haemorrhage and infection, which can lead to chronic reproductive tract infections, ectopic pregnancy, premature

delivery, infertility and death. Data from Kenya and Nigeria indicate that about one-third of women seeking care for abortion complications experience severe complications, the risk of which increases with the duration of pregnancy.

Most abortion-related complications are easily treated if care is received in a timely manner. However, evidence suggests that one in five women who require treatment for complications of unsafe abortion never receives such care. Among those who do seek treatment, many experience delays in obtaining it that exacerbate their conditions.

One encouraging development is that some countries and regions are reporting a decline in some of the most serious complications of unsafe abortion, such as uterine perforation and infection. This trend appears to be associated with the increasing availability and use of misoprostol, an anti-ulcer drug and abortifacient that is also part of most regimens for medical abortion. Although in many ways this trend represents positive movement, women's access to information about proper usage of misoprostol is typically limited, exposing them to other health risks and highlighting the need for education.

“That unsafe abortion merits the same scientific approach as other threats is evident from its consequences.”

Dr Akinrinola Bankole
Guttmacher Institute



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Costs

In addition to serious negative health consequences, unsafe abortion also has a severe economic impact, especially in poor countries with already overburdened health systems. Indirect costs of unsafe abortion are extremely difficult to calculate and have been little studied but include lost productivity, social stigmatisation, and hundreds of thousands of children left motherless every year. Direct costs include personnel, medications, blood, supplies, and equipment and hospitalisation expenses associated with treating women who suffer complications of unsafe abortion.

Country-level studies, such as one in Nigeria described by Dr Akinrinola Bankole of the Guttmacher Institute, suggest that these costs consume significant resources. Researchers in the Nigerian study estimated that the government spends the equivalent of US\$19 million a year on postabortion care, a package of services for women suffering complications of unsafe abortion that includes emergency care and provision of contraceptive counselling and methods. Ironically, researchers calculated that the unwanted pregnancies that ultimately lead to those complications could be prevented through contraceptive services costing only US\$4.8 million. Similarly, in Kazakhstan, it costs the public sector about US\$26 to provide one abortion, compared to US\$60 to treat one woman with complications from an unsafe abortion. Clearly, with more effective preventive services in place, including sex education, contraceptive provision and safe abortion, governments can save immense health system resources, while also sparing many women the trauma and dangers of unintended pregnancy and unsafe abortion.

In many settings, both the risks and costs associated with postabortion care are higher than necessary because health systems and providers rely on outdated clinical methods to provide such care. The WHO recommends that, wherever possible, health systems replace sharp curettage (also known as dilatation & curettage, or D&C) with vacuum aspiration for uterine evacuation, which is the essential treatment for incomplete abortion. Experience around the world shows that, in addition to increasing safety, replacing sharp curettage with aspiration for treating abortion complications significantly reduces resource consumption. Resource savings are especially likely when services shift from use of general anaesthesia and overnight hospitalisation to outpatient care using local anaesthesia. Such changes resulted in cost savings ranging from 32 to 72 percent in hospitals in Bolivia, Mexico and Peru, for example.

Offering safe legal abortion, and thereby dramatically reducing the need for postabortion care, can lead to even more resource savings. When Dr Heidi Bart Johnston of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and colleagues applied an economic-analysis model developed by Ipas to cost data from Uganda, they found that a switch from provision of postabortion care with sharp curettage in a restrictive legal setting to provision of legal induced abortion using aspiration techniques would reduce per-patient costs by 86 percent.

Future directions

Globally, there has been progress in addressing the impact of unsafe abortion, notably in making high-quality postabortion care more widely available and accessible. Since its introduction in the late 1980s, the postabortion care model of emergency treatment linked to postabortion family planning and other elements of reproductive health care has helped hundreds of thousands of women worldwide receive much-needed services; it has also effectively sensitised healthcare providers, communities and policymakers to the dangers of unsafe abortion. While postabortion care remains necessary, it is an insufficient response to the health challenge of unsafe abortion; making safe abortion available is more effective and more respectful of women's rights.

Developing and implementing more effective, evidence-based strategies to address and ultimately eradicate unsafe abortion requires more extensive and more robust data, especially at the country level. Yet the lack of specific data in every country must not be used as an excuse for inaction. With support from donors and governments, health systems need to invest in more systematic and comprehensive collection of data on the incidence and impact of unsafe abortion; it is also important for health facilities and systems to disaggregate deaths and injuries from unsafe abortion that may be hidden in data already being collected so that the true extent of the problem is evident.

HIV-positive women, refugees and internally displaced persons, immigrants, ethnic minorities, the least educated, the very young and the very poor are especially likely to face societal and personal barriers to safe abortion and related care. Healthcare providers and planners need to make specific efforts to reach out to and address the needs of these groups. For example, youth-friendly reproductive health services that emphasise privacy, confidentiality, accessibility and non-judgmental service provision have proved effective in numerous settings.

ABORTION AS A HUMAN RIGHT

Thanks to years of advocacy, sexual and reproductive rights are now squarely positioned in the human rights framework that the international community uses to guide and assess countries' fulfilment of obligations toward their citizens. Global progress on safe abortion, in particular, reflects growing acknowledgment of abortion as

a human right inextricably entwined with others that have long been recognised. The discourse on abortion as a human right is continuing to evolve, as scholars, activists and others explore more deeply concepts such as reproductive justice and how to ensure that they are actualised.

Luisa Cabal, of the Center for Reproductive Rights, told conference delegates that framing abortion in a human rights context provides a universal language that unites people across political, cultural and other divides and is grounded in the shared desire to safeguard human dignity and protections to which all people are entitled. Moreover, human rights discourse is by definition empowering; it encourages women to claim this and other rights that they have historically been denied. On a practical level, using a human rights framework to address abortion provides access to respected mechanisms for holding governments accountable, especially since in many countries ratification of international human rights instruments confers on them the status of national law.

“The promise of human rights is not for some but for all human beings, and that includes safe and legal abortion for women.”

Luisa Cabal
The Center for Reproductive Rights

Bodies such as the United Nations Human Rights Council (UNHRC) and the Committee on the Elimination of Discrimination against Women, which are charged with monitoring compliance with international agreements upholding human rights, play a key role in defining reproductive rights and governments' related obligations. As such, they have become important sources of interpretation and direction for governments and catalysts for change, issuing several landmark rulings in recent years. For example:

- The UNHRC has called for liberalisation of laws criminalising abortion, asserting that they are incompatible with women's right to life. Ruling in 2005 on a complaint brought against Peru for forcing a 17-year-old girl with an anencephalic foetus not only to give birth but to breastfeed the baby until its inevitable death, the Committee said the government violated the girl's rights to privacy and to be free from cruel, inhumane and degrading treatment. It was the first time that a UN human rights body had held a government accountable for failing to ensure an individual's right to abortion.
- In 1999, the committee monitoring compliance with the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) recommended that governments “remove punitive provisions imposed on women who undergo abortion.” The same committee has several times expressed concern over laws that do not permit access to abortion for women who have been raped and has affirmed that denying access to health services that only women need is discriminatory.
- Reacting to reports of emergency medical treatment being withheld unless women confessed to undergoing illegal abortion, in 2004 the Commission against Torture and Other Cruel, Inhuman or Degrading Treatment Punishment called on Chile to ensure prompt, unconditional treatment for women suffering complications from unsafe abortions.

Recent regional developments include a March 2007 decision by the European Court on Human Rights obligating Poland—and, by extension, all countries in Europe—to ensure women's actual, rather than only theoretical, right to appeal denials of requests for abortion. The case prompting the ruling involved a woman whose doctors advised her that continuing her pregnancy would likely cause her to go blind but refused to authorise abortion. Latin America was the source of an important precedent in 2006, when the Inter-American Commission on Human Rights expressed strong concern to Nicaragua's Ministry of Foreign Affairs about the country's recently passed ban on abortion, calling it contrary to international law because it threatened women's human rights and health.

**A promising new strategy:
Using courts and human rights arguments to fight restrictive abortion laws**

In Colombia, abortion-rights advocates recently won an important victory through the groundbreaking strategy of challenging a restrictive abortion law in the national courts.

In 2005, Mónica Roa, a young lawyer with Women's Link Worldwide, filed a complaint charging that Colombia's near-total ban on abortion violated the country's commitments to international human rights treaties. Roa spent two years studying global reform efforts before launching the case, basing much of her legal strategy and arguments on what she learned from others' experiences. Reform advocates also cultivated a strong network of legal and other allies and, through a carefully planned communications strategy, succeeded in building strong public support for the decriminalisation of abortion. Their hard work paid off in May 2006, when Colombia's Constitutional Court eased the ban to allow abortion in cases of rape, foetal malformation, or endangerment to the life or health of the mother or foetus.

Roa encouraged conference delegates to explore judicial routes to reform in their own countries and to include judges among their key audiences and partners. The success in Colombia indicates that debates about abortion are moving from the realm of politics to the realm of law, she said, and that strategic work with courts and judges can be very effective.

In Africa, an essential resource is the African Commission on Human and Peoples' Rights, represented at the Global Safe Abortion Conference by Commissioner Angela Melo, who was then Special Rapporteur on the Rights of Women in Africa. Dr Melo reminded participants that the right to abortion has special urgency in Africa because, although only 14 percent of the world's population lives on the continent, more than a quarter of all unsafe abortions occur there. Her office monitors compliance with a number of human rights instruments, including the Protocol on the Rights of Women in Africa, an expansion of the African Charter on Human and People's Rights which entered into force in 2005. Ratified to date by 27 African nations, this document affirms women's right to abortion in cases of rape, incest and to protect the life and health of the woman. It is the only international human rights agreement that explicitly recognises abortion rights, noting that they are integral to the right to health and a matter of equality between men and women.

Another important marker of regional agreement on the need to address unsafe abortion is the 2006 Maputo Plan of Action. Ministers of Health and delegates from 48 African countries approved this plan for implementing a framework for sexual and reproductive health and rights to accelerate the continent's progress in meeting the Millennium Development Goals. It identifies unsafe abortion as one of nine action areas and calls for increased advocacy, policy and other actions to reduce unsafe abortion.

NGOs play a key role in holding governments accountable to human rights commitments. Amnesty International (AI), one of the leading international organisations working to encourage support and respect for human rights, recently provided mainstream confirmation of the human rights imperative to address unsafe abortion. In 2007, AI adopted a policy supporting women's right to information and services for safe, legal abortion in cases of unwanted pregnancy as a result of rape, sexual assault or incest and where continuation of pregnancy poses a risk to their life or grave risk to their health. The policy asserts that imprisonment and other criminal sanctions for seeking or having an abortion violate women's reproductive rights. "Abortion is not 'an issue apart' in women's lives," AI's Stephanie Schlitt told conference delegates. "Abortion laws and policies are not special or particular in any way that sets them beyond human rights scrutiny. There are no excuses for state violations of human rights."

"Criminal abortion laws turn hundreds of thousands of women into criminals."

Stephanie Schlitt
Amnesty International



Future directions

Although much progress has been made in establishing the right to safe abortion as a basic human right, more action is needed to make it a reality for women around the world. While scholars continue to refine human rights arguments and to find even more bases for the right to abortion in internationally accepted human rights law, activists and others need to make greater use of existing mechanisms, including monitoring bodies and national judicial systems, for holding governments accountable to citizens and to international human rights commitments.

For their part, more governments around the world need to honour basic principles of human dignity by ratifying human rights instruments and treaties and actively working to ensure that their citizens realise concrete benefits from their commitments. In Africa, more governments should show respect for the women they serve by ratifying the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Women's health advocates and other citizens can help the African Commission on Human and People's Rights promote compliance with the charter's principles at the country level by providing information to support its fact-finding missions. Dr Melo urged use of the African Courts on Human and People's Rights, once they are fully functioning, as a venue for adjudicating and enforcing the charter. She also called for an international network on safe abortion to promote sharing of knowledge and information, along with a working group to develop safe-abortion guidelines for Africa.

LEGAL AND POLICY INFLUENCES

Recent global momentum for liberalisation of abortion laws reflects growing consensus on the need for safe abortion. In 1995, the United Nations Fourth World Conference on Women called on governments worldwide to re-examine restrictive abortion laws that punish women. By 2007, 17 countries as diverse as Albania, Cambodia,

Colombia, Mali, Nepal, Portugal, South Africa and Switzerland had removed legal restrictions on abortion. Similar advances at state and municipal levels include Mexico City's 2007 amendment of its penal code to permit abortion without restriction in the first 12 weeks of pregnancy, breaking new legal ground in Latin America.

“What happened in my country is a tragic example of politicians playing with human lives. And women are paying the price, with their health and in many cases with their lives.”

Dr Arnoldo Toruño
Obstetrician-Gynaecologist Nicaragua

During the same period, a few countries have moved in the opposite direction, often succumbing to pressures exerted by powerful political and religious forces. Dr Arnoldo Toruño of the Nicaraguan National Autonomous University told conference participants about events leading to his country's 2006 total ban on abortion, making it only the fourth nation in the world to outlaw abortion entirely. The vote occurred just before national elections, after a vigorous campaign by religious leaders and strong objections from the national association of obstetricians and gynaecologists, the National Health Council, faculties of medicine, women's groups and others who know most about women's health.

The United States government has also been part of this retreat on abortion rights. In 2003 it banned a second-trimester abortion procedure called intact dilation and evacuation that is used in only a small percentage of abortions but is without question the safest method for those cases in which it is needed. The US Supreme Court's 2007 decision to uphold the ban was significant, and potentially very harmful, because it was the first time the Court weighed foetal interests directly against women's and approved an abortion ban without an exception to protect women's health. Many US states have also enacted restrictions on abortion access, eroding the right of many American women, especially poor women, to safe abortion.

Today, abortion is permitted on broad grounds or without restriction in 70 countries, where more than 60 percent of the world's population lives. Most of the 36 percent of the world's people who live under very restrictive laws are in poor countries. It is no coincidence that of the nearly 20 million unsafe abortions that occur each year (about half the total number of abortions), 98 percent are in poor countries. The impact is especially severe in Africa, which accounts for more than half of the 66,500 deaths from unsafe abortion each year. As Professor Fred Sai, former Senior Population Advisor at the World Bank and reproductive health advisor to the government of Ghana, said in London, “Abortion laws inherited from colonial powers are the main reason so many women in developing countries die.” Most former colonisers liberalised their own laws years ago.

If the purpose of restrictive abortion laws is, as many claim, to reduce women's reliance on abortion, they fall woefully short of their goal. New data from the WHO and Guttmacher Institute confirm that restrictive laws do not stop abortions from occurring; the abortion rate in Europe, where most abortion laws are liberal, is almost the same as in Africa, where most are restrictive. But restrictive laws are clearly associated with increased deaths and injuries of women from unsafe abortion, and more liberal laws unmistakably correlate to lower risks and better health outcomes, including fewer deaths. Experience in Romania illustrates both dynamics: After severe legal restrictions were imposed in 1967 under dictator Nicolae Ceausescu, deaths from unsafe abortion quickly

increased seven-fold, until unsafe abortion was the leading cause of maternal mortality. When the law was liberalised 23 years later, after the dictator's downfall, deaths from unsafe abortion dropped precipitously. South Africa experienced similar benefits after making safe abortion available on broad grounds with its 1996 Choice on Termination of Pregnancy Act; between 1994 and 2004, deaths of South African women from unsafe abortion fell by 90 percent.

Liberal legislation alone does not guarantee women's access to safe abortion or improvements in mortality and morbidity, however. After positive laws are enacted, women's health and human rights advocates must be continually vigilant in protecting legal gains from political opposition that seeks to overturn or weaken them. Along with government and the health sector, advocates also play an important role in promoting awareness of new laws among policymakers and the public, and in guiding and monitoring implementation of the law. According to Getachew Bekele, MSI's Senior Adviser, for example, after Ethiopia amended its criminal code in 2005 to make safe abortion more accessible, reform advocates worked with the government to develop and disseminate technical and procedural guidelines for safe abortion based on international standards.

Legal restrictions do not determine whether abortion takes place—only where and how safely. Politics, and the politicisation of abortion, exert great influence on its cultural acceptability and thus on how openly and with how much accountability it is available. Where abortion is highly politicised, healthcare providers who fear social or professional stigma—or worse—may be too intimidated to include abortion among the services they offer. Women may be similarly intimidated and delay deciding what to do, turn to clandestine providers or dangerous methods, or continue a pregnancy they do not want.

Politics play a central role in access to safe abortion globally as well as locally. Although global political influences can be helpful—as in the case of pressure on governments to ratify international agreements that uphold reproductive rights—one of the most conspicuous examples is decidedly negative. The United States government's Mexico City Policy, or Global Gag Rule, still in effect at the time of the conference, prohibited US family planning assistance to foreign nongovernmental organisations (NGOs) that use funds from any source to perform, provide counselling or referral, or lobby for abortion; initially imposed in 1984, it was rescinded by President Bill Clinton but reinstated in 2001 by President George W. Bush. Several presenters at the Global Safe Abortion Conference offered concrete evidence of the policy's detrimental effect on some of the world's most needy populations, including in Ghana, Kenya, Ethiopia, and Nepal. [*Editor's note: President Barack Obama rescinded the Global Gag Rule on January 23, 2009.*]

Ambiguities in laws and policies governing abortion can be as detrimental as explicit restrictions. In countries where abortion is legally restricted, for example, but the government provides no clear guidelines about conditions in which it is permissible, both providers and women may decide to err on the side of caution. This understandable reaction can result in abortion being less accessible than the law permits and unnecessarily drive women to clandestine providers and unsafe methods. Governments and health systems can ensure women's access to safe abortion to the full extent permitted by law by issuing and monitoring compliance with technical and policy guidelines that explicitly identify when, where, by whom and using what methods abortion is to be provided. Several countries, including Ethiopia, Nepal and Vietnam, have taken this important step.

Future directions

With so many of the world's most vulnerable women still living under abortion laws that restrict their rights and endanger their health, there is a vital need to sustain and propel the global trend toward liberalising access to

abortion. Reform efforts can benefit from creating broader alliances representing multiple sectors of society. There is an urgent need for the global community to support the empowerment of grassroots organisations and local NGOs representing refugees, adolescents, and other marginalised women—those most affected by unsafe abortion. Greater exchange of successful strategies for promoting positive legal reform is also needed.

Governments, providers, advocates and others working to protect women's reproductive health and rights must remember that the ultimate goal is not legal change *per se* but true access to high-quality services. Successful legal reform must include careful planning for and follow-through on implementation, including budgeting, infrastructure support, provider training, public education and other steps.

Where short-term legal or policy reform is less likely, an important approach for improving women's access to safe abortion is to encourage broad interpretation of existing laws and policies, including disseminating and monitoring compliance with clear, evidence-based guidance on when, where and how abortion can be provided. Medically unnecessary requirements imposed on women, providers and healthcare facilities need to be abolished. Additionally, governments and health systems need to increase their investments in making available affordable abortion-care technologies, including manual vacuum aspiration (MVA) and medical abortion, which are insufficiently implemented. Concurrently, pre- and in-service training in clinical abortion skills needs to be expanded, with a special emphasis on non-physician or midlevel providers such as nurses, midwives, physician assistants and others. And where laws permit abortion to preserve the woman's health, providers can be urged to apply the WHO's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

“What is the use of having a liberal law when it restricts access to safe abortions?”

Dr Christine Kaseba
University Teaching Hospital
Lusaka, Zambia

ABORTION SERVICES: ACCESS AND QUALITY

Even where abortion is legally permitted, technical and policy barriers related to healthcare personnel, facilities, medical equipment and supplies, and other factors commonly inhibit access to safe care. Particularly in decentralised service-delivery settings, for instance, shortages of trained personnel limit the availability and quality of abortion care, especially second-trimester services. Lack of trained, authorised personnel may reflect health system policies regarding decentralisation of services, staff turnover or inadequate investment in training. Abortion is commonly omitted from pre-service training at medical and other health-professional schools, making in-service or on-the-job training an important strategy for diffusing knowledge and skills, along with curriculum reform.

Unavailability or inconsistent supply of equipment, medications and other materials needed for abortion care frequently prevents delivery of services or diminishes their quality. Such problems may be due to resource shortages, failure to make appropriate budgetary allocations, or weak or nonexistent requisition and distribution systems. In addition, instruments for MVA and drugs for medical abortion may require approval from relevant regulatory bodies; obtaining such approvals is often a lengthy and cumbersome process.

Policy restrictions that inhibit women's access to safe abortion include requirements imposed by health systems or individual health facilities that may extend beyond those in the law. A common example is the prohibition of midlevel providers—often the only healthcare providers accessible to women—from performing abortion. Whether dictated by law, policy, custom or managers' personal preference, such restrictions are particularly illogical and harmful when they inhibit midlevel personnel from providing medical abortion. Other medically unnecessary administrative constraints that hinder access to care include requirements for spousal and parental consent and authorisation from multiple physicians, which in many cases may be nearly or completely impossible for women to meet. For example, Zambia's legal requirement that women obtain signatures from three physicians to obtain legal abortions essentially negates the country's rather liberal law, since the vast majority of women live in rural areas without doctors. Even where doctors are more accessible, such requirements make physicians into gatekeepers with the power to delay or withhold services from women.

Establishing abortion services where they do not previously exist only partially meets the objective of ensuring women's access to high-quality abortion care. Also necessary is attention to elements such as use of appropriate technologies, technical competence, information and counselling, postabortion contraception and confidentiality. Assuring the highest possible quality of abortion care can be difficult, especially where resources are scarce. Lack of political will and other manifestations of the stigma attached to abortion, such as healthcare providers' negative attitudes toward abortion and women who seek it, can also hinder progress. These and other challenges can be addressed effectively, however, often at little cost.

Technical competence

Ensuring technical competence in abortion care begins with striving to adhere to international clinical standards, including using the safest, most effective abortion methods feasible. As noted earlier, the WHO recommends medical and aspiration methods for first-trimester abortion and specifically urges health systems and facilities to replace dilatation and curettage, or D&C, with these methods. Both MVA and medical abortion offer great potential for expanding access to abortion in low-resource settings, and thus to the world's most disadvantaged women, since both can be safely provided by midlevel providers on an outpatient basis; both methods, however, are underutilised.

Perhaps more than any previous abortion technology, medical abortion has the potential to make safe first-trimester abortion accessible to women in even the most remote settings, including the privacy of their own homes. Also known as "medication abortion," "abortion with pills," or "the abortion pill," this relatively new method uses medicines in pill form to induce abortion. The "gold standard" regimen is mifepristone followed by misoprostol; mifepristone antagonises the hormone needed to maintain pregnancy, and misoprostol produces uterine contractions and thus empties the uterus. The drugs work together to facilitate cervical dilation and expulsion of uterine contents.

"Medical abortion is the most important revolution in reproductive health technology since the oral contraceptive pill."

Dr Beverly Winikoff
Gynuity Health Projects



In addition to expanding women's options, medical abortion is less costly than other methods, can be offered in a wider variety of settings and administered by less-skilled providers, and carries a lower risk of infection. Despite an excellent record of safety, efficacy and acceptability, however, medical abortion remains insufficiently available, especially where women could benefit from it most. Challenges include pharmaceutical companies' reluctance to risk negative publicity by entering new markets or to make drugs available at locally sustainable prices; some doctors' reluctance to relinquish control of the abortion process to other providers or to women; inadequate donor support; and the difficulty of adopting new service-delivery models within the constraints of existing infrastructure and policies. Ongoing testing of modifications in dosage, timing and route and location of administration seeks to enhance the method's promise by increasing efficacy, acceptability, accessibility and affordability. Two particularly promising adaptations involve home administration of misoprostol and use of misoprostol (or another prostaglandin) alone.

Another area in which improvements in technical competence are urgently needed is broadening the base of healthcare providers proficient in second-trimester abortion, which typically is offered only in centralised, tertiary-level hospitals that are inaccessible to most women. The recommended technique for second-trimester abortion is dilation and evacuation, or D&E, which requires significant clinical skill and caseloads sufficient for physicians to maintain them. In many settings, expanding the availability of this critical service requires addressing some healthcare staff's reluctance to participate in later abortion procedures and negative attitudes toward women who seek them. Overcoming such challenges is important, as, even with increased access to family planning and to early abortion, some women will always need later procedures.

Ancillary skills such as pregnancy dating, confirmation of complete abortion, infection prevention and pain management are also important. Development and use of evidence-based norms and standards for these and other aspects of abortion care is an important strategy for assuring healthcare providers' skills and performance. Vietnam offers one example of how such guidelines can promote higher quality of abortion care; in association with the Reproductive Health Projects (RHP), a coalition of international NGOs, the government outlined, supported skills development and now monitors compliance with numerous quality standards, with very positive results.

Counselling

Good counselling—defined by one participant as “the process of enhancing a woman's ability to assess and understand her situation, evaluate options and make an informed choice or decision”—is fundamental to high-quality abortion care. Trained counsellors play an important role in helping women decide whether to continue a pregnancy, what method to choose if they decide on abortion, and what contraceptive method, if any, to use afterward; they also provide emotional support that can profoundly affect the woman's overall experience.

Unfortunately, counselling is a common weakness in many abortion-care programmes, especially in low-resource and legally restricted environments. Where resources are scarce, individualised counselling may be seen as a luxury that overworked healthcare staff do not have time to indulge. Where abortion is legally restricted or subject to strong social stigma, providers may hold negative attitudes toward abortion and women who seek it, which may inhibit understanding of and appropriate attention to their individual circumstances and needs and even lead to punitive treatment. Values-clarification work has been used successfully in countries such as Ghana, Nepal, South Africa and Vietnam to help providers become more aware of the personal biases they may bring to their work, better distinguish between those views and their professional obligations, and become more empathetic toward their clients.

In settings where there is no tradition of open interaction and communication between clients and providers, primary obstacles to effective counselling may be healthcare staff's failure to understand its importance and their lack of familiarity with counselling techniques; both of these obstacles can be addressed through training. In Vietnam, where the Reproductive Health Projects (RHP) helped the Government of Vietnam respond to a WHO assessment of abortion care that identified counselling as a principal weakness, providers introduced to and trained in interactive counselling techniques reported greater satisfaction in their work. Benefits for women included greater attention to their individual needs and more emphasis on informed choice of postabortion contraceptive methods.

Postabortion contraception

Research showing that nearly 70 percent of unintended pregnancies in developing countries occur among women who were not using contraception underscores the imperative to address women's potential need for contraception when they receive abortion or postabortion care. Research also supports the clear conceptual link between increasing knowledge of and access to modern contraception and reducing abortion. A study in the Russian Federation, for example, documented a 78 percent increase in contraceptive use and a 53 percent decline in the abortion rate between 1988 and 1998. Such compelling evidence justifies views such as that expressed in 2006 by Britain's Royal College of Obstetrician and Gynaecologists (RCOG), which referred to a recent rise in abortions in the United Kingdom as a "failure of preventive medicine."

"The one thing worse than a woman having an unsafe abortion is her having to repeat it."

Professor Fred Sai
Former Senior Population Advisor, The World Bank

Research also shows that offering contraceptive counselling and methods to women as part of abortion or postabortion care increases contraceptive use and reduces repeat abortions. Postabortion contraceptive services are especially effective when offered at the same site and by the same healthcare staff as abortion care. Offering a mix of method choices enhances the likelihood that, with appropriate counselling, women will choose a method that fits their personal circumstances and that they can use correctly, consistently and effectively.

Future directions

Conference delegates identified a number of promising approaches and priorities for action to improve the quality of abortion care. Primary among these is the ongoing need to train and equip all cadres of healthcare workers in aspiration and medical abortion techniques and related clinical skills. Both pre- and in-service training need to be strengthened and sustained, and more investment is required in making instruments, medications and other supplies affordable and available on a reliable basis at all levels of health systems. While maintaining a focus on safety and efficacy, the international community should continue to support adaptations in medical abortion regimens that respect women's needs for privacy, confidentiality and convenience. Second-trimester abortion services also need to be expanded, since some women will always need to terminate pregnancies later than the first trimester; difficulty finding providers and facilities who perform second-trimester procedures exposes women to additional risks.

THE STIGMA OF ABORTION

Although abortion is extremely common, it remains subject to a powerful stigma in most societies and cultures. The taboo surrounding both unintended pregnancy and abortion is one of the biggest obstacles in addressing unsafe abortion effectively. For many people, these topics are fraught with moral and religious significance, philosophical uncertainty and deep, often painful emotion, and are difficult to talk about. For some, opposing abortion or altogether avoiding the questions it raises is easier than grappling with its complex dimensions, including its real-life impact on the lives of women and girls.

Societal silence about women's experiences with unintended pregnancy and abortion leaves many women facing these issues without guidance or support, at a time in their lives when they may be in most need of aid. Even where abortion is broadly permitted and available, women who choose to terminate a pregnancy may face disapproval or harassment from family members, neighbours or even strangers; many feel alone and socially condemned, even if they are certain the decision is right for them and their families. Girls and women who are shamed or marginalised for other reasons, too—for example, those who are young, unmarried, refugees, victims of rape or HIV-positive—may bear the burden of a double stigma.

Stigma also helps explain why so many vitriolic, scientifically unsound arguments against ensuring access to abortion go unchallenged. For instance, despite scientific evidence to the contrary, abortion rights opponents' claims that pregnancy termination is linked to cancer, infertility and severe psychological trauma continue to be perpetuated, including by people in influential positions. Similarly, stigma inhibits accurate discussion of the diversity of religious views on abortion. Islam is often described as prohibiting abortion, for instance, but in fact many Muslim scholars interpret the Q'uran and other Islamic teachings as permitting abortion in some circumstances, including as an option for preserving a woman's and family's well-being. Stigma is also a powerful obstacle to legal and policy reform, as even legislators or other leaders who understand what is at stake may be unwilling to take the political risk that too often is inherent to publicly voicing support for women's access to abortion.

Among the most harmful manifestations of the stigma surrounding abortion are those within the health system. These include some healthcare workers' negative attitudes and even punitive treatment toward women seeking both abortion and postabortion care and others' refusal—often on grounds of conscientious objection—to provide or participate in abortion care. Although many laws and policies require physicians and other providers who do not want to be involved in abortion to refer women in a timely manner to others who will provide needed care, this does not always happen. In a survey administered by Marie Stopes International in the United Kingdom in 2007, for instance, one in five general practitioners—all potential gatekeepers for women's access to information and services—identified themselves as anti-abortion.

For many women, obstacles in obtaining safe abortion are part of a much larger context of limited autonomy. Many poor women in developing countries are economically and socially dependent on their husbands and families; many are unable to make independent decisions about health care, such as to use contraception, to seek abortion or even to see a doctor. Such constraints increase many women's likelihood of experiencing unintended pregnancies and unsafe abortions. In addition, a strong sense of personal shame, reflecting the stigma that surrounds abortion in many societies, can lead women to seek clandestine abortion even when safe, legal abortion is available. They may fear being identified as abortion patients by neighbours at a community clinic, for example, and instead go to a traditional healer in another village to avoid recognition, rumour and consequent social isolation.

Also impeding women's access to safe abortion is their lack of knowledge about reproductive physiology, the dangers of unsafe abortion, safe abortion methods and where they are available, and their legal rights. Community outreach by healthcare providers and facilities and by NGOs to address these knowledge gaps can help reduce the incidence of unsafe abortion and its consequences. Women's increasing reliance on misoprostol to self-induce abortion, often with little or no information to guide them, highlights the urgent need for such measures.

Future directions

Speaking out honestly and boldly about women's experiences with unintended pregnancy and unsafe abortion is essential to dismantling the stigma, replacing fiction with fact, and improving access to safe care. More qualitative research to illuminate women's experience in specific locales is needed to increase local understanding of and attention to their needs through policy and services. Topics that need to be discussed more openly include the multiple, often complex reasons that women have abortions, such as limited access to contraception, contraceptive failure, and the desire to make responsible choices for themselves and their families. Greater understanding of the personal, societal and health system factors that contribute to the ongoing need for later abortion services, even when safe early abortion is available, is especially needed.

"We can't change what we don't acknowledge."

Ndola Prata
University of California, Berkeley

Young women, especially, need to be encouraged and empowered to share both their negative and positive experiences of sexuality, violence, pregnancy and abortion with policymakers and the public. And it is critical for the global reproductive rights movement to embrace and support young women more actively, including by mentoring and elevating them to positions of influence. Speaking on behalf of the Youth Coalition, an international group of sexual and reproductive health and rights advocates under the age of 30, Laura Villa Torres, Ipas Associate for Youth Programs, underscored this point in the conference's closing plenary:

"We, the young people, are 'those women'—the ones getting pregnant, having unsafe abortions, not learning about contraception. We are the ones living our sexuality in very challenging contexts.

We have an important voice, and we want to contribute to the debate. When do we get taken seriously for who we are and what we have to offer? When do we stop being the youth representative and start being a full-fledged member of the discussion and the solution?"

Delegates also agreed on the need to shift the tone of their own discourse. Several presenters called for abortion rights advocates to reclaim the moral high ground in discussing abortion and to adopt a pro-active rather than defensive stance, one that affirms women as rational, competent decisionmakers and moral agents.

Eliminating the stigma surrounding abortion also requires more effective use of media and partnership with media professionals, including journalists. To be most effective, strategic communication on matters related to sexuality, reproductive health and abortion should be inclusive, involving target audiences and other stakeholders from the beginning of efforts to educate populations, improve services, and conduct research aimed at informing policy and practice.

Societal and personal barriers to safe abortion can be addressed through efforts to promote women's empowerment; through education and outreach focused on the dangers of unsafe abortion, where to obtain safe abortion, and correct usage of misoprostol; and by tailoring services to the specific needs of vulnerable populations. There is a particularly urgent need to better integrate abortion care with HIV prevention and treatment, to ensure the full reproductive rights of women living with HIV/AIDS.

CONCLUSION

As the Global Safe Abortion Conference drew to an end, delegates were clearly energised by all they had heard and shared about successes in promoting women's and girls' sexual and reproductive health and rights, including access to modern contraception and safe, legal abortion. They were eager to go home to continue their work and looked forward to exploring the promise and power of new strategies to confront ongoing challenges.

“Spontaneous abortion is a natural healing process. Safe induced abortion heals social inequities. Access to safe abortion is as essential to modern living as the internal combustion engine or the silicon chip.”

Professor Malcolm Potts
University of California, Berkeley

As Bene Madunagu, co-founder of Girls' Power Initiative in Nigeria and Vice-Chair of the Ipas Board of Directors, reminded them in her closing remarks, the question before the assembled activists, providers, researchers, media professionals and others gathered in London was not which strategy to use but how to use multiple strategies more effectively and more inclusively, through broader, more powerful coalitions. Referring to the challenge to Britain's Abortion Act as well as to the worldwide struggle to ensure women's access to safe abortion, Anne Quesney, Director of Abortion Rights, declared, “With our combined commitment and knowledge, we will fight and will win the battles.”

Dr Mohsina Bilgrami, Programme Director of Marie Stopes Society (Pakistan), took the opportunity to remind delegates of the pressing need for urgent, concerted global action. “The sad thing is that since the beginning of this two-day conference, more than 250 women will have died from unsafe abortion somewhere in the world,” she said. “But also remember that many others have been lucky and have lived because of the work we all do—because of you.”

Delegates recognised that commitment and knowledge must nevertheless be backed by financial resources and political will. On that point, The Honourable Bert Koenders, Minister for Development Cooperation of The Kingdom of The Netherlands, said that preventing unsafe abortion should be part of the common political agenda for protecting women's health and rights. “By any measure, this situation is deplorable,” he said, calling deaths and injuries from unsafe abortion a violation of women's rights to health, well-being and dignity and noting their enormous social and economic consequences.

Minister Koenders pointed to liberalisation of abortion laws as one of the most effective ways to address unsafe abortion. He called on governments and donors to follow the lead of The Netherlands in making sexual and

reproductive health and rights a development priority; without significantly greater investment, he said, the Millennium Development Goals related to reducing child mortality and improving maternal health cannot be achieved. Most importantly, Minister Koenders said, the silence around sexual and reproductive health and rights must be broken. "The simple fact of holding an event like this helps us break the silence," he concluded.

Nearly 800 people travelled from every corner of the globe to attend the Global Safe Abortion Conference. Delegates included men and women of all ages and of every race, religion and region. They were researchers, public health experts, healthcare providers, government representatives, journalists and activists. But in all their diversity, the delegates were united in one thing: their vision of a world motivated by compassion and caring for women and the challenges they face as they strive to live healthy, productive, authentic lives. The individuals who convened in London on 23-24 October 2007—most of whom signed the Global Call to Action for Women's Access to Safe Abortion, reprinted on page 27—trust and want to empower women to make the choices they know are right for themselves and their families, without risking their lives and health.

Their vision is shared by millions of people around the world. It is the hope of Marie Stopes International, Ipas and Abortion Rights that the Global Safe Abortion Conference has launched a global movement that will bring about and will settle for nothing less than the full realisation of that vision.

"We can save the lives of women and girls
around the world. Let us do so."

The Honourable Bert Koenders
Minister for Development Cooperation
The Kingdom of The Netherlands

UNITED KINGDOM PROGRAMME

In addition to its international agenda, the Global Safe Abortion Conference maintained a parallel programme exploring significant developments, challenges and opportunities around abortion law and practice in the United Kingdom.

Introduction

The **Global Safe Abortion Conference** was launched in London on the eve of the 40th anniversary of the 1967 Abortion Act, amidst heightened media interest in the issue. The months preceding the event were marked by extraordinary political and public debate about later abortion. Inspired by the successes of their US counterparts, the British anti-abortion movement had launched a determined attack to reduce the 24-week time limit on provision of abortion. 4D ultrasound-scan pictures of foetuses “smiling” in the womb and claims that foetal viability had significantly improved dominated the tabloid press, leaving little room for discussion of the difficult circumstances facing women who need later abortion. The relentless anti-abortion campaign led to a parliamentary enquiry into “scientific developments relating to the Abortion Act of 1967” in which Members of Parliament (MPs) from the Science and Technology Select Committee concluded that no evidence supported lowering the abortion time limit.

In this context, the conference provided a unique platform to explore challenges and opportunities ahead. It played a key role in bringing together key actors, inspiring advocates and galvanising abortion rights support across the UK.

“In the UK, 83 percent of the general public support a woman’s right to have an abortion, yet the anti-abortion lobby continue to dominate the debate.”

Anne Quesney, Head of Advocacy
Marie Stopes International
(formerly Director, Abortion Rights)

Presentation overview

Marie Stopes International’s Director of UK and Western European Programmes, Liz Davies, and Senior Clinical Consultant, Dr John Spencer, outlined the basis of the law governing abortion provision in Great Britain—the 1967 Abortion Act as amended by the Human Fertilisation and Embryology Act (1990)—and reviewed current legal, social and medical barriers to access.

Ms Davies pointed to the irony that although the United Kingdom was one of the first countries in the world to introduce a comprehensive legislative framework governing provision of abortion, its law was now sadly anachronistic in comparison to many other countries that had introduced legislation in more recent times.

The legal stipulation requiring two doctors to give written permission for any abortion to be carried out is a central flaw. By requiring women to seek “permission” for abortion, it constitutes a major barrier to equality for 21st century women in the UK, who are denied privacy and autonomy with regard to their own fertility by an

act of legislation. Not surprisingly, most countries that enacted abortion legislation after Great Britain introduced abortion on request, at least in the first trimester.

Placing decisionmaking into the hands of doctors makes them gatekeepers, not facilitators. It also raises the issue of conscientious objection and leads to a small proportion of doctors actively working to deny women access to a service that is lawfully available to them.

Other barriers inhibiting women's access to safe abortion included:

- long wait times to access abortion services, principally in the National Health Service (NHS) sector, where waits still often exceeded three weeks or more
- vocal and highly mobilised opposition groups which, despite representing a tiny minority of public opinion, nevertheless were mounting successful challenges to abortion access by relying on spurious "research" findings linking abortion to breast cancer, infertility and mental health issues; in the parliamentary arena the same groups were mounting challenges to reduce the 24-week limit on abortion and to force women to have counselling or a compulsory "breathing space" between consultation and procedure
- increasing reliance on NHS-supported agencies and non-NHS providers for performance of second-trimester abortions
- the increasing reluctance of some medical practitioners to engage in training and subsequently to provide abortion services to women
- denial to all women from Northern Ireland of access to an NHS abortion where they reside, forcing them to travel to England or elsewhere and to pay privately

Ms Davies also challenged arguments put forward by those who claim that there are too many abortions in Britain today, that the abortion process is "too easy," and that liberalising the law would merely exacerbate the problem. There is no link between the decision to have an abortion and the nature of the service being offered. Most women who make a decision to have an abortion do so without any real prior knowledge of what that decision will mean in practice.

"If you accept the premise that a woman is entitled to safe, legal abortion under the law, then there is simply no logic in the argument that it should be an obstacle course of obstruction and delay. This will only increase the fear and anxiety of women, and push them towards later abortion."

Liz Davies
Marie Stopes International

Dr Kate Paterson, Consultant Gynaecologist at St Mary's Hospital, London, explored the controversial issue of late abortion. She looked at definitions of "later abortion," which can vary substantially in different contexts and from different perspectives. She went on to discuss methods of procuring late abortion, both medical and surgical, citing recent advances in both arenas, from introduction of mifepristone and misoprostol in medical induction to cheaper scanners and better methods of cervical preparation for surgical procedures,

Reasons women seek later abortions include:

- a late diagnosis of pregnancy
- a change in personal circumstances
- denial of pregnancy, especially among younger women
- discovery of foetal abnormalities at later gestational ages
- administrative delays

Dr Paterson added that women presenting for later abortion often require more sensitive handling and more counselling, as their pregnancies often start out as being very much wanted.

Dr Kate Guthrie, Clinical Director of the Hull and East Riding Sexual and Reproductive Healthcare Partnership, provided delegates with an overview of challenges and barriers to accessing a good abortion service from the perspective of an NHS primary care trust (PCT). She noted that the move from central purchasing of services to a greatly devolved system with a focus on targeted assessments of local populations' needs was designed to increase access and improve health services, but that it had created several barriers to high-quality abortion services, related to access, process and resources. She defined these as:

Access barriers:

- difficulties securing appointments with General Practitioners (GPs) and practice nurses
- fewer GPs willing to refer, and lack of training and engagement in the issue of abortion among all levels of the medical profession
- closure of family planning clinics
- distances some women have to travel to access services
- waiting times for clinics and hospitals, and arbitrary regulations about who qualifies for abortion

Process barriers:

- bureaucracy involved in women's obtaining referral from GPs to abortion service providers
- resource barriers
- PCTs' lack of funding for abortion procedures
- shortage of PCT medical personnel trained in abortion procedures
- lack of sex education and advice in the local community

Representatives of **the UK Department of Health (DoH)** outlined their priorities, which included improving provision of and access to abortion within the current legal framework. With that in mind, the DoH was conducting pilot studies on provision of Early Medical Abortion (EMA) in community settings.

DoH funding for abortion services had increased. In 2007, 89 percent of abortions were funded by the NHS; of these, just over half (57 percent) took place in the independent sector under NHS contract. The DoH was giving priority to ensuring that an increasing number of procedures were carried out as early as possible. In 2007, 90 percent of abortions were carried out at under 13 weeks gestation, and 70 percent were at under 10 weeks.

But unfortunately the DoH failed to endorse calls for reform and did not publicly acknowledge that proposed amendments would improve early access as well as save valuable government resources and public funding.

The Royal College of Nursing (RCN) spoke in support of moves to enable suitably trained nurses to carry out abortions, including prescribing the medication required for EMA and performing early surgical procedures. Allowing all suitably trained healthcare practitioners to perform abortions would have a big impact on abortion provision. Across Britain, nurses are already involved in the care of women having abortions and carry out virtually all tasks in provision of both first- and second-trimester medical abortion except prescribing drugs. Formalising the role of nurses and other appropriate healthcare practitioners involved in abortion care would facilitate access to abortion services, reduce waiting times and minimise delays many women face when seeking abortion.

The situation regarding access to safe abortion is critical in **Northern Ireland**, the only part of the UK where abortion remains illegal, barring extreme circumstances. For the past 40 years, Northern Irish women have been forced either to carry unwanted pregnancies to term or to travel to mainland Britain or another European country such as Spain or the Netherlands to obtain safe, legal abortion—a healthcare service that is free and available from the National Health Service to all other women who are citizens of the United Kingdom.

Guidance for professionals on providing abortion in Northern Ireland was so unclear that in 2001 the fpa (Family Planning Association) sought, and, on appeal, won a Court ruling requiring the DoH to issue guidelines to health professionals. *Termination of Pregnancy: the Law and Clinical Practice in Northern Ireland* was finally published in March 2009 and indicates a small step in the right direction. Pro-choice groups in Northern Ireland are relatively pleased with the guidance and especially welcome clarification that each Health and Social Care Trust must ensure that its patients have access to termination of pregnancy (TOP) services. Significantly, the document states that General Practitioners (GPs) must have alternative arrangements in place where there is conscientious objection. It also mentions that information should be available for both women and healthcare professionals on the choices available within the service, on routes of access to the service and ensuring clear referral and care pathways are in place.

Official figures show that in 2007, 1,343 women travelled from Northern Ireland to England for an abortion. They paid an average of about £2,000 for travel, accommodation and the abortion procedure, underscoring the huge financial and emotional cost women bear at a vulnerable time. Official data further show that almost 50,000 women have travelled from Northern Ireland to England to access abortion since the 1967 Abortion Act came into effect. Given that some women give false addresses when accessing services in England, or seek abortions in other European countries, these numbers are likely to be conservative estimates.

“No Act of Parliament can abolish abortion, but it can make the difference between safe and unsafe abortion, as the 1967 Act has.”

Lord David Steel

Future directions

A pioneering piece of legislation at the time, the 1967 Act is now out of step with clinical practice and technology, including the advent of medical abortion, and with women's needs. A government Bill tabled in 2007 to review the Human Fertilisation and Embryology Act of 1990, which would also allow abortion legislation to

be amended, gave rise to great hopes and fears among both abortion rights and anti-abortion camps: Abortion rights supporters feared that, in spite of all available scientific evidence, the minority anti-abortion lobby would successfully roll back the time limit, but they also harboured great hope that with a large abortion rights majority in Parliament, the law could at last be modernised.

Finally, in May 2008, Members of Parliament voted on a first series of amendments aiming to reduce the time limit to anything between 12 and 22 weeks. When a significant majority voted to retain the 24-week limit, the abortion rights movement felt a huge sense of relief. Emboldened by the victory, campaigners proposed modernising amendments ahead of the second passage of the Bill in October.

These included:

- removing the legal requirement for two doctors' signatures to authorise abortions
- allowing suitably trained nurses and other healthcare practitioners to carry out abortions
- extending the locations where abortions can take place to the primary-care level
- allowing women the option of completing early medical abortion at home
- ensuring that anti-abortion organisations are transparent about their position when offering pregnancy "counselling"
- clarifying the limits of conscientious objection with respect to provision of contraception
- extending the 1967 Act to Northern Ireland

In a cowardly move, however, in October 2008 the government refused to allow time for debate on abortion. By opting for the status quo, British Parliamentarians missed a huge opportunity to make a stand for women's reproductive rights. Efforts to ensure policy changes to improve access to and provision of EMA are ongoing.

"... The two-doctors requirement in the current Act causes undesirable delays, and since 1967 many European neighbours have legislated to make abortion available without such requirements. ... I believe we should now change the law [i.e., abolish the need for two doctors to authorise abortions]."

Lord David Steel

Global Call to Action for Women's Access to Safe Abortion

on the occasion of the Global Safe Abortion Conference,
London, 23-24 October 2007

We are women and men, young and old, professionals, elected officials, civil servants, researchers, students, and advocates committed to the health and human rights of women.

We sign this Global Call to Action to demand that women everywhere facing unwanted pregnancies be treated with respect and compassion and have **full access to legal, voluntary, safe, and affordable abortions** as part of comprehensive sexual and reproductive health care.

It is intolerable that:

- Millions of women continue to suffer severe injuries and trauma, and more than **66,000 die needlessly each year** from abortions that are procured unsafely from unskilled providers or self-induced, almost all in developing countries. Others are criminalised or imprisoned.
- Women throughout the developing world are often **denied the information and means to prevent unwanted pregnancy**; many also face sexual violence, often resulting in pregnancy, without adequate protection or treatment.
- The **contraceptive and abortion technologies to save women's lives have been well known for decades, yet these technologies are often not used** because of politically and ideologically-motivated interference; restrictive laws; inappropriate, inaccessible, and poor quality services; lack of resources; or other barriers.
- With few exceptions, donor and government programmes aimed at the Millennium Development Goal to improve maternal health **neglect the 13 per cent of maternal deaths caused by unsafe abortion globally** and fail to support the full range of preventive actions required.

We call for a global safe abortion movement promoting the following goals:

- **Women's rights to contraception and safe abortion are protected and supported through reformed laws and policies at all levels.**
- **Governmental authorities and donors commit increased resources** to ensure that comprehensive sexual and reproductive health care, including contraception and safe abortion services, is widely available through skilled providers in both public and private health systems.
- **Medical training institutions routinely provide training in abortion-related care** for physicians, nurses, midwives, and other healthcare workers.
- **Women and healthcare providers are informed about women's legal rights and reproductive options**, and know where contraception, safe abortions and other reproductive health care can be obtained.
- **Women in vulnerable circumstances have access to comprehensive sexual and reproductive health care** that responds to their special needs - including young women and women who are poor, are refugees or displaced, or are survivors of sexual violence.

**We will form new alliances with all who support these goals and the need for urgent action.
We will hold accountable all those who by their words or actions stand in the way.
The lives and health of millions of women are at stake. We will be heard, and we will act now.**

www.globalsafeabortion.org

SELECTED RESOURCES in addition to conference presentations

Berer, Marge. 2009. Provision of abortion by mid-level providers: international policy, practice and perspectives. *Bulletin of the World Health Organization*, 87:58-63.

Boland, Reed and Laura Katzive. 2008. Developments in laws on induced abortion: 1998-2007. *International Family Planning Perspectives*, 34(3): 110-20.

Grimes, David A., Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E Okonofua, Iqbal H Shah. 2006. Unsafe abortion: the preventable pandemic. *The Lancet*, 368: 1908-19.

Guttmacher Institute. 2007. *Abortion: Worldwide levels and trends*. New York: Guttmacher Institute.

Johnston, Heidi B., Maria F. Gallo, Janie Benson. 2007. Reducing the costs to health systems of unsafe abortion: a comparison of four strategies. *Journal of Family Planning and Reproductive Health Care*, 33(4): 250-257

Sedgh, Gilda, Stanley Henshaw, Elisabeth Ahman, Iqbal H. Shah. 2007. Induced abortion: estimated rates and trends worldwide. *The Lancet*, 370: 1338-45.

Singh, Susheela. 2006. Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *The Lancet*, 368: 1887-92.

World Health Organization. 2007. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. Fifth edition*. Geneva: World Health Organization.

---. 2003. *Safe abortion: Technical and policy guidance for health systems*. Geneva: World Health Organization.

APPENDIX: CONFERENCE PROGRAMME

DAY ONE – TUESDAY 23RD OCTOBER, 2007

08.45 – 09.30 Registration and Refreshments

SESSION ONE: 09.30 – 11.00

Abortion: The Political and the Personal

Seminar Location: Fleming Room – 3rd Floor

Session Chair: Christine McCafferty MP

Chair of Parliamentary All Party Group on Population, Development and Reproductive Health

09.30 - 10.00 **Welcome and overview**

Dana Hovig, *Chief Executive*, MARIE STOPES INTERNATIONAL

Elizabeth Maguire, *President and CEO*, IPAS

Anne Quesney, *Director*, ABORTION RIGHTS

10.00 – 10.15 **Perspectives on Progress in Women's Access to Abortion**

Mark Lowcock, *Director General, Policy and International Division*, DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID)

10.15 – 10.30 **Permission denied: Harnessing the outrage that allows us to ignore women**

Professor Fred Sai, *Advisor to the President of Ghana and former Senior Population Advisor to the World Bank*

10.30 – 10.45 **Bringing it back to the personal**

Dr Christine Kaseba-Sata, *Consultant Obstetrician/Gynaecologist*, UNIVERSITY TEACHING HOSPITAL, ZAMBIA

10.45 – 11.00 **Questions and Discussion**

11.00 – 11.30 **Refreshments and Exhibition**

SESSION TWO: 11.30 – 13.00

INTERNATIONAL KEYNOTE SESSION

**Abortion: The Realities,
the Risks, the Rights**

Seminar Location: Fleming Room – 3rd Floor

Session Chair: Gill Greer, *Director-General,*
INTERNATIONAL PLANNED PARENTHOOD FEDERATION

- 11.30 – 11.45 **Reviewing the Evidence on the Impact of Unsafe Abortion**
Dr Akinrinola Bankole, *Director of International Research,*
GUTTMACHER INSTITUTE
- 11.45 – 12.00 **Risks to Vulnerable Groups**
Ambassador Dr Eunice Brookman-Amisah, *Vice President,* IPAS, AFRICA
- 12.00 – 12.30 **Abortion as a Human Right**
Luisa Cabal, *Director, International Legal Program,* CENTRE FOR REPRODUCTIVE RIGHTS
Dr Angela Melo, *Special Rapporteur on the Rights of Women in Africa*
- 12.30 – 12.45 **Human Rights Perspectives on Abortion**
Stephanie Schlitt, *Reproductive Rights Coordinator, Gender Unit,* AMNESTY INTERNATIONAL
- 12.45 – 13.00 **Questions and Discussion**
- 13.00 – 14.15 **Buffet Lunch and Exhibition**

DOMESTIC KEYNOTE SESSION

**Confronting the Barriers to
Abortion Access**

Seminar Location: Whittle Room – 3rd Floor

Session Chair: Sam Rowlands
Honorary Senior Lecturer, WARWICK MEDICAL SCHOOL

- 11.30 – 11.45 **Overview**
Liz Davies, *Director of UK Operations,* MARIE STOPES INTERNATIONAL
- 11.45 – 12.00 **Medical Barriers**
Dr John Spencer, *Senior Clinical Consultant,* MARIE STOPES INTERNATIONAL
- 12.00 – 12.15 **Late Abortion**
Dr Kate Paterson, *Consultant Gynaecologist,* ST MARY'S HOSPITAL, LONDON
- 12.15 – 12.30 **NHS Barriers – A Primary Care Trust Perspective**
Dr Kate Guthrie, *Clinical Director,* HULL AND EAST RIDING SEXUAL AND REPRODUCTIVE HEALTHCARE PARTNERSHIP
- 12.30 – 13.00 **Questions and Discussion**

SESSION THREE: 14.15 – 15.05

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 1: Abortion Needs Among Refugees and Displaced People

Seminar Location: Whittle Room – 3rd Floor

Moderator: Dr Therese McGinn, *Mailman School of Public Health, COLUMBIA UNIVERSITY USA, Director, RAISE INITIATIVE*
Dr Ndola Prata, *School of Public Health, UNIVERSITY OF CALIFORNIA BERKELEY, USA*
Mr Fred Mubiru, *Research, Monitoring and Evaluation Officer, MARIE STOPES INTERNATIONAL UGANDA*
Ms Marleen Bosmans, *Political Scientist and affiliate of the International Centre for Reproductive Health, GHENT UNIVERSITY*

Seminar 2: Assessing The Cost Of Abortion

Seminar Location: Henry Moore Room – 4th Floor

Moderator: June Wyer, *Contracts and Operations Manager, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*
Dr Heidi Bart Johnston, *Social Scientist, ICDDR BANGLADESH*
Armin Neogi, *Senior Manager, Monitoring And Evaluation, FAMILY PLANNING ASSOCIATION, INDIA*

Seminar 3: Improving Access To Quality Services: Two Country Case Studies

Seminar Location: Rutherford Room – 4th Floor

Moderator: To be announced
Dr Nguyen Quoc Chinh, *Vice Director, HO CHI MINH CITY REPRODUCTIVE HEALTH CARE CENTRE*
Ben Rolfe, *Research and Reproductive Health Specialist, OPTIONS CONSULTANCY, REDUCTION IN MATERNAL MORTALITY PROGRAMME*

Seminar 4: HIV and Reproductive Choice – Integrating the Agenda

Seminar Location: Abbey Room – 4th Floor

Facilitator: Jennifer Gatsi Mallet, *Programme Coordinator, INTERNATIONAL CONFEDERATION OF WOMEN LIVING WITH HIV/AIDS, NAMIBIA*
Facilitator: Marion Stevens, *Project Manager, HEALTH SYSTEMS TRUST, SOUTH AFRICA*

Seminar 5: Why Women Have Abortions

Seminar Location: St James's Suite – 4th Floor

Moderator: Lucy Palmer, *Senior Programme Support Manager, MARIE STOPES INTERNATIONAL, UK*
Aamna Khalid, *Behaviour Change Communication Consultant, MINISTRY OF HEALTH, PAKISTAN*

Seminar 6: Mid-Level Providers and Abortion— Global Experience

Seminar Location: Wordsworth Room – 4th Floor

Moderator: Martha Campbell, *President, VENTURE STRATEGIES, Lecturer, School Of Public Health, UNIVERSITY OF CALIFORNIA, BERKELEY, USA*
Nguyen Bich Hang, *Programme Director, MARIE STOPES INTERNATIONAL, VIETNAM*
Dr Chelsea Morrone, *Doctor, Women's Health Research Unit, UNIVERSITY OF CAPE TOWN*
Vicki Saporta, *President and CEO, NATIONAL ABORTION FEDERATION*

Seminar 7: Ensuring Women's Access to Medical Abortion in their Own Communities

Seminar Location: Fleming Room – 3rd Floor

Facilitated by: Dr Bela Genatra, *Senior Research and Policy Advisor for Asia, IPAS*
Dr Hilary Bracken, *Senior Program Associate, GYNUITY HEALTH PROJECTS*
Dr Laura Miranda, *Programme Director, MARIE STOPES INTERNATIONAL, MEXICO*
Busi Kunene, *Director of Maternal Health, REPRODUCTIVE HEALTH RESEARCH UNIT, SOUTH AFRICA*

Seminar 8: Crossing Borders to Obtain Abortion Care

Seminar Location: Chaucer Room – 4th Floor

Moderator: Stefanie Wallach, *Strategic Projects Manager, MARIE STOPES INTERNATIONAL, UK*
Claudia Diaz, *Senior Researcher, NATIONAL INSTITUTE OF PUBLIC HEALTH, Consultant, POPULATION COUNCIL, MEXICO*
Video Screening of: LIKE A SHIP IN THE NIGHT, a film by Melissa Thompson, *Director and Filmmaker, IRELAND – Introduced by Kirsten Sherk, Senior Associate for Media Relations, IPAS, USA*

SESSION THREE: 14.15 – 15.05 *continued*

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 9: Issues Around Later Abortion in the UK

Seminar Location: Keats Room – 4th Floor

Moderator: Dr Peter Waweru, *MDT Medical Advisor, MARIE STOPES INTERNATIONAL, KENYA*
Dr Ellie Lee, *Senior Lecturer in Social Policy, UNIVERSITY OF KENT, UNITED KINGDOM*
Dr Kate Worsley, *Head of Medical Development Team, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*

Seminar 10: Abortion and Young People in the UK

Seminar Location: Shelley Room – 4th Floor

Moderator: Ros Davies, *Chief Executive, WOMEN AND CHILDREN FIRST, UNITED KINGDOM*
Martha Bishop, *Project Manager, BROOK SEXUAL HEALTH SERVICES FOR YOUNG PEOPLE, UNITED KINGDOM*
Natalie Misaljevich, *Operations Director, EDUCATION FOR CHOICE, UNITED KINGDOM*

Seminar 11: Attitudes Toward Pregnancy and Abortion In Europe

Seminar Location: Westminster Suite – 4th Floor

Moderator: Julie Douglas, *Marketing Manager, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*
Ann Furedi, *Chief Executive, BPAS, UNITED KINGDOM*
Dr Cecile Wijssen, *RUTGERS NISSO GROEP, THE NETHERLANDS*

Seminar 12: Changes in Abortion Provision and Practice

Seminar Location: Byron Room – 4th Floor

Moderator: Dr Oscar Ambani, *MDT Medical Advisor, MARIE STOPES INTERNATIONAL, KENYA*
Dr Susanna Rance, *CIDES-UMSA, LA PAZ, BOLIVIA*
Lily Liu Liquing, *Programme Director, MARIE STOPES INTERNATIONAL CHINA*
Elizabeth Oliveras, *Operations Research Scientist, ICDDR, BANGLADESH*

SESSION FOUR: 15.10 – 16.00

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 13: Clandestine Abortion Providers

Seminar Location: Wordsworth Room – 4th Floor

Moderator: Aika van der Kleij, *WOMENS GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS*
Speakers: Anonymous

Seminar 14: Using Media and Communications to Increase Access to Abortion

Seminar Location: Henry Moore Room – 4th Floor

Moderator: Michael Holscher, *Director External Relations and New Business, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*
Mayowa Joel, *Head, Research and Communication Unit, DEVCOMMS, NIGERIA*
Melanie Croce-Galis, *Senior Communications Associate, GUTTMACHER INSTITUTE, USA*

Seminar 15: Attitudes and Expectations Around Abortion

Seminar Location: Rutherford Room – 4th Floor

Moderator: Dr Agnes Mnguni, *MDT Medical Advisor, MARIE STOPES INTERNATIONAL, SOUTH AFRICA*
Prof Colin Francome, *Emeritus Professor, MIDDLESEX UNIVERSITY, UNITED KINGDOM*
Louise Bury, *Research, Monitoring and Evaluation Manager, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*
Dr Harry Cohen, *Medical Director, MARIE STOPES INTERNATIONAL IN AUSTRALIA, PERTH, AUSTRALIA*

SESSION FOUR: 15.10 – 16.00 *continued*

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 16: Extending Access to Northern Ireland

Seminar Location: Byron Room – 4th Floor

Moderator: Gabrielle Malone, *Centre Manager*, MARIE STOPES REPRODUCTIVE CHOICES, IRELAND
Audrey Simpson, *Director*, FPANI, NORTHERN IRELAND

Seminar 17: The Impact of Medical Abortion Around The World

Seminar Location: Fleming Room – 3rd Floor

Moderator: Kathy Toner, *Programme Officer*, DAVID AND LUCILE PACKARD FOUNDATION, USA
Dr Laila Shah, *Medical Development Team Leader*, MARIE STOPES SOCIETY, PAKISTAN
Dr Sarah Saleem, *Assistant Professor*, AGA KHAN UNIVERSITY, PAKISTAN
Dr Guadalupe Mainero, *Physician*, COMUNICACIÓN E INTERCAMBIO PARA EL DESARROLLO HUMANO EN AMÉRICA LATINA, MEXICO

Seminar 18: Barriers to Access

Seminar Location: Abbey Room – 4th Floor

Moderator: To be announced
Marijke Alblas, *Medical Consultant*, WESTERN CAPE DEPARTMENT OF HEALTH, SOUTH AFRICA
Marion Stevens, *Project Manager*, HEALTH SYSTEMS TRUST, SOUTH AFRICA
Dawn Fowler, *Canadian Director*, NATIONAL ABORTION FEDERATION, CANADA
Elizabeth Oliveras, *Operations Research Scientist*, ICDDR, BANGLADESH

Seminar 19: Trends in Medical Abortion Provision in the United Kingdom

Seminar Location: Keats Room – 4th Floor

Moderator: Caroline Lewis-Jones, *Leeds Centre Manager*, MARIE STOPES INTERNATIONAL, UNITED KINGDOM
Dr Kate Worsley, *Head of Medical Development Team*, MARIE STOPES INTERNATIONAL, UNITED KINGDOM

Seminar 20: The Influence of Islam on Abortion Access

Seminar Location: St James's Suite – 4th Floor

Moderator: Dr Yasmin Ahmed, *Programme Director*, MARIE STOPES CLINIC SOCIETY, BANGLADESH
Leila Hessini, *Senior Policy Advisor*, IPAS, USA
Professor Gheyas Uddin Siddiqui, *Chairman*, Department Of Social Work, UNIVERSITY OF BALOCHISTAN, PAKISTAN
Dr Zeba Sathar, *Country Director*, POPULATION COUNCIL, PAKISTAN

Seminar 21: Output Based Aid

Seminar Location: Shelley Room – 4th Floor

Moderator: David Griffith, *Consultant*, KfW ENTWICKLUNGSBANK, GERMANY
Srabani Majumder, *Department of Health and Welfare*, GOVERNMENT OF INDIA
Jacqueline Routledge, *Programme Manager*, Commissioning for Health and Wellbeing, CENTRAL LANCASHIRE PRIMARY CARE TRUST, UNITED KINGDOM
Paul Cornellsen, *Programme Director*, MARIE STOPES SOUTH AFRICA

Seminar 22: Clarifying Values to Transform Attitudes About Abortion

Seminar Location: Whittle Room – 3rd Floor

Moderators: Katherine Turner, *Senior Training and Services Advisor*, IPAS
Mosotho Gabriel, *Country Director*, IPAS, SOUTH AFRICA

SESSION FIVE: 16.25 – 17.30

Exposing the Truth about the Opposition

Seminar Location: Fleming Room – 3rd Floor

Session Chair: Wanda Nowicka, President,
THE FEDERATION FOR WOMEN AND FAMILY PLANNING, ASTRA NETWORK, POLAND

- 16.25 – 16.40 Jon O'Brien, *President*, CATHOLICS FOR A FREE CHOICE, USA
- 16.40 – 16.55 Dr Arnoldo Toruño, *Obstetrician-gynaecologist*, NATIONAL AUTONOMOUS UNIVERSITY OF NICARAGUA
- 16.55 – 17.10 Dr Leslie Cannold, *Ethicist and author of 'The Abortion Myth'*, AUSTRALIA
- 17.10 – 17.30 Questions and Discussion
- 17.30 – 19.00 Drinks Reception

DAY TWO – WEDNESDAY 24TH OCTOBER, 2007

- 07.45 – 09.00 Registration for Day Two Delegates

BREAKFAST SEMINAR, COUNTRY FOCUS: 08.00 – 08.50

Delegates can select one seminar from the list below. Each session will include time for Q&A

Breakfast Seminar A: NEPAL Scaling Up After Legal Reform

Seminar Location: Henry Moore Room – 4th Floor

Moderator: Wendy Darby, *Asia Regional Director*, IPAS, USA

Anand Tamang, *Director*, CENTRE FOR RESEARCH ON ENVIRONMENT, HEALTH AND POPULATION ACTION

Dr Indira Basnett, *Country Program Manager*, DEPARTMENT OF HEALTH SERVICES, NEPAL

Breakfast Seminar B: NIGERIA Women Speak Out for Safe Abortion

Seminar Location: St James's Suite – 4th Floor

Moderator: Hauwa Shekarau, *Policy Associate*, IPAS, NIGERIA

Ramatu Bala Usman Halilu, *President*, NATIONAL COUNCIL OF WOMEN'S SOCIETIES, NIGERIA

Ezinwa Okoroafor, *Country Vice President*, FDA, NIGERIA

Breakfast Seminar C: INDIA Safe Abortions in India: Protecting Gains, Advancing Rights

Seminar Location: Shelley Room – 4th Floor

Moderator: Dr Bela Genatra, *Senior Research and Policy Advisor for Asia*, IPAS, INDIA

Dr Manisha Malhotra, *Assistant Commissioner - Maternal Health, Department of Family Welfare*, MINISTRY OF HEALTH AND FAMILY WELFARE, INDIA

Shveta Kalyanwala, *POPULATION COUNCIL*, INDIA

Dr Malabika Roy, *Deputy Director-General*, INDIAN COUNCIL OF MEDICAL RESEARCH, INDIA

Dr Asha George, *Coordinator*, COALITION FOR MATERNAL – NEONATAL HEALTH & SAFE ABORTION, INDIA

BREAKFAST SEMINAR, COUNTRY FOCUS: 08.00 – 08.50 *continued*

Delegates can select one seminar from the list below. Each session will include time for Q&A

Breakfast Seminar D: URUGUAY
A Risk-Reduction Approach To Safe Abortion

Seminar Location: Keats Room – 4th Floor

Moderator: Dr Rodolfo Gomez, *Senior Health Systems Advisor, IPAS, USA*

Leonel Briozzo, *Director, INICIATIVAS SANITARIAS, MONTEVIDEO, URUGUAY*

Alejandra Lopez Gomez, *Co-ordinator, WOMEN AND HEALTH IN URUGUAY MYSU, URUGUAY*

Breakfast Seminar E:
UNITED STATES OF AMERICA
Legal is not enough: How Abortion Access is Becoming a Myth in the USA

Seminar Location: Chaucer Room – 4th Floor

Moderator: Kristine Ziwick, *Media Director, EQUAL OPPORTUNITIES COMMISSION, UNITED KINGDOM*

Mara Clark, *ABORTION RIGHTS, UNITED KINGDOM (formerly HAVEN COALITION, NEW YORK, USA)*

Vicki Saporta, *President and CEO, NATIONAL ABORTION FEDERATION, USA*

Breakfast Seminar F: PAKISTAN
Enriching The Global Debate – A Case Study

Seminar Location: Abbey Room – 4th Floor

Moderator: Dr Yasmeen Qazi, *Country Representative, THE DAVID LUCILLE AND PACKARD FOUNDATION, PAKISTAN*

Mohsina Bilgrami, *Programme Director, MARIE STOPES INTERNATIONAL*

Kausar Khan, *Associate Professor, Department of Community Health Sciences, AGA KHAN UNIVERSITY, PAKISTAN*

Dr Neelofar Sami, *Senior Instructor, Department of Community Health Science, AGA KHAN UNIVERSITY*

Dr Zeba Sathar, *Country Director, POPULATION COUNCIL*

Breakfast Seminar G: MEXICO
Avant Garde Abortion Reform in Mexico City: How did it happen and what lies ahead?

Seminar Location: Rutherford Room – 4th Floor

Moderator: Sandy Garcia, *Director of Reproductive Health for Latin America and the Caribbean, POPULATION COUNCIL, MEXICO*

Maria Consuelo Mejia, *Director, CATHOLICS FOR THE RIGHT TO DECIDE, MEXICO*

Maria Luisa Sanchez Fuentes, *Executive Director, GIRE, MEXICO*

Maria Eugenia Romero, *Executive Director, EQUIDAD DE GENERO, MEXICO*

Laura Villa Torres, *Associate for Youth Programming, IPAS, MEXICO*

Breakfast Seminar H: UNITED KINGDOM
Moving the campaign forward

Seminar Location: Westminster Suite – 4th Floor

Moderator: Anne Quesney, *Director, ABORTION RIGHTS, UNITED KINGDOM*

Emily Thornberry, *MP, UNITED KINGDOM*

Sharon Greene, *UNISON, UNITED KINGDOM*
SESSION CANCELLED

Breakfast Seminar I: PERU AND NICARAGUA
Denial of Access to Therapeutic Abortions

Seminar Location: Wordsworth Room – 4th Floor

Moderator: Charlotte Hord Smith, *Policy Director, IPAS, USA*

Angela Heimbürger, *Americas Researcher, Women's Rights Division, HUMAN RIGHTS WATCH, USA*

Breakfast Seminar J:
POLAND / EASTERN EUROPE
Political and Cultural Challenges in Abortion Access

Seminar Location: Shelley Room – 4th Floor

Moderator: Wanda Nowicka, *President, THE FEDERATION FOR WOMEN AND FAMILY PLANNING, POLAND*

Daniela Draghici, *Board Member, ASTRA NETWORK and Policy Consultant, IPAS, ROMANIA*

SESSION SIX: 09.00 – 10.30

Women Deserve More: Using Law to Expand Access to Safe Abortion

Seminar Location: Fleming Room – 3rd Floor

Session Chair: Sue MacGregor, Journalist and Broadcaster, RADIO 4, UNITED KINGDOM

- 16.25 – 16.40 Jon O'Brien, *President, CATHOLICS FOR A FREE CHOICE, USA*
- 09.00 – 09.15 Barbara Hewson, *Attorney – Human Rights, Health and Public Law, HARDWICKE BUILDING, UNITED KINGDOM*
- 09.15 – 09.30 Monica Roa, *Programmes Director, WOMEN'S LINK WORLDWIDE, COLOMBIA*
- 09.30 – 09.45 Getachew Bekele, *Country Director, MARIE STOPES INTERNATIONAL ETHIOPIA*
- 09.45 – 10.00 Joanna Erdman, *Co-director of Program on Reproductive and Sexual Health Law, UNIVERSITY OF TORONTO, CANADA*
- 10.00 – 10.30 Questions and Discussion
- 10.30 – 11.00 Refreshments and Exhibition

SESSION SEVEN: 11.00 – 12.30

INTERNATIONAL KEYNOTE SESSION

Complacent No Longer: Finding New Ways to Serve Women's Needs

Seminar Location: Fleming Room – 3rd Floor

Session Chair: Dr Paul Van Look, Director, Department of Reproductive Health and Research, WORLD HEALTH ORGANISATION

- 11.00 – 11.15 **Medical abortion: New opportunities for meeting women's needs**
Dr Beverley Winikoff, *President, GYNUITY HEALTH PROJECTS*
- 11.15 – 11.30 **Providers as Advocates**
Dr Kamini Rao, *Chair, INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS, WOMEN'S SEXUAL AND REPRODUCTIVE RIGHTS COMMITTEE*
- 11.30 – 11.45 **Scaling Up National Health Services To Fulfil The Law**
Dr Gloria Asare, *Family Planning Coordinator, Reproductive and Child Health Department. GHANA HEALTH SERVICES*
- 11.45 – 12.30 **Questions And Discussion**

DOMESTIC KEYNOTE SESSION

Improving Choice, Increasing Access and Improving Debate

Seminar Location: Whittle Room – 3rd Floor

Session Chair: Ann Weyman, Chief Executive, FPA

- 11.00 – 11.15 **New Models for NHS Service Delivery**
Andrea Duncan, *Programme Manager, Sexual Health and HIV, DEPARTMENT OF HEALTH, UNITED KINGDOM*
- 11.15 – 11.30 **The Role of the Nurse and Abortion**
Kathy French, *Sexual Health Adviser ROYAL COLLEGE OF NURSING and Member, INDEPENDENT ADVISORY GROUP AT THE DEPARTMENT OF HEALTH, UNITED KINGDOM*
- 11.30 – 11.45 **Northern Ireland**
Goretti Horgan, *ALLIANCE FOR CHOICE, NORTHERN IRELAND*
- 11.45 – 12.15 **Abortion in the Media: Panel Discussion**
Moderator: Ann Furedi, *Chief Executive, BPAS, UNITED KINGDOM*
John Curtis, *Managing Director, MEDIA MEASUREMENT*
Marie O'Riordan, *Editor, MARIE CLAIRE UK*
Anne Atkins, *Novelist and Writer, UNITED KINGDOM*
Michelle Goldberg, *Auther and Journalist, USA*
- 12.15 – 12.30 **Questions And Discussion**

SESSION EIGHT: 13.30 – 14.20

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 23: Experiences with Abortion Law Reform

Seminar Location: Byron Room – 4th Floor

Moderator: Dr Hilary Standing, *Fellow*, INSTITUTE OF DEVELOPMENT STUDIES, UNITED KINGDOM
Cynthia Mugo, *Kenya Human Rights Commission*, REPRODUCTIVE HEALTH AND RIGHTS ALLIANCE, KENYA
Gilberta Soares, *BRAZILIAN CAMPAIGN FOR SAFE ABORTION*
Patience Aniteye, *Doctoral Student*, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, UNITED KINGDOM
Susannah Mayhew, *Lecturer*, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, UNITED KINGDOM
Andrea Cornwall, *Fellow*, INSTITUTE OF DEVELOPMENT STUDIES, UNITED KINGDOM

Seminar 24: Empowering Young People To Become Advocates for Abortion Rights Worldwide

Seminar Location: Fleming Room – 3rd Floor

Moderator: Maria Eugenia Miranda, *Journalist and Social Activist*, ARGENTINA
Doortje Braeken, *Senior Advisor*, Adolescents, INTERNATIONAL PLANNED PARENTHOOD FOUNDATION
Nadia Ribadeneira, *Youth Activist and Volunteer*, COORDINADORA POLITICA JUVENIL (CPJ), ECUADOR
Joana Chamusca Chagas, *Youth Coalition Member*, Co-chair HUMAN RIGHTS TASK FORCE, BRAZIL

Seminar 25: Increasing Access to Comprehensive Abortion Care

Seminar Location: Abbey Room – 4th Floor

Moderator: Giselle Carino, *Abortion Focal Point*, INTERNATIONAL PLANNED PARENTHOOD FEDERATION, WESTERN HEMISPHERE REGION, NEW YORK, USA
Marcel Vekemans, *Senior Medical Advisor (Abortion)*, INTERNATIONAL PLANNED PARENTHOOD FEDERATION, UNITED KINGDOM
Upeka de Silva, *Youth Officer (Abortion)*, INTERNATIONAL PLANNED PARENTHOOD FEDERATION, UNITED KINGDOM

Dr Vicente Díaz, *Executive Director*, MEXFAM, MEXICO

Maria Consuelo Mejia, *Executive Director*, CATHOLICS FOR A FREE CHOICE, MEXICO

Dr Leonel Briozzo, *Director*, INICIATIVAS SANITARIAS, URUGUAY

Seminar 26: Forty Years On: A New Model For UK Law Reform

Seminar Location: Keats Room – 4th Floor

Moderator: Anne Quesney, *Director*, ABORTION RIGHTS, UNITED KINGDOM
Prof Wendy Savage, *Spokesperson*, DOCTORS FOR A WOMAN'S CHOICE ON ABORTION, UNITED KINGDOM
Mandy Myers, *Director of Nursing*, BPAS, UNITED KINGDOM
Dr Audrey Simpson, *Director*, FPANI, NORTHERN IRELAND
Natalie Misaljevich, *Operations Director*, EDUCATION FOR CHOICE, UNITED KINGDOM

Seminar 27: Expanding Access Within The Law

Seminar Location: St James's Suite – 4th Floor

Moderator: Carol Bradford, *Consultant in Sexual and Reproductive Health*, UNITED KINGDOM
Anand Tamang, *Director*, CENTRE FOR RESEARCH ON ENVIRONMENT, HEALTH AND POPULATION ACTION, NEPAL
Nongluk Boonthai, *WOMEN'S HEALTH AND REPRODUCTIVE RIGHTS FOUNDATION OF THAILAND*
Dr Samita Bhardwaj, *Medical Officer*, FPA INDIA

Seminar 28: Abortion Advocacy: A space for Global Sharing

Seminar Location: Shelley Room – 4th Floor

Moderator: Dr Sylvia Estrada Caludio, *Associate Professor*, UNIVERSITY OF THE PHILIPPINES
Marlene Gerber Fried, *Founding President*, NATIONAL NETWORK OF ABORTION FUNDS, Member, WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS, USA
Dr Rebecca Gomperts, *Founder*, WOMEN ON WAVES, THE NETHERLANDS
Christine Santos, *UNIVERSITY OF LEEDS*, UNITED KINGDOM
Evelyn Mutio, *REPRODUCTIVE HEALTH AND RIGHTS ALLIANCE*, KENYA

SESSION EIGHT: 13.30 – 14.20 *continued*

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 29: Moving to Substantive Equality for Women: Abortion Rights in International Law

Seminar Location: Henry Moore Room – 4th Floor

Moderator: Barbara Crane, Executive Vice President for Technical Leadership and Advocacy, IPAS, USA

Katherine McDonald, Executive Director, ACTION CANADA FOR POPULATION AND DEVELOPMENT (ACPD), CANADA

Professor Rebecca Cook, UNIVERSITY OF TORONTO, CANADA

Seminar 30: Threats to Abortion Access

Seminar Location: Chaucer Room – 4th Floor

Moderator: Mary Fjerstad, PLANNED PARENTHOOD CONSORTIUM OF ABORTION PROVIDERS, USA

Vicki Saporta, President and CEO, NATIONAL ABORTION FEDERATION, USA

Seminar 31: Advocacy: From the Grassroots to Governments

Seminar Location: Rutherford Room – 4th Floor

Moderator: Beth Frederick, INTERNATIONAL WOMEN'S HEALTH COALITION, USA

Catherine Maternowska, UNIVERSITY OF CALIFORNIA, USA

Julio Pacca, Country Representative, PATHFINDER INTERNATIONAL, MOZAMBIQUE

Seminar 32: Legal and Ethical Barriers Limiting Abortion Access

Seminar Location: Wordsworth Room – 4th Floor

Moderator: Mosotho Gabriel, Country Director, IPAS, SOUTH AFRICA

Professor Bernard Dickens, *Professor Emeritus of Health Law and Policy*, UNIVERSITY OF TORONTO, CANADA

Joanna Mishtal, *Postdoctoral Fellow and Research Scientist*, COLUMBIA UNIVERSITY, USA

Seminar 33: Second Trimester Abortion—Barriers to Access

Seminar Location: Westminster Suite – 4th Floor

Moderator: Dr Indira Basnett, Country Program Manager, DEPARTMENT OF HEALTH SERVICES, NEPAL

Dr Rodica Comendant, *International Consortium for Medical Abortion (ICMA) Coordinator*, REPRODUCTIVE HEALTH TRAINING CENTRE, MOLDOVA

Dr Veena Rani Shrivastava, Associate Professor, NEPAL MEDICAL COLLEGE, NEPAL

Seminar 34: Providers as Advocates

Seminar Location: Whittle Room – 3rd Floor

Moderator: Dr Wendy Chavkin, *Professor of Public Health and Obstetrics and Gynaecology*, COLUMBIA UNIVERSITY

Dr Juliet Bressan, *Founder*, DOCTORS FOR CHOICE, IRELAND

Dr Mirella Parachini, *Gynaecologist*, HOSPITAL OF SAN FILIPPO NERI, ROME, ITALY

Silvina Ramos, *Director*, CENTRE FOR THE STUDY OF STATE AND SOCIETY, ARGENTINA

SESSION NINE: 14.25 – 15.15

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 35: Can We Untie The Gag?

Seminar Location: Westminster Suite – 4th Floor

Moderator: Amy Coen, *President & CEO*, POPULATION ACTION INTERNATIONAL, USA

Andrew Arkutu, *Managing Director*, Board Member, PATHFINDER INTERNATIONAL, GHANA

Rosemarie Muganda Onyando, *Executive Director*, CENTRE FOR THE STUDY OF ADOLESCENCE, KENYA

Cara Hesse, *Director of Advocacy*, PATHFINDER INTERNATIONAL, USA

Seminar 36: Cross-Regional Experiences With Abortion Law Reform

Seminar Location: Wordsworth Room – 4th Floor

Moderator: Veena Siddharth, *Vice President for International Programmes*, PLANNED PARENTHOOD FEDERATION OF AMERICA (PPFA)

Sarah Onyango, *Regional Director for Africa*, PLANNED PARENTHOOD FEDERATION OF AMERICA, KENYA

Sona Sethi, *Regional Director for Asia*, PLANNED PARENTHOOD FEDERATION OF AMERICA, THAILAND

Heather Sayette, *Associate Regional Director for Latin America and the Caribbean*, PLANNED PARENTHOOD FEDERATION OF AMERICA

Seminar 37: Second Trimester Abortion—Country Experiences

Seminar Location: Abbey Room – 4th Floor

Moderator: Sue Baldock, *Clinical Services Manager*, MARIE STOPES INTERNATIONAL, UNITED KINGDOM

Dr Samita Bhardwaj, *Medical Officer*, FAMILY PLANNING ASSOCIATION, INDIA

Jane Harries, *Senior Researcher*, UNIVERSITY OF CAPE TOWN, SOUTH AFRICA

Seminar 38: Human Rights Accountability Strategies

Seminar Location: St James's Suite – 4th Floor

Moderator: Nancy Northup, *President*, CENTER FOR REPRODUCTIVE RIGHTS, USA

Luisa Cabal, *Director*, International Legal Program, CENTER FOR REPRODUCTIVE RIGHTS, COLOMBIA

Elisa Slattery, *Legal Adviser for Africa*, CENTER FOR REPRODUCTIVE RIGHTS, USA

Giannina Paredes, *Psychologist*, DEMUS (COMMITTEE FOR THE DEFENCE OF WOMEN'S RIGHTS), PERU

Seminar 39: From Endorsement to Implementation: The Maputo Plan of Action

Seminar Location: Fleming Room – 3rd Floor

Chair: Ambassador Dr Eunice Brookman-Amissah, *Vice President*, IPAS AFRICA

Hon Rebecca Kadaga, *Deputy Speaker*, UGANDA NATIONAL ASSEMBLY

Dr Chisale Mhango, *Director for Reproductive Health*, MINISTRY OF HEALTH, MALAWI

Dr Nono Simelela, *Director*, International planned parenthood federation UNITED KINGDOM

Seminar 40: How Law Affects Access To Abortion

Seminar Location: Rutherford Room – 4th Floor

Moderator: Julie Mundy, *CEO/Regional Representative*, MARIE STOPES INTERNATIONAL AUSTRALIA

Lynne Randall, *PLANNED PARENTHOOD CONSORTIUM OF ABORTION PROVIDERS*, USA

Mary Fjerstad, *PLANNED PARENTHOOD CONSORTIUM OF ABORTION PROVIDERS*, USA

SESSION NINE: 14.25 – 15.15 *continued*

Delegates are requested to select one seminar from the list below. Each session will include time for Q&A

Seminar 41: Ireland

Seminar Location: Chaucer Room – 4th Floor

Moderator: Richard Keene, *Coordinator, Safe and Legal (in Ireland) ABORTION RIGHTS CAMPAIGN, IRELAND*

Rosie Toner, *Director of Counselling, IRISH FAMILY PLANNING ASSOCIATION, IRELAND*

Rhonda Donaghy, *Trade Union Official, SIPTU, IRELAND*

Seminar 42: Strategic Advocacy With Institutions

Seminar Location: Whittle Room – 3rd Floor

Moderator: Joanna Mishtal, *Postdoctoral Fellow and Research Scientist, COLUMBIA UNIVERSITY, USA*

Dr Wendy Chavkin, *Professor of Public Health and Obstetrics Gynecology, COLUMBIA UNIVERSITY, USA*

Barbara Hewson, *Attorney – Human Rights, Health and Public Law, HARDWICKE BUILDING, UNITED KINGDOM*

Rebecca Cook, *Faculty Chair, International Human Rights, UNIVERSITY OF TORONTO*

Wanda Nowicka, *President, THE FEDERATION FOR WOMEN AND FAMILY PLANNING, ASTRA NETWORK*

Seminar 43: Challenges Implementing Safe Abortion Services in Low Resource Settings

Seminar Location: Henry Moore Room – 4th Floor

Moderator: Baroness Shreela Flather of Windsor and Maidenhead, *Board of Trustees Member, MARIE STOPES INTERNATIONAL, UNITED KINGDOM*

Swaraj Rajbhandari, *Technical Director, OPTIONS CONSULTANCY, REDUCTION IN MATERNAL MORTALITY PROJECT, CAMBODIA.*

Dr Kamela Thapa, *Programme Director, SUNUALO PARIVAR NEPAL*

Seminar 44: Campaigning Workshop

Seminar Location: Keats Room – 4th Floor

Moderator: Anne Quesney, *Director, ABORTION RIGHTS, UNITED KINGDOM*

Dr Rebecca Gomperts, *Founder, WOMEN ON WAVES, THE NETHERLANDS*

Jeannette Llaja, *Lawyer, Gender and Human Rights, DEMUS (COMMITTEE FOR THE DEFENCE OF WOMEN'S RIGHTS), PERU*

SESSION TEN: 15.45 – 17.15

Breaking from the Past: Looking to the Future

Session Chair: Dr Sara Seims, Director of the Population Program, HEWLETT FOUNDATION

- 05.45 – 16.00 **The 1967 Abortion Act and its Legacy – Domestic and International**
Lord Steel of Aikwood, *Architect of 1967 Abortion Act*, UNITED KINGDOM
- 16.00 – 16.15 **The Next Generation: What Young People Want from Abortion Services**
Laura Villa Torres, *Associate for Youth Programming*, IPAS
- 16.15 – 16.30 **Charting the Way Forward**
Prof Malcolm Potts, Population and Family Planning, UNIVERSITY OF CALIFORNIA, BERKELEY
- 16.30 – 16.45 **Safe Abortion as an International Development Priority**
Bert Koenders, *Minister for Development Cooperation of the Kingdom of the Netherlands*
- 16.45 – 17:00 **Questions and Discussion**
- 17.00 – 17.15 **Final Remarks**
Dr Bene Madunagu, *Vice Chair*, IPAS Board of Directors, and Co-founder and Chair, GIRLS' POWER INITIATIVE, NIGERIA
Anne Quesney, *Director*, ABORTION RIGHTS
Mohsina Bilgrami, *Programme Director*, MARIE STOPES INTERNATIONAL
- 17:15 **Close of Conference**

