The evidence speaks for itself:

TEN FACTS ABOUT ABORTION

Ipas
Health. Access. Rights.

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Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or her health because she lacks safe reproductive health choices.

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Introduction

Abortion is a controversial issue. Those opposed to abortion's availability and legality have actively peddled misinformation in order to curtail women's access to a full range of reproductive choices. They aim to stigmatize the procedure, the providers and the women who get abortions. This is why Ipas has developed *Ten facts about abortion,* a resource providing scientifically derived data for reproductive rights advocates.

The anti-abortion movement has created and propagated many myths, intended to cast abortion as a dangerous procedure that should be prohibited. These distortions of science and good health practices have a detrimental effect on women's health, rights and lives. Unfortunately, these myths have gained traction in some circles.

The pro-choice community's support for a woman's right to have an abortion is based on science, history and human rights. We have an abundance of scientific evidence to refute misinformation about abortion, from the falsehood that abortion causes breast cancer to the notion of a "postabortion syndrome."

This manual serves as a quick reference guide for pro-choice advocates. The guide offers factual evidence debunking ten widely disseminated abortion myths, and provides supporting background information and resources. We hope this guide will help reproductive rights activists to confidently respond to challenges to our work and to continue advocating for abortion based on clear, scientific and unbiased data.

1 Myth: Abortion results in "postabortion syndrome."

Fact: Postabortion syndrome is not a valid psychiatric diagnosis.

No scientific evidence exists to support the idea that women who have abortions experience so-called "postabortion syndrome." Because of the lack of scientific evidence, the American Psychiatric Association does not recognize "postabortion syndrome" as a legitimate mental health diagnosis (APA 2002).

Rigorous literature reviews analyzing the quality of studies that examine the mental health consequences of abortion conclude that the highest quality studies find *few, if any, differences among women who had abortions and women who had not had abortions in terms of long-term mental health outcomes* (Vignetta et al. 2008, Ney and Wicket 1989, Thorp et al. 2005). The American Psychological Association also supports these conclusions (APA 2008).

Reputable scientific studies also conclude that rates of psychiatric disorder are the same for women after abortion as after childbirth (Gilchrist et al. 1995); that women who abort are no more likely to be clinically depressed than women delivering an unwanted pregnancy (Schmiege and Russo 2005); and that violence, specifically rape, is associated with unwanted pregnancy and abortion (Coker 2007, Garcia-Moreno et al. 2005, Goodwin et al. 2000); as well as anxiety and other mental health problems (Adams and Bukowski 2007).

Well-conducted studies consistently find that *the strongest predictor of mental health **after** an abortion is the woman's mental health **before** the abortion.* When a woman's mental health prior to the abortion is not taken into account, postabortion mental health problems may seem to be an outcome of the abortion when in reality these conditions already existed.

Women's abortion experiences are diverse and vary across socioeconomic, religious and cultural contexts. Attempts to define all women's experiences as homogenous deliberately disregard the personal ways in which each individual woman lives, experiences and interprets her pregnancy and abortion.

Background:

The term *"postabortion syndrome"* was first coined in the early 1990s and is based on a 1992 study of 30 women in the United States. It posits that abortion is a traumatic experience that leads to severe mental health problems including depression, grief, anger, shame, substance abuse, sexual dysfunction, eating disorders and suicidal thoughts (Speckhard and Rue 1992, Speckhard 1985). "Postabortion syndrome" is defined by its defenders as a form of post-traumatic stress disorder (PTSD).

Women in the study's small sample were recruited *because* they defined their abortion experience as "highly stressful." Nearly half of the women included in the study had second-trimester abortions and some had their abortion before it was legally permitted in the United States. The study was therefore biased to represent only women in the United States who felt that their abortion experiences were negative.

2 Myth: Abortion causes breast cancer.

Fact: There is no causal relationship between abortion (spontaneous or induced) and an increase in women's risk for developing breast cancer.

Many studies with strong research designs conducted throughout the world with hundreds of thousands of women unanimously conclude that women who have had either spontaneous or induced abortions do not have a subsequent elevated risk for developing breast cancer. These conclusions are supported by the World Health Organization (WHO 2000) and by the Royal College of Obstetricians and Gynaecologists (RCOG 2004).

In 2003, the U.S. National Cancer Institute (NCI), held the Early Reproductive Events and Breast Cancer Workshop. More than 100 of the world's leading experts on pregnancy and breast cancer risk attended. The experts reviewed studies and found that:

- Breast cancer risk is increased for a short time after a pregnancy resulting in the birth of a living child;
- Neither induced nor spontaneous abortions are linked to an increase in breast cancer risk (NCI 2003).

In August 2003, the American College of Obstetricians and Gynecologists' (ACOG) Committee on Gynecologic Practice also reviewed the available evidence and published its own findings, which agreed with the NCI Workshop conclusions:

"More rigorous recent studies argue against a causal relationship between induced abortion and a subsequent increase in breast cancer risk" (ACOG 2003).

Background:

How a study is designed affects its results and conclusions. Studies that compare women with and without breast cancer encounter the problem of *recall bias* when they ask women to remember or *recall* their abortions. Studies show that recall bias is a concern because of the stigma attached to abortion. Healthy women tend to underreport past abortions while women with breast cancer tend to accurately report their reproductive history as they search for causes of their cancer.

Factors known to increase a woman's chance of developing breast cancer include age (a woman's chance of developing breast cancer increases as she gets older), family history of breast cancer, early age at first menstrual period, late age at menopause, late age at the time of birth of her first full-term baby and certain breast conditions. Obesity is also a risk factor for breast cancer in postmenopausal women (NCI 2008). Exercise and decreased exposure to estrogen over one's reproductive years may be protective factors against breast cancer.

3 Myth: Emergency contraception causes abortion.

Fact: Emergency contraception prevents pregnancy. If a woman is already pregnant, emergency contraception will have no effect on the pregnancy and will not cause an abortion.

Emergency contraception is birth control that prevents pregnancy up to five days after unprotected sex. The primary and very likely only mechanism of action is that emergency contraception (EC) stops or disrupts ovulation (Reznik 2010, UNDP et al. 2010, FIGO and ICEC 2008). This means that no mature egg is released from the ovary. If a mature egg is not released, then it cannot be fertilized and a woman cannot become pregnant. This is similar to the mechanism by which regular hormonal contraceptives work. EC use does not prevent a fertilized egg from attaching to the uterine lining.

The most widely available form of emergency contraception is levonorgestrel-alone Emergency Contraceptive Pills (LNG-ECPs), sometimes called "the morning after pill" and available under many brand names, including Norlevo, Postinor and Plan B. This is the regimen recommended by the World Health Organization and available in most countries.

Research shows that making ECPs more widely available does not adversely affect regular contraceptive use or

increase risk-taking, such as having unprotected sex (Polis et al. 2010).

Safety of LNG-ECPs

Levonorgestrel, the active ingredient in LNG-ECPs, has been widely used in various formulations for more than thirty years and has been extensively studied in women of reproductive age. LNG-ECPs have been found to be safe. Side effects from using LNG-ECPs are uncommon and generally mild (UNDP et al. 2010, FIGO and ICEC 2008).

LNG-ECPs cannot harm a pregnant woman or a developing fetus if they are taken early in pregnancy (WHO 2005). A study that compared pregnancy outcomes in women who used LNG-ECPs during their conception cycle with women who had not used LNG-ECPs found no differences in rates of miscarriage, birth weight, malformations or in the sex ratio at birth (Zhang et al. 2009).

LNG-ECPs are safe for use by all women, including adolescents (UNDP et al. 2010, FIGO and ICEC 2008). Research shows that the use of hormonal contraception, including ECPs, have no adverse effect on future fertility and that LNG-ECPs do not interrupt an established pregnancy or harm a developing embryo (Liskin and Rutledge 1984).

Most brands of oral contraceptives (OCs) can be used as post-coital contraception. The website, www.not-2-late.com has instructions, including brand names of OCs and how many pills need to be taken for them to serve as effective post-coital emergency contraception. It is important to have accurate information since the hormonal dosage varies by brand.

4 Myth: Pregnancy is safer than abortion.

Fact: Abortions performed by trained providers under hygienic conditions are much safer than pregnancy and childbirth.

The World Health Organization estimates that in 2008 approximately 358,000 women worldwide died from pregnancy and childbirth-related issues such as hemorrhage, hypertensive disorders, sepsis and infections, anemia and obstructed labor (WHO 2010). Earlier WHO estimates, reflecting data for 2003, indicate 66,500 deaths from complications related to unsafe abortion (WHO, 2007A). According to the World Health Organization, an unsafe abortion is the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or that takes place in an environment that does not meet minimal medical standards, or both (WHO 2003).

Context matters: 87 percent of women who die annually from pregnancy and childbirth live in poverty in Sub-Saharan Africa and South Asia. These women face enormous social, legal and economic barriers to obtaining prenatal care, emergency obstetric care and *safe* abortion services. As a result, they suffer from pregnancy complications that are preventable or treatable. These complications often result in death or long-term health problems. In developing countries, 59 women per 100,000 live births die from unsafe abortion complications (Hill et al. 2007, Shah and Say 2007, WHO 2007A), while an estimated 260 women die for every

100,000 live births due to pregnancy and childbirth (WHO 2010).

In developed countries where abortion is legally permitted and health-care providers are trained to offer safe services, abortion mortality is low — 0.2-2.0 deaths per 100,000 abortions (WHO 2007A, WHO 2007B) — though pregnancy-related mortality is approximately nine times higher, at nine deaths per 100,000 live births (Hill et al. 2007).

Background:

Global campaigns to reduce death related to pregnancy and childbirth include the Safe Motherhood Initiative and The White Ribbon Alliance for Safe Motherhood. One of the eight Millennium Development Goals (MDGs) adopted at the Millennium Summit is improving maternal health (MDG5) (United Nations Development Programme 2010). These initiatives all recognize that pregnancy and childbirth present serious risks to women's health and lives, particularly those women whose access to health services and education is limited. *Unsafe* abortion also is recognized by global health experts as an important risk factor for women's health and lives. Efforts to make safe abortion services available and accessible to women and to decrease the incidence of unsafe abortion are important so that their health and lives are preserved.

5 Myth: Legalizing abortion does not make it safe.

Fact: When women have access to safe, legal and affordable abortion, maternal death and injuries due to unsafe abortion decrease dramatically.

Restrictive laws that criminalize abortion do not stop women from obtaining unsafe abortions to end unwanted pregnancies (Sedgh et al. 2007). The legal framework regulating abortion directly affects the safety of the abortion procedure. Where abortion is not legally permitted, services are not regulated and cannot be provided openly. In countries where abortion is illegal, the risk of death and injury to women seeking abortion is on average 30 times higher than countries where abortion is legally permitted (Grimes et al. 2006).

Unsafe abortions occur primarily in the developing world where abortions are highly restricted by law.

Of the estimated 41.6 million abortions performed worldwide in 2003, almost half — 19.7 million —were unsafe abortions and took place in developing countries with highly restrictive abortion laws (Singh et al. 2009). Unsafe abortions are often performed by unskilled practitioners using dangerous methods in unhygienic conditions. They can also be self-induced by women inserting foreign objects or liquids into the vagina and/or cervix, drinking harmful substances, engaging in traumatic or dangerous physical activities, taking pharmaceutical

products, or manipulating the abdomen, among other methods.

Three well-documented case studies demonstrate how legalizing abortion increases the safety of the procedure.

Romania:

Before 1966, Romanian women could obtain safe, legal abortions through the country's health-care system. At that time, Romania's low maternal mortality rate was similar to that of other Eastern European countries with legal abortion. In 1966, President Nicolae Ceausescu criminalized both abortion and the use of contraceptives. This resulted in a huge increase in Romania's abortion mortality ratio from 16.9 per 100,000 live births in 1965 to 151.3 per 100,000 live births in 1982 — 10 times greater than any other European country with legal abortion (David 1999). From 1980 to 1989, approximately 500 Romanian women died annually from complications related to unsafe abortion. Following Ceausescu's ouster in 1989, Romania legalized abortion and contraception. This led to a 50 percent drop in maternal deaths in the first year after legalization (Stephenson et al. 1992).

South Africa:

In 1996, the Choice on Termination of Pregnancy Act (CTOP) liberalized abortion laws in South Africa. Based on a study conducted before legalization, in 1994, an estimated 45,000 women were seen annually in public hospitals for complications from unsafe abortion; of these, approximately 425 women died (Rees et al. 1997). Abortion-related maternal deaths declined by 91 percent in the seven years between 1994 and 2001 (Jewkes and Rees 2005). Serious morbidity also declined in the period between 1994 and 2000, from 17 to 10 percent among women seeking

postabortion care in South African hospitals (Jewkes et al. 2002).

North Carolina, USA:

From 1963 to 1972, 15 percent of all pregnancy-related deaths in North Carolina, USA, were due to unsafe abortion complications (Meyer and Buescher 1994). In 1973, the U.S. Supreme Court ruled in the case of *Roe v. Wade* that state laws restricting a woman's right to legal abortion were unconstitutional. Accordingly, the North Carolina state legislature amended its abortion statute to permit abortions during the first 20 weeks of pregnancy by licensed physicians in certified hospitals and clinics. Immediately following *Roe v. Wade,* from 1973 to 1977, the abortion-related maternal death rate declined by 85 percent in North Carolina compared with the previous period (Meyer and Buescher 1994).

Background:

Abortion data from 2003 indicate that the vast majority of abortions (92 percent) in industrialized countries with progressive abortion laws are *safe* as compared to developing countries with restrictive laws, where 55 percent of abortions are performed under *unsafe* and clandestine conditions (Sedgh et al. 2007). Young women disproportionately suffer immediate and long-term disability and death from complications related to unsafe abortion. In 2003, about 40 percent, or two in five of all unsafe abortions in developing regions were among young women under 25 (Shah and Ahman 2009).

According to the World Health Organization (WHO) 2003 abortion incidence data, approximately 70,000 women die annually worldwide as a result of unsafe abortions. The vast majority of these deaths occur in developing countries: 36,000 in Africa, 28,400 in Asia, and 2,000 in Latin America and the Caribbean (1,400 of these deaths are in South American countries) (WHO 2007).

6 Myth: Restricting access to abortion is the best way to reduce abortions.

Fact: The best way to reduce abortions is to reduce unintended pregnancies through comprehensive sexuality education, prevention of gender-based violence, and access to woman-centered and effective contraception.

Restricting access to *safe* abortion only increases women's risk for *unsafe* abortion. When women decide to terminate an unwanted pregnancy and do not have access to safe, legal abortion services provided by well-trained medical providers, they are forced to either self-induce or seek clandestine abortions, often provided by unqualified medical providers under unhygienic conditions.

Countries with permissive abortion laws, primarily developed countries, do not have increased rates of abortion whereas countries with highly *restrictive* abortion laws — primarily developing countries — do have high *unsafe* abortion rates (Sedgh et al. 2007). Forty percent of the world's women (ages 15-44) live under highly restrictive abortion laws in developing countries (Singh et al. 2009).

A 2009 Guttmacher Institute survey of 197 countries found that restricting access to legal abortion does not reduce the number of women trying to end unwanted pregnancies (Singh et al. 2009). Abortion rates are roughly equal when

comparing world regions, regardless of what the law permits. An estimated 70,000 women and girls die worldwide each year as a result of unsafe abortion, and millions suffer severe complications (WHO 2007). Of all *unsafe* abortions in 2003, 97 percent occurred in developing countries with restrictive abortion laws.

Where abortion is severely restricted, it often costs women their health and lives (Singh et al. 2009).

Background

Rigorous, well-conducted studies demonstrate that providing women and men with information about and access to contraception is the best way to reduce unplanned pregnancies and abortions. The American College of Obstetricians and Gynecologists (ACOG), the United States' leading professional association providing health care for women, found that *reducing unplanned pregnancies clearly contributes to lowering both rates of unsafe abortion and the overall level of abortion* (ACOG 2009).

ACOG strongly recommends that strategies to reduce unwanted pregnancies include:

- Comprehensive sexuality education;
- Improved access to effective contraceptive methods and emergency contraception for all women and girls who want to avoid pregnancy;
- Availability of safe, legal and accessible high-quality abortion services;
- Education about reproductive health and contraception, and training on abortion provision for all medical

students as an integral part of reproductive health education and as an integrated component of the obstetrics and gynecology residency training.

7

Myth: Medical abortion is dangerous and can kill women.

Fact: Medical abortion is a safe and effective option for terminating a pregnancy in the first trimester.

Medical abortion, also known as the "abortion pill," refers to pregnancy termination with abortion-inducing medications in place of surgical interventions. The World Health Organization recommends medical abortion, along with vacuum aspiration, as a safe method of terminating first-trimester pregnancy (WHO 2003, Winikoff et al. 1997). Women have used medications to induce abortion for centuries. Only in the last 25 years have evidence-based, safe and reliable medical regimens for abortion during the first trimester been developed (Creinin 2000). This is an important technological breakthrough for women's health.

Scientific studies show that when used correctly, medical methods for abortion in early pregnancy are safe and effective. The risk of death associated with medical abortion is remote and virtually identical to that with spontaneous miscarriage. The estimated death rate from medical abortion in the United States is 0.8 deaths per 100,000 procedures. This risk is indistinguishable from the death rate of 0.7 per 100,000 miscarriages. The risk of death from medical abortion is much lower than that associated with childbirth and other pregnancy-related causes (Grimes 2005).

The most effective medical abortion regimen is the combination of mifepristone (commonly referred to as RU-486, or the "abortion pill") and misoprostol (Christin-Maitre et al. 2000, Kulier et al. 2004).

Studies with strong research designs conducted globally with thousands of women conclude that this regimen can be delivered in safe, effective ways for women (Elul et al. 2001).

Background:

Since 1988, data on deaths and harm related to medical abortion in Europe and the United States show that death among the approximately 5.5 million women who have had medical abortions is extremely rare (Delchambre 2009). In other areas of the world, such as India and China, millions of women have received medical abortions but systems for tracking adverse outcomes are not in place or have not been reported. In the United States, eight deaths were caused by infection due to a rare organism, *Clostridium* (CDC 2005). This organism is not unique to medical abortion and women have also died from *Clostridium* after childbirth, miscarriage, surgical abortion and treatment for cervical disease among non-pregnant women (Fisher et al. 2005, Cohen et al. 2007, Ho et al. 2009). There have been eight deaths in Europe from various causes, primarily hemorrhage. One death involved a prostaglandin medication that is no longer used (Delchambre 2009). The estimated fatality rate from medical abortion in the United Kingdom and Europe using a mifepristone/misoprostol regimen for medical abortion is 0.2 deaths per 100,000 procedures (RCOG 2004, Delchambre 2009).

All medical procedures carry some risk. However, medical abortion is a very safe procedure, especially in comparison to other pregnancy outcomes. In the United States, for example, the risk of death in childbirth is 12.9 per 100,000 live deliveries (Grimes 2005), but maternal mortality in childbirth is much higher in some other countries; 900 women per 100,000 live births die in some developing regions (WHO 2007B).

Medical abortion is safe particularly in comparison to unsafe abortion, which millions of women resort to each year. The risk of death associated with unsafe abortion worldwide is estimated at 300 deaths per 100,000 unsafe abortion procedures, but in some regions of the world, risk is as high as 750 deaths per 100,000 unsafe abortion procedures (WHO 2007A).

8 Myth: If abortion is legal, women will use it as birth control.

Fact: Women who do not have information and access to reliable contraceptive methods face higher rates of unplanned pregnancy and may use abortion to terminate the pregnancy, regardless of the legality of abortion.

There is a direct correlation between lack of access to contraceptives and elevated abortion rates.

Approximately half of all unintended pregnancies worldwide end in abortion (Singh et al. 2009). A 2007 report showed that when contraceptives are not widely available or their use is not a culturally accepted practice, abortions are likely to occur at higher-than-average levels among women wishing to avoid or delay childbearing (Sedgh et al. 2007).

Evidence also shows that in developed countries with high abortion rates the use of abortion quickly declines when a range of contraceptive methods becomes widely available and the methods are used effectively. Legalization of abortion and access to abortion services do not lead to increased reliance on abortion for fertility control in the long term (Marston and Cleland 2003, Henshaw et al. 1999).

The Netherlands

The Netherlands provides an excellent example of a country where a pragmatic and comprehensive approach to family planning has resulted in low abortion rates.

The Dutch family planning program began in the mid-1960s. By the late 1960s, almost all family doctors in the Netherlands offered family planning services. In 1971, family planning was included in the national public health insurance system, which provided women free birth control pills, the intrauterine device and the diaphragm.

Holland's family planning program was in effect for nearly a decade by the time the country liberalized the practice of abortion between 1967 and 1972. There was an initial increase in the incidence of abortion following liberalization. However, the number of abortions dropped steadily by the early 1970s. Induced abortion was officially legalized in 1984. From 1973 to 2003, the Dutch abortion rate fluctuated between 5 and 9 per 1000 women. This rate is historically lower than the abortion rate of other European countries (Ketting and Visser 1994, Sedgh et al. 2007).

Romania

Before 1966, Romanian women could obtain legal abortions but access to contraceptives was extremely limited. Birth control pills and the intrauterine device were illegal and other contraceptive methods were essentially unavailable. Unreliable traditional methods for controlling fertility, such as withdrawal, were used (David 1999). Abortion was the only legal and accessible option for controlling fertility: it was low cost, generally safe and available on a walk-in basis. In 1965, the abortion rate was as high as 252 per 1000 women of childbearing age, and the maternal mortality rate was low.

In 1966, President Nicolae Ceausescu criminalized abortion and banned all contraceptives in order to increase Romania's population. In one year the abortion rate dropped to 46 per 1000 women. However, the drop in the abortion rate coincided with a massive spike in the abortion-related maternal death rate as women who needed abortions obtained them illegally under unsafe conditions. Before 1966, the abortion-related maternal death rate was 16.9 per 100,000 live births; by 1982 it had risen to 151.3 per 100,000 live births.

Following a regime change in 1989, abortion was legalized. The abortion rate initially jumped to 199 per 1000 women. The following year, Romania authorized the importation, production and sale of modern contraceptives. In 2001, the Ministry of Health (MOH) expanded contraceptive services by providing free and subsidized birth control. They also ensured that the cost of abortion remained affordable. As access to modern contraceptives improved, the abortion rate dropped (David 1999). By 2003, the abortion rate was 35 per 1000 women in Romania.

Background:

Abortion rates rise in some countries following legalization partly because of the shift from unreported illegal abortions to reported legal abortions. Increases in abortion rates are a response to the demand for services, which often are made accessible and safe following legalization. In countries where couples practice contraception effectively to limit or space births, abortion declines to moderate levels. By comparison, in countries where contraceptive use remains low or ineffective and the motivation for small families and birth spacing is strong or increasing, abortion levels may increase and take some time to moderate (Guttmacher 1999).

9 Myth: Abortion is a Western imperialist export to developing countries.

Fact: Since the beginning of recorded history, women throughout the world have terminated unwanted pregnancies. This practice is well documented (Rylko-Bauer 1996, Devereux 1976, Gallen et al. 1981, Riddle 1992).

Historians and anthropologists have conducted numerous cross-cultural, descriptive studies focusing on traditional beliefs, women's knowledge and practices related to abortion, and fertility regulation (Devereux 1967, Devereux 1976). These studies have found that abortion is one of the oldest medical practices, dating back to ancient Egypt, Greece and Rome. Abortion techniques were documented in the ancient Egyptian Ebers Papyrus (1550 B.C.) (Dabash and Roudi-Fahimi 2008). Five thousand years ago, the Chinese Emperor Shen Nung described the use of mercury for inducing abortion (Glenc 1974).

Historically, the majority of pregnancies were terminated through non-surgical methods including the administration of abortifacient herbs (Riddle 1997) and irritant leaves, fasting, bloodletting, pouring hot water onto the abdomen, starving and lying on a hot surface. Other common techniques, which are often very dangerous, included the use of sharpened tools, the application of abdominal pressure and potentially harmful physical activities such as strenuous labor, climbing, paddling, carrying heavy loads or diving into a body of water.

In *A Typological Study of Abortion in 350 Primitive, Ancient, and Pre-industrial Societies,* ethno-psychiatrist and anthropologist George Devereux writes, "(T)here is every indication that abortion is an absolutely universal phenomenon, and that it is impossible even to construct an imaginary social system in which no woman would ever feel at least compelled to abort." Devereux cites 20 groups: the Aztec, the Inca, Achaemenid Persia, Islamic Persia, ancient Assyria, ancient Egypt and modern Egypt (Devereux 1967).

Abortion Laws Worldwide

The practice of abortion is not a Western export, but restrictive abortion laws dating to colonial times are. During and after the colonial period most colonized countries adopted restrictive laws based on the European country laws (Ernst et al. 2004). The first condemnations of abortion appeared in the Code of Canon Law of the Roman Catholic Church in the 12th century. By the late 19th century, the Church had decreed that abortion at any time following conception was a crime punishable with excommunication (Francome 1988, Cook 2003).

England was the first country to prohibit abortion at *all* stages of pregnancy with passage of the 1803 Irish Chalking Act. Offenders were punished with life imprisonment (Francome 1988). This law laid the groundwork for the 1861 Offenses against the Person Act, which criminalized abortion in England and was the basis for criminalizing abortion throughout the Commonwealth countries (Cook and Dickens 1979). England legalized abortion in 1967 with passage of the Abortion Act.

Influenced by the Code of Canon law, France prohibited abortion with the 1810 Napoleonic Code. The Napoleonic Code treated abortion as homicide and imposed stiff criminal penalties upon women consenting to the procedure, as well as those providing it. The Napoleonic Code was widely replicated in Europe, and imposed on French colonial territories (Knoppers and Brault 1990). The 1975 Veil Law decriminalized abortion in France.

10

Myth: Abortion is never necessary to save a woman's life.

Fact: Abortion to save the life of a woman or girl is medically necessary under certain circumstances and is widely accepted by professionals and institutions like the World Health Organization.

A medically necessary abortion is performed to decrease the physical or mental health risk to a woman or girl or in order to save her life. It may also refer to pregnancy termination in instances of rape and fetal anomaly (McNaughton et al. 2003).

Defining what constitutes a medically necessary abortion poses a challenge because medical decisions regarding potential morbidity and mortality are highly subjective. A variety of medical conditions in pregnant women have the potential to negatively affect women's health and cause complications that may be life-threatening.

Approximately 94 percent of countries in the world permit abortion to save a woman's life (Singh et al. 2009). Some countries provide detailed lists of conditions considered life-threatening. According to the World Health Organization, "These lists are generally meant to provide illustrative examples of situations that are considered life-threatening, but they are not meant to preclude the doctor's clinical judgment of what is life-threatening for a particular woman.

Such lists, however, may be interpreted restrictively, or be considered exhaustive, when in fact they are not. For example, if a list of physical dangers to life is considered exhaustive, that would exclude mental health conditions that are life-threatening" (WHO 2003).

If an abortion to save the life of a woman is determined by medical professionals who refer only to set lists of life-threatening physical conditions, then women are left with little control over their legal right to an abortion.

Anti-abortion activists argue that abortion is never medically necessary because of technological advances in medical care (American Life League 2002). However, even in countries with highly advanced medical technology, women facing life-threatening conditions during pregnancy, such as previously undiagnosed cancer or life-threatening conditions that develop during pregnancy such as pre-eclampsia (an advanced form of hypertension) may still need an abortion (Cook et al. 2003). Moreover, medical advances are not available to the vast majority of women and girls, primarily those living in lower-resource settings.

Background:

Three countries — Chile, El Salvador, and Nicaragua — have specific laws that prohibit abortion in all cases, even to save the life of the woman (Center for Reproductive Rights 2008). Thirty-six countries permit induced abortion only to save the life of a woman; 21 percent of all women of childbearing age live in these countries. A handful of countries in this category make exceptions in their penal codes for cases of rape, incest or fetal impairment. When laws on abortion are restrictive and/or ambiguous, health professionals are often

left to their own judgment and interpretation of the law. In many cases, health providers may refuse to perform a life-saving abortion because of fear of criminal prosecution.

GLOSSARY

Abortifacient: A drug, herb or device that can cause an abortion.

Abortion: The termination and expulsion of a pregnancy before viability.

Abortion pill: Popular term for mifepristone, a medication used to terminate pregnancy. Sometimes used to describe the general process of medical abortion.

Abortion rate: The number of abortions per 1,000 women aged 15-44 (childbearing age).

Birth control: An umbrella term for behaviors, devices or medications used to avoid pregnancy. Birth control methods include all forms of contraception, as well as sterilization procedures.

Comprehensive sexuality education: An approach to sexuality and reproductive health education that includes information about abstinence, faithfulness to a partner/reducing the number of sexual partners, LGBTQ relationships, and contraception/condom use to prevent HIV/STIs and unwanted pregnancy, as well as the health benefits and side effects of all contraceptives and barrier methods. These programs also encourage family communication about sexuality between parent and child and teach young people the skills to make responsible decisions about sexuality.

Conception: The moment when the pre-embryo attaches to the lining of the uterus and pregnancy begins. Also used to describe the fertilization of the egg.

Contraception / Contraceptive: The intentional use of any behavior, device, medication or procedure used to prevent conception. All forms of contraceptives are also forms of birth control (though some forms of birth control, such as sterilization, are not contraceptives).

Embryo: The organism that develops from a successfully fertilized and implanted egg (zygote), from the second through the 10th week of pregnancy.

Emergency contraception (EC): Medicines or certain high-dose birth control pills used to prevent pregnancy after unprotected vaginal intercourse.

Family planning: The conscious effort of individuals or couples to plan for and attain their desired number of children and to regulate the spacing and timing of their births. Family planning includes a range of contraception services and treatment of involuntary infertility in order to enhance women's choices to avoid or induce pregnancy.

Fertility: The ability to conceive and have children or the ability to become pregnant through sexual activity. Infertility is defined as the failure to have offspring or to conceive after a year of penile-vaginal intercourse without contraception if the woman is younger than 35 years old.

Fetus: The stage of development of a pregnancy after the embryonic stage.

First trimester: The first three months of pregnancy.

Gender: The economic, social and cultural attributes and opportunities associated with being male or female at a particular time.

Gender-based violence: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether they occur in public or in private life.

Health-care provider: An individual or institution that provides medical services (for example, a physician, nurse, midwife, hospital or laboratory).

Hemorrhage: Heavy bleeding or the abnormal flow of blood, typically defined as loss of more than 500cc of blood.

High-risk pregnancy: A pregnancy at increased risk of complications for the woman or the fetus.

Incomplete abortion: An abortion – whether spontaneous or induced – in which some pregnancy tissue passes out of the uterus but some remains.

Indication for abortion: Specific conditions under which an abortion is legal according to a law or a policy, for example, a pregnancy caused by rape, or a pregnancy that threatens the life of the woman.

Induced abortion: The intentional termination of a pregnancy.

Intrauterine device (IUD): A small, plastic device containing copper or a hormone that is inserted into the uterus to prevent pregnancy.

Maternal morbidity: Serious disease, disability or physical damage to women caused by pregnancy-related complications.

Maternal mortality: Deaths of women while they are pregnant or within 42 days of the end of a pregnancy (either an abortion or birth) caused by or related to the pregnancy or its management.

Medical abortion: The use of one or more medications to end pregnancy. These medications terminate the pregnancy, which is then expelled by the uterus in a process similar to miscarriage. Medical abortion is sometimes called medication abortion or the abortion pill. Medical abortion is not the same as emergency contraception (EC), also known as the "morning-after pill," which prevents pregnancy from occurring.

Mifepristone: Originally known as RU-486, mifepristone blocks progesterone activity in the uterus, which stops the growth of the fetus and leads to detachment of the pregnancy. Additionally, it sensitizes the uterus to prostaglandins (such as misoprostol), increasing their effects and softens the cervix.

Misoprostol: A prostaglandin analogue often used for medical abortion in the first or second trimester, with or without mifepristone. It is administered at varying intervals to soften the cervix, stimulate uterine contractions and cause expulsion of the pregnancy.

Morning-after pill: (See "Emergency contraception").

Postabortion care (PAC): A specific set of services for women experiencing complications of abortion, especially unsafe abortion, including retained tissue, hemorrhage and infection.

Public health: The collective well-being of populations and activities undertaken by a society to assure conditions

in which people can be healthy. This includes organized community efforts to prevent, preempt and counter threats to the public's health.

Rape: Forced or manipulated nonconsensual sexual contact, including vaginal or anal intercourse, oral sex or penetration with an object or digit.

Recall bias: A type of *systematic bias* which occurs when the way a *survey* respondent answers a question is affected not just by the correct answer, but also by the respondent's memory of past events or experiences.

Reproductive health: A state of complete physical, mental and social wellbeing in all matters relating to the reproductive system and to its functions and processes.

Reproductive rights: Rights that rest on the recognition of the basic right of all individuals and couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. Reproductive rights also include the right of all individuals and couples to make decisions concerning reproduction free of discrimination, coercion and violence.

Safe abortion: Abortions (a) performed in countries where abortion law is *not restrictive* (defined as countries in which abortion is legally permitted for social or economic reasons, or without specification as to reason, and a few countries and territories with more restrictive formal laws in which safe abortion is nevertheless broadly available), and (b) that meet legal requirements in countries where the law *is restrictive.*

Spontaneous abortion: A miscarriage; the unintentional termination of any pregnancy that is not viable (the fetus cannot survive). Spontaneous abortion occurs in at least 15-20 percent of all recognized pregnancies and usually takes place before the 13th week of pregnancy.

Therapeutic abortion: A legally induced abortion for medical reasons (as when the mother's life is threatened).

Trimester: The nine months of pregnancy are traditionally divided into three trimesters: distinct periods of roughly three months each in which different phases of fetal development take place.

Unsafe abortion: A procedure for terminating an unwanted pregnancy either by persons lacking the necessary knowledge or skills or in an environment lacking the minimal medical standards, or both.

Woman-centered abortion care (WCAC): A comprehensive approach to providing abortion services that takes into account the factors that influence a woman's individual mental and physical health needs, as well as her ability to access services and her personal circumstances. A woman-centered model for abortion care comprises three key elements: choice, access and quality (see "Comprehensive abortion care").

World Health Organization (WHO): The United Nations specialized agency for health, established on April 7, 1948. WHO's objective, as set out in its constitution, is the attainment by all peoples of the highest possible level of health, which it defines as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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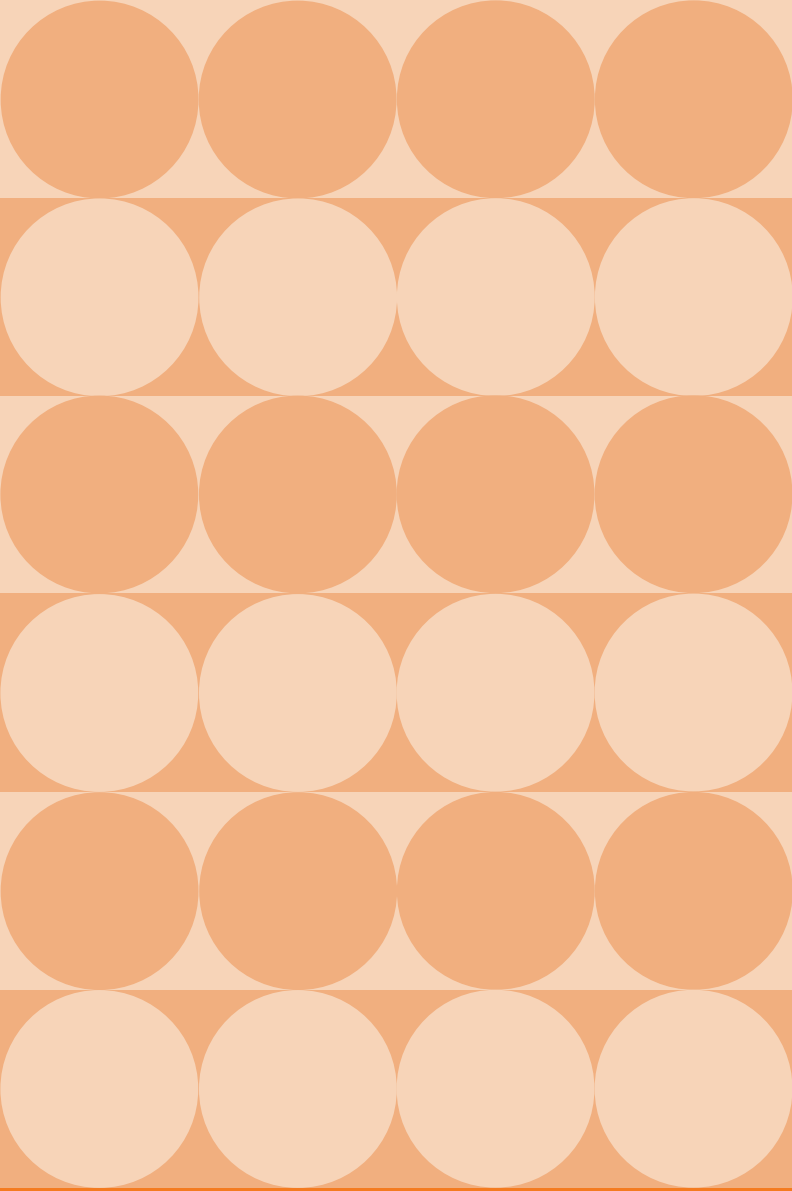

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