Mapping abortion policies, programmes and services in the South-East Asia Region
Mapping abortion policies, programmes and services in the
WHO South-East Asia Region
WHO Library Cataloguing-in-Publication data

World Health Organization, Regional Office for South-East Asia.

Mapping abortion policies, programmes and services in the WHO South-East Asia Region.

1. Abortion, Induced
2. Abortion, Legal - trends
3. Maternal Mortality - statistics and numerical data
4. Contraception
5. 

# Table of Contents

Executive summary ........................................................................................................................................ iv

Foreword ................................................................................................................................................... v

1. Background ........................................................................................................................................ 1

2. Methodology ...................................................................................................................................... 3

3. Setting the context ............................................................................................................................. 4

4. Legal scenario ...................................................................................................................................... 5

5. Service provision ............................................................................................................................... 12

6. Summary and challenges in abortion provision ............................................................................... 20

7. Acknowledgements ........................................................................................................................... 22

8. References ......................................................................................................................................... 23
An estimated 21.6 million unsafe abortions took place globally in 2008, resulting in 47,000 pregnancy-related deaths and 5 million women suffering temporary or permanent disabilities (WHO, 2011). Most of these were estimated to have occurred in the developing regions, accounting for 98% of all unsafe abortions. Of these, an estimated 10.8 million unsafe abortions were reported to have taken place in Asia. Restrictive legal provisions, non-availability of national standards and guidelines to guide abortion provision, lack of availability of trained service providers and registered facilities are some of the leading reasons for unsafe abortions and the resulting high maternal mortality and morbidity.

The overall objective of this exercise is to map the legal situation of abortion in the countries of the World Health Organization’s (WHO) South-East Asia Region (SEAR), namely Bangladesh, Bhutan, the Democratic People’s Republic (DPR) of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. It also aims to describe the existing policies and guidelines regulating abortion service delivery as well as to identify the gaps in making safe abortion a reality for women in the Region.

Abortion is permitted in all countries of SEAR, at least when there is threat to the woman’s life. As far as national standards and guidelines are concerned, 4 out of the 11 countries have developed guidelines and efforts made to ensure that abortion provision follows them. However, liberal abortion laws alone cannot ensure safe abortion. There are many barriers that delay access to safe abortion services, both within the laws binding provision of abortion as well as health service delivery guidelines, availability of an adequate number of facilities and trained abortion providers.

Abortions will continue to occur regardless of the status of abortion laws. Unintended pregnancies occur all over the world, and some women who do not want the unplanned birth will resort to abortion – whether safe or unsafe. It is essential to reduce the incidence of unwanted pregnancies and unsafe abortion by ensuring access to safe abortion services and post-abortion care (PAC).
The need to improve maternal health is identified as one of the key Millennium Development Goals, with a target of reducing levels of maternal mortality by three-quarters between 1990 and 2015. Women die because complications during pregnancy, childbirth and the postpartum period go unrecognized or are inadequately managed.

An important cause of maternal deaths is complications arising as a result of unsafe abortion. Women die because they seek to end unwanted pregnancies and lack knowledge, and have limited access to family planning services and appropriate safe abortion services. Among the 208 million women estimated to become pregnant each year worldwide, 59% (or 123 million) experience a planned (or intended) pregnancy leading to a birth or miscarriage or a stillbirth. The remaining 41% (or 85 million) of pregnancies are unintended.

An estimated 22 million abortions continue to be performed unsafely each year, of which Asia accounts for 10.8 million. Globally, this results in the death of an estimated 47 000 women (13% of pregnancy related deaths) and disabilities for an additional 5 million women.

Unsafe abortions are associated with serious health consequences, including about 20–30% that cause reproductive tract infections and about 20–40% results in infection of the upper genital tract. One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability requiring medical care. Evidence shows that major physiological, financial, emotional and legal reprisals are incurred by women who undergo unsafe abortion.

Over the past two decades, evidence has been generated and technologies developed for providing safe, comprehensive abortion care. The human rights imperative has made the call stronger for making safe abortion services accessible to women who need it.

The number of declarations and resolutions signed by countries over the past two decades indicates a growing consensus that unsafe abortion is an important cause of maternal death that can, and should, be prevented through the promotion of family planning, sexuality education, and the provision of safe abortion services to the full extent of the law.

As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets. The role of the World Health Organization is to
develop norms and standards and assist Member States in strengthening the capacity of health systems. With the updated technical guidance from WHO, Member States would be able to develop or adapt national strategies for improving women’s reproductive health and reducing unsafe abortion.

This document maps the legal situation of abortion in the countries of the World Health Organization’s South-East Asia Region, namely Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. It also aims to describe the existing policies and guidelines regulating abortion service delivery as well as to identify the gaps for taking actions in making safe abortion a reality for women in the Region.

Dr Samlee Plianbangchang
Regional Director
The United Nations Millennium Summit in 2000 reaffirmed the need to reduce poverty and inequities in the world and improving maternal health (Millennium Development Goal (MDG) – 5). Reducing the level of maternal mortality by three quarters between 1990 and 2015 was one of the key MDGs. However, maternal mortality remains unacceptably high across much of the developing world.

An estimated 21.6 million unsafe abortions\(^1\) took place in 2008, resulting in 47 000 pregnancy-related deaths and 5 million women suffering temporary or permanent disabilities (WHO, 2011). Most of these abortions were estimated to have occurred in the developing regions – 10.8 million in Asia alone – accounting for 98% of all unsafe abortions. The burden of unsafe abortion and the maternal deaths that result is quite high in the developing regions. For example, Asia’s share of global unsafe abortions was 50% and more seriously, 36% of all deaths related to unsafe abortion occurred in Asia in 2008 (WHO, 2011).

The rates for unsafe abortion for Asia are estimated to be 19 per 1000 women aged 15–44 years. The South-Central Asia subregion (including Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka) has the highest number of unsafe abortions of any subregion, owing to the sheer size of its population. In 2008, 6.8 million unsafe abortions were estimated or 17 unsafe abortions per 1000 women of reproductive age, which poses a formidable challenge. The South-Eastern Asia subregion (including Indonesia, Myanmar, Thailand and Timor-Leste) accounts for 3.1 million unsafe abortions or 26 per 1000 women aged 15–44 years. (WHO, 2011) (Table 1).

### Table 1: Regional estimates of annual number, rates, and ratios of unsafe abortion, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Unsafe abortion numbers</th>
<th>Rate and ratio calculations including only countries with evidence of unsafe abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Unsafe abortion rate ((per 1000 women aged 15–44 years))</td>
</tr>
<tr>
<td>Developed regions</td>
<td>360 000</td>
<td>6</td>
</tr>
<tr>
<td>Developing regions</td>
<td>21 200 000</td>
<td>23</td>
</tr>
<tr>
<td>Asia</td>
<td>10 780 000</td>
<td>19</td>
</tr>
<tr>
<td>East Asia</td>
<td></td>
<td>No estimate shown for region where the reported incidence of unsafe abortion is negligible</td>
</tr>
<tr>
<td>South-Central Asia</td>
<td>6 820 000</td>
<td>17</td>
</tr>
<tr>
<td>South-Eastern Asia</td>
<td>3 130 000</td>
<td>26</td>
</tr>
<tr>
<td>Western Asia</td>
<td>830 000</td>
<td>16</td>
</tr>
</tbody>
</table>


\(^1\) Unsafe abortion is defined by WHO as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.
The proportion of maternal deaths due to unsafe abortion is high in Asia, ranging between 10 and 30 per 100 000 live births compared with just 3 deaths per 100 000 in the developed regions. Asia accounts for 13% of maternal deaths due to unsafe abortion compared with 11% in the developed region (WHO, 2011) (Table 2).

Abortion prevalence is higher where family planning services are scarce, contraceptive prevalence is low, and less effective contraceptive methods prevail. It is estimated that, of the 210 million pregnancies that occur each year (Singh et al, 2009), some 80 million are unintended, 33 million of which are due to ineffective use of (mostly traditional) contraceptive methods (WHO, 2012a). In 2007, it is estimated that 67% of women in Asia used any method of family planning and the unmet need for family planning was 9%. South-Central Asia reported a high unmet need - 15% of women aged 15-49 years reported an unmet need for family planning, while the proportion in South-East Asia was 10% (WHO, 2011).

In view of the need for evidence-based best practices for providing safe abortion care to protect the health and human rights of women, WHO updated its 2003 publication Safe abortion: technical and policy guidance for health systems, and developed evidence-based recommendations (WHO, 2012b). As a step towards creating an enabling environment to implement the new recommendations, it is imperative to understand the legal scenario as well as the existing national standards and guidelines being used for provision of abortion.

### Table 2: Regional estimates of mortality due to unsafe abortion, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of maternal deaths due to unsafe abortion</th>
<th>Mortality calculations including only countries with evidence of unsafe abortion</th>
<th>Mortalities due to unsafe abortion per 100 000 live births (rounded)</th>
<th>Maternal deaths (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed regions</td>
<td>90</td>
<td></td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Developing regions</td>
<td>47 000</td>
<td></td>
<td>50</td>
<td>13</td>
</tr>
<tr>
<td>Asia</td>
<td>17 000</td>
<td></td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>East Asia</td>
<td>No estimate shown for region where the reported incidence of unsafe abortion is negligible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South-Central Asia</td>
<td>14 000</td>
<td></td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>South-Eastern Asia</td>
<td>2 300</td>
<td></td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Western Asia</td>
<td>600</td>
<td></td>
<td>10</td>
<td>16</td>
</tr>
</tbody>
</table>

The overall objective of this exercise is to map the legal situation of abortion in the SEAR countries and the existing policies and guidelines regulating abortion service delivery, as well as identify the gaps in making safe abortion a reality for women in the Region.

Information and data gathered for the paper relied mainly on a desk review of available documents explaining the legal status of abortion in countries as well as the national standards and guidelines for providing abortion services where available. The literature search was conducted through several search engines. Technical references were accessed from specialized web sites such as WHO, International Planned Parenthood Federation (IPPF), United Nations Population Fund, United Nations Development Programme, Ipas, Asia Safe Abortion Partnership (ASAP) and Guttmacher Institute. Peer reviewed articles in journals were accessed by placing key words in the search engine. A further search was carried out to find country reports on population policy and programmes using www.google.com. This also searched for further grey literature published by nongovernmental organizations (NGOs) or international agencies regarding abortion.

Acknowledging the limited information available on the web, a set of three tables were prepared and shared with the focal point in each SEAR country as well as partners within the Region, including the IPPF South Asia Regional Office. The tables aimed to collect information on the legality of abortion, consent procedures, facilities where abortion can be provided, authorized providers of abortion services, national standards and regulations, availability of essential drugs and equipment, training requirements and current environment towards abortion. The country focal points and partner NGOs were requested to complete the tables and return them to SEAR Office. Information thus gathered has been used to fill the gaps on available information.
SEAR countries vary in their reproductive health profile. For example, maternal mortality ratios range from as low as 35 per 100,000 live births in Sri Lanka to as high as 300 per 100,000 live births in Timor-Leste. The prevalence of contraceptive methods also varies – just 22% of women reported using contraception in Timor-Leste as compared to 80% in Thailand. Unmet need for family planning ranges from 3% in Thailand to as high as 32% in Timor-Leste (WHO, 2013) (Table 3).

Table 3: Maternal mortality ratio and percentage of unmet need for contraception, contraceptive prevalence and in SEAR Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Maternal Mortality ratio</th>
<th>Unmet need for family planning (%)</th>
<th>Contraceptive prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>240</td>
<td>12</td>
<td>61</td>
</tr>
<tr>
<td>Bhutan</td>
<td>180</td>
<td>12</td>
<td>66</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>81</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>India</td>
<td>200</td>
<td>21</td>
<td>55</td>
</tr>
<tr>
<td>Indonesia</td>
<td>220</td>
<td>13</td>
<td>61</td>
</tr>
<tr>
<td>Maldives</td>
<td>60</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>Myanmar</td>
<td>200</td>
<td>–</td>
<td>46</td>
</tr>
<tr>
<td>Nepal</td>
<td>170</td>
<td>27</td>
<td>50</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>35</td>
<td>7</td>
<td>63</td>
</tr>
<tr>
<td>Thailand</td>
<td>48</td>
<td>3</td>
<td>80</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>300</td>
<td>32</td>
<td>22</td>
</tr>
</tbody>
</table>


While country-specific robust data may not be available to estimate the number of maternal deaths due to unsafe abortion, there are indications that maternal mortality due to unsafe abortion is high in SEAR countries. For example, in India, complications arising from abortion contribute to some 8% of all maternal deaths each year (Office of the Registrar General, India, 2006). According to the Indonesian Health Ministry, abortions constituted 30–50% of the total number of maternal deaths (Dalvie et al, 2011a) while another estimate puts it at 15–30% (WHO, 2005). The Maternal Mortality Review conducted by the Family Health Bureau, Sri Lanka identified unsafe abortion as a crucial cause of maternal mortality. Data from the 2005 review attributes 11.7% of maternal deaths to unsafe abortions, making it the third largest cause of direct maternal deaths (Sri Lanka, Family Health Bureau, 2005). In Bangladesh, the proportion of maternal mortality attributed to unsafe abortion is 15–18% (Chowdhury, 2007).
Women all over the world are highly likely to have an induced abortion when faced with an unplanned pregnancy – irrespective of legal conditions prevailing in their country (WHO, 2011). In SEAR countries, abortion is legal, though it ranges from being very restrictive to being available on request.

While the legal status of abortion and risk associated with the procedure are not perfectly correlated, it is well documented that morbidity and mortality resulting from abortion tend to be high in countries and regions characterized by restrictive abortion laws (WHO, 2011; Grimes et al, 2006; Rossier, 2003) and can be extremely low when these are liberal (WHO, 2012a).

The 11 countries in SEAR have been signatory to international declarations that aim to build consensus on increasing access to safe abortion as well as to put pressure on governments to reform laws and policies. For example, all countries are signatories to the Programme of Action of the 1994 International Conference on Population and Development (ICPD), which established abortion as a major public health issue. The ICPD Programme of Action also endorses each individual’s right to determine the number and spacing of her children and to have the information, education and means to do so (ICPD, Principle 8) (United Nations, 1995a). The Fourth World Conference on Women in 1995 reiterated ICPD Principle 8 and called on governments to consider reviewing abortion laws containing punitive measures against women (United Nations, 1995b).

Over the past 15 years, advocacy efforts have been geared towards making abortion a human rights issue. However, notwithstanding the commitments made at the various international forums, safe abortion continues to elude women in SEAR.

As is evident from Table 4, Bangladesh, Myanmar, Sri Lanka and Timor-Leste have limited conditions under which a woman can access abortion services, i.e. abortion can be accessed only to save her life. Indonesia permits abortion to save a woman’s life, in case of pregnancy resulting from rape and in case of fetal impairment. Maldives permits abortion to save a woman’s life and to preserve her physical health. Thailand and India allow abortion to save a woman’s life, to preserve her physical/mental health, in case of a fetal impairment or in case of a pregnancy resulting from rape/incest. India additionally permits abortion under other economic/social reasons. In Nepal and DPR Korea abortion is permitted on request, albeit with certain conditions (Table 4).
Table 4: Grounds on which abortion is permitted in SEAR countries

<table>
<thead>
<tr>
<th>Country</th>
<th>To save a woman’s life</th>
<th>To preserve a woman’s physical health</th>
<th>To preserve a woman’s mental health</th>
<th>In case of rape or incest</th>
<th>Because of fetal impairment</th>
<th>For economic or social reasons</th>
<th>On request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>X</td>
<td>X1</td>
<td>X</td>
<td>X</td>
<td>X1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPR Korea</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>India</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>X</td>
<td></td>
<td>X1</td>
<td>X1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Only in case of pregnancy resulting from rape.

The following is a description of the legal scenario of each of the 11 SEAR countries, starting from the most liberal to the most restrictive. Information provided in this section was gathered through documents and research articles accessed from the web and personal communication with SEAR country offices and the IPPF South Asia Regional Office.

**DPR Korea** provides abortion up to a gestational age of seven months on request without any restrictions. The law does not require authorization or certification by doctors for abortion except in cases of fetal malformation, uterine deformation of the mother, tuberculosis, hepatitis, cardiac diseases that could endanger the mother’s health during pregnancy and delivery. Further, in case of potential risks to a woman’s health due to pregnancy, three doctors need to certify the need for abortion. As per the law, only the woman undergoing abortion needs to give her consent for the procedure. In case of minors or the mentally challenged, a guardian can provide consent for the procedure.

**Nepal** has been through a long journey in legalizing abortion. The previous laws of the country as per the existing civil code (*Muluki Ain*) did not permit abortion under any circumstances and even imprisoned women who sought and underwent abortion. Nepal went through a process of reforms and passed the 11th Amendment to *Muluki Ain* of 1959 in 2002, which is a validation of the country’s commitment to addressing women’s rights and to improve the health status of women and their family life (WHO, 2007a). As per the Amendment, a woman can request an abortion up to 12 weeks of gestation and up to 18 weeks if the pregnancy results from rape or incest. It further states that the woman can terminate the pregnancy at any time on the advice of a medical practitioner, if her physical or mental health or life is at risk, or if the fetus is impaired or has a condition incompatible with life (Nepal Ministry of Law, Justice and Parliamentary Affairs, 2002; Abortion Laws of the World). Consent for minors (below 16 years) and for women who are mentally challenged can be provided by the nearest guardian or relative.
Nepal moved from a country that criminalized abortion to one with liberal abortion laws. The process can be used as a model for other countries. The journey involved a range of stakeholders in making safe abortion a reality for women. For example, the Nepal Society of Obstetricians and Gynaecologists (NESOG) was very supportive in this process through training and undertaking studies on safe abortion services. NESOG has also advocated with policy-makers to take evidence-based decisions. In order to build evidence, research activities were undertaken by local research organizations on the safety and efficacy of abortion, including that provided by trained nurses and ANMs. NGOs undertook the task of increasing community-level awareness on women’s rights and protecting women’s reproductive health. A Technical Committee for the Implementation of Comprehensive Abortion Care (TCIC) was established in late 2002. This was a multi-partner forum with membership drawn from various government divisions and ministries, NGOs and professional bodies, whose role was to advise and support the Government in implementing the reformed abortion law. TCIC developed training manuals, managed training programmes and public sector services, set standards and monitored the procedures for both public and private sectors. It was also responsible for information and behaviour change communication activities.

Box 1 : Nepal’s journey towards making abortion safe

In India, the Medical Termination of Pregnancy (MTP) Act, 1971 governs the provision of abortions. Under the Act, abortion can be sought for a range of conditions, including instances when there is risk of life or grave injury to the physical or mental health of the woman, and in case of the child being born with such physical or mental abnormalities as to be seriously handicapped, Pregnancy caused by rape or incest is deemed to cause mental anguish serious enough to harm the woman’s mental health. Abortion can be sought in case of failure of any contraceptive device or method used by a married woman or her husband for the purpose of limiting the number of children. The MTP Act allows termination of a pregnancy up to 20 weeks for the above-mentioned indications. As per the Act, the abortion procedure has to be certified by one physician for first trimester (up to 12 weeks of gestational age) termination and by at least two physicians in case of second trimester (up to 20 weeks of gestational age) termination (Government of India, 1971). The rules and regulations governing the MTP Act were further amended in May 2003 to specify that medical abortion could be provided by certified providers in their clinic (even if an unapproved site), as long as there was access to a registered and approved facility for back-up and a certificate from the owner of the approved site was displayed (Government of India, 2003).

The MTP Act stipulates that only the pregnant woman’s consent is required for an abortion provided she is above 18 years of age and is not mentally ill. For minors (below 18 years) or a mentally ill woman, the consent of a parent or guardian is required.

The MTP Act protects practitioners that adhere to and fulfil all requirements of the Act. However, there are specific punitive measures for abortions provided by unqualified persons and in places not approved and certified either by the Government or by the empowered District Level Committee. For example, an abortion performed by a person who is not a registered medical practitioner carries a penalty of 2–7 years imprisonment. The same penalty applies to those who perform abortions outside of hospitals or other approved locations. In addition, the owner of the non-approved facility can also face 2–7 years in prison.

In Thailand, abortion can be provided for a range of conditions. The abortion law is nested within Section 305 of the Penal Code, which states that abortion can be provided if “it is necessary for the sake of the health of such woman” or if she is pregnant as a result of a criminal offence.
(United Nations, 2002). In 2006, the law was slightly modified to bring in a Regulation on Criteria for Performing Therapeutic Termination of Pregnancy in accordance with Section 305, whereby termination of pregnancy could be performed only by a medical practitioner up to 12 weeks of gestation. It further states that abortion can be carried out if necessary to save a woman’s life or in case of physical or mental health problems of the pregnant woman. Mental health is further defined as “severe stress caused by finding out that the foetus has or is at risk of having a severe disability or genetic disease”. Abortion or Therapeutic Termination of Pregnancy can also be accessed if there is a probability of fetal impairment or in cases of pregnancy resulting from rape or incest (Section 305 of the Criminal Code of Thailand as cited in Bhardwaj and Divan, 2011).

First trimester abortion needs be certified by two doctors (gynaecologist and medical practitioner) while second trimester abortion needs to be certified by three doctors (gynaecologist, medical practitioner, psychiatrist). The regulation stipulates that in the case abortion is sought for a mental health condition, the condition has to be certified by at least one medical practitioner (psychiatrist) other than the one performing the procedure. Further, physical and health problems are required to have clear indications, and examination and diagnosis must be recorded. For abortions in case of pregnancy resulting from sexual assault, the regulations require evidence or facts leading to a “reasonable belief” of this cause.

Consent has to be given only by the pregnant woman; if she is under 15 years old, the consent form also needs to be signed by her parents.

The Penal Code provides punishment for the woman and the person causing the abortion unless the conditions for the need for abortion have been fulfilled by the provider. The punishments are different for abortions with or without the consent of the woman and where the abortion results in bodily harm or death of the woman (United Nations, 2002; Section 305 of the Criminal Code of Thailand as cited in Bhardwaj and Divan, 2011).

**Bhutan’s** Penal Code 146 states that abortion is illegal except when it is conducted “in good faith for the purpose of saving the life of the mother or when the pregnancy is the result of rape or incest or when the mother is of unsound mental condition” (Abortion Laws of the World; Center for Reproductive Rights, 2011). Additional conditions for abortion include a substantial risk to the child born with serious handicap or congenital or physical or mental abnormalities.

Abortion is permitted up to 20 weeks of gestational age provided the need for abortion is certified by at least two doctors, though in an emergency, certification by one doctor is permissible. In cases where abortion is sought for pregnancy resulting from rape or incest, the law requires that the case be proven in a court of law. The Penal Code does not indicate the procedure required if a minor girl is pregnant or if the case of rape or incest cannot be proven in court. The consent should be provided and signed by both the doctor and the client.

As per the Penal Code 146, abortion is unlawful if it is not performed for the specific conditions stated above. The punishment is not specified but it is stated that the “offence of illegal abortion shall be a misdemeanour” (Abortion Laws of the World).

Although **Indonesia’s** Penal Code provides no exceptions, the Law Concerning Health No. 36/2009 Articles 75, 76 and 77 provide limited circumstances under which abortion can be provided. These are - when a “medical emergency [is] detected from the early age of pregnancy, both threatening the life of the mother and/or foetus, suffering from severe genetic diseases and/or congenital defects, or that cannot be repaired so as to cause difficulty for the infant to survive out the womb,” or “pregnancy due to rape that may result in psychological trauma for the rape victim.” It further stipulates that abortion can be performed only up to six weeks of gestational age, except in case of medical emergency, and that the woman seeking abortion
Continuous attempts have been made in Indonesia to reform the abortion law since the 1970s. These efforts were spearheaded by members of the legal and medical professions, as well as by women’s organizations that sought to reduce morbidity and mortality associated with clandestine abortions (United Nations, 2002). Although the Code contains no exceptions to its general prohibition on abortion, in the 1970s an “understanding” was reached by medical professionals, on the advice of the Chief Justice of the High Court, that abortion could be performed to save—a woman’s life or health. However, actual reform of the abortion law did not take place until 1992 when the Government enacted Health Law 23/1992 containing abortion provisions. The new Health Law specified that “in the case of emergency and with the purpose of saving the life of a pregnant woman or her foetus, it is permissible to carry out certain medical procedures” (United Nations, 2002). The language on abortion was vague and therefore led to certain provisions that were not mandated in the law including a positive pregnancy test, confirmation from a doctor that the pregnancy is life-threatening, consent of the husband or family member and a statement from the woman that she will practise post-abortion contraception. A group of NGOs lobbied for reforms to the Health Law of 1992 and in September 2009, amendments were passed. The new Health Law no. 36/2009 stated that no-one is allowed to provide abortion. But this prohibition can be exempted on the basis of indications of medical emergencies detected from early pregnancy, threatening the life of the mother and/or infant; suffering from severe genetic disease and/or congenital defects, or those that cannot be repaired so as to make it difficult for the infant to live outside the womb; or pregnancy due to rape which could bring about psychological trauma for the rape victim. The abortion can only be undertaken after thorough pre-counselling and/or mentoring and concluded with post-abortion counselling from competent and authorized counsellors. Further provisions on the indications of medical emergencies and rape shall be governed by Government Regulations.

Abortion can only be performed before pregnancy attains the age of six weeks counted from the first day of the last menstruation, except in the case of medical emergencies; by health workers who have skills and authority and are certified by the Minister; with the consent of the pregnant woman; with permission from the husband, except for rape victims; and with health service providers satisfying the requirements stipulated by the Minister.
**Maldives** permits abortion under two conditions – to save a woman’s life and to preserve a woman’s physical health. Abortion is permitted up to 120 days of gestational age where thalassaemia is diagnosed and for cases where major congenital anomalies are reported. A doctor is required to certify the need for abortion, though the number of doctors for this certification is not indicated.

Consent for abortion is required from the woman undergoing the procedure but abortion can only be provided with spousal authorization; if the spouse is not available, consent is required from the paternal father or guardian.

There are penalties for illegal provision of abortion, both for the service provider as well as for the woman who accesses these services.

**Bangladesh** Penal Code Sections 312–316 criminalize abortion except where it is “performed in good faith for the purpose of saving the life of the pregnant woman” (Abortion Laws of the World). Such an abortion requires the approval of two physicians and can only be performed by an obstetrician/gynaecologist in a hospital (United Nations, 2002).

**Bangladesh** provides Menstrual Regulation (MR) services, termed as “an interim method to establish non-pregnancy” (Benson et al, 2011). Hence, since the pregnancy is not confirmed, the provision of these services does not violate any laws of the country. MR can be performed up to 8 weeks after the last menstrual period (LMP) by a trained paramedic and up to 10 weeks by a trained physician. MR services have been available in the Government’s family planning programme since the 1970s. The Government also supports these services as a family planning method and not as an abortifacient (United Nations, 2002).

Consent of the woman undergoing an MR procedure is required. In special cases (mentally handicapped or younger women) consent of the guardian/relative/husband is also obtained (Directorate General of Family Planning, 2011).

Abortion that does not follow the legal requirements is punished with imprisonment for a term that may extend to 3 years, or a fine, or with both; and if the woman is quick with child, the punishment may extend to seven years, and is liable to be fined. A woman who performs an abortion on herself is also subject to the above penalties. If an abortion is performed without the woman’s consent at any point during the pregnancy, the person performing the procedure is subject to up to 10 years’ imprisonment and to a fine (United Nations, 2002).

As per **Myanmar** Penal Code Article 312, 313 and 314, abortion is generally illegal except when “performed in good faith for the purpose of saving the life of the woman” (Abortion Laws of the World). Abortion can be provided up to 22 weeks of gestational age and a doctor needs to certify the need. For example, if the woman has severe heart disease, a consultation is required with both a physician as well as an obstetrician/gynaecologist and both are required to certify the need for abortion procedure. Consent for abortion needs to be given by the woman alone or with her husband/partner.

Any person performing an abortion outside of these restrictions is subject to up to 3 years’ imprisonment and/or payment of a fine. A woman who induces her own abortion is subject to the same penalties. If the abortion results in the death of the woman, punishment is 10 years’ imprisonment and a fine. The punishment varies depending on the gestational age of the pregnancy, whether the woman’s consent has been obtained and if the abortion results in the death of the woman (United Nation, 2002).
In Sri Lanka, despite a series of efforts to legalize abortion since the 1970s, abortion laws remain restrictive and abortion is permitted only to save the life of the woman. Access is further restricted since the procedure has to be certified by two obstetricians/gynaecologists and/or a psychiatrist. The law does not specify the gestational age up to when abortion can be sought and provided. Consent for abortion has to be provided by the woman and the procedures are similar to other surgical procedures.

Abortion is criminalized under Penal Code Section 303 and 304. Section 303 stipulates that “whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend up to three years, or with fine, or with both; and if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend up to seven years, and shall also be liable to fine” (Abortion Laws of the World). The punishment varies depending on the gestational age, whether the woman has induced her own miscarriage, whether the woman’s consent has been obtained and whether the procedure caused the death of the woman (United Nations, 2002; Abortion Laws of the World).

Timor-Leste was occupied by Portugal until 1975 and was then governed under Indonesian law until 1999. Initially, the Indonesian Penal Code prohibited abortion under any circumstances, but subsequent amendments permitted abortion to save the life of the woman. In 2009, Timor-Leste adopted a Penal Code that permitted “interruption of pregnancy” to save a woman’s life and health. It indicated that “.....the interruption of pregnancy is (permitted if this is) the only means to counter the risk of death or irreversible lesion to the body and physical or psychological health of the mother or the fetus, as long as the procedure is authorised and monitored by a medical team and performed by a doctor or health professional in a public health institution with the consent of the pregnant woman and/or her life partner” (Belton et al, 2009).

However, a month after the ratification of the Penal Code, Decree Law 19/2009 was passed with 13 amendments to Article 141, making access to abortion highly restrictive. The proposed amendment to Artlice 141, said that the woman must be facing imminent death and have no option other than to terminate the pregnancy. It also stipulated that three doctors should agree to the procedure and sign a certificate. A fourth doctor, not one of the original three, should perform the abortion and at least one of the doctors should be an obstetrician/gynaecologist (Belton et al, 2009).

The woman must consent and her spouse or another person are also sought to give consent. There should be a delay where possible of two days between gaining consent and performing the procedure. Furthermore, medical practitioners may conscientiously object to performing an elective abortion but must refer the woman to another colleague.
In many countries, evidence-based standards and guidelines for abortion service delivery, including treatment of abortion complications, do not exist. Standards refer to the underlying principles and essential requirements for providing equitable access to, and adequate quality of, lawful abortion services. Guidelines are evidence-based instructions for the delivery of safe abortion care (WHO 2012b). Standards and guidelines should be developed and updated with the intent of eliminating barriers to obtaining the highest attainable standard of sexual and reproductive health.

Not all SEAR countries have national standards and guidelines in place. Information on guidelines recommended is even more difficult to obtain from countries where abortion is extremely restricted. Described below are the national standards and guidelines followed by countries, including those who can legally provide abortion, where it can be provided, training requirements, methods of abortion recommended, availability of essential drugs and equipment, and management and information systems requirements.

Information provided in this section was gathered through documents and research articles accessed from the web and personal communication with regional country offices of WHO and the IPPF.

**DPR Korea** has developed national abortion standards and guidelines including Guidelines on safe abortion care, which have been translated and introduced in the system, and Guidelines on comprehensive safe abortion (for clinics).

As per the guidelines, abortion can be provided only by doctors in an obstetrics/gynaecology department. Graduates from medical colleges undergo a three-month training in abortion provision by senior doctors at the service delivery points at the county level or higher level facilities.

Abortion can be provided at public health settings of county-level hospitals or above free of charge. Main methods of abortion include vacuum aspiration. Electric vacuum aspiration (EVA) was the main method of abortion procedure and it is only since 2007 that manual vacuum aspiration (MVA) is provided in selected sites. Medical abortion is still in pilot phase and has not yet been introduced in the system.

National-level training manuals are available. Additionally, in-service training is undertaken at provincial level lasting for about three months. As far as availability of essential drugs and equipment is concerned, mifepristone and misoprostol are not registered in the handbook of national drugs nor are they included in national or subnational Essential Drugs lists. MVA syringes are also not available through the government procurement system. Post-abortion contraception counselling is undertaken and the methods suggested are intrauterine devices (IUDs), pills, injectables, and male condoms. The national guidelines require that a monthly report is submitted to the Ministry of Public Health. Data are analysed on selected indicators to track provision of services and include abortion ratio, maternal mortality due to abortion, ratio of health workers trained on safe abortion care, and ratio of hospitals that provide family planning care after abortion.
Nepal developed national standards and guidelines in line with the recommendations of the WHO Safe abortion: technical and policy guidance for health systems, 2003.

Physicians and health workers who are trained and registered are authorized to provide abortions, the latter up to eight weeks of gestation. To be registered, health workers must be skilled in obstetrics/midwifery and have completed a minimum of six months midwifery course; skilled in the provision of PAC and have completed a minimum of 50 cases; they should also be willing to provide comprehensive abortion care (CAC) under the supervision of CAC trained physicians in listed CAC sites (Ministry of Health and Population, 2007). This category of health workers therefore includes staff nurses and auxiliary nurse midwives (ANMs), many of whom already have experience using MVA for post-abortion care (PAC). Second trimester abortion is provided exclusively by obstetrician-gynaecologists and general practitioners and only in higher-level facilities (Samandari et al, 2012).

The CAC guidelines indicate that only doctors who are members of the Nepal Medical Council are eligible to undergo training in CAC. The duration of training varies depending on the number of years of experience. Thus, obstetricians/ gynaecologists with more than five years of experience undergo five days of training and those with less than five years undergo seven days of training. Doctors who have completed Bachelors of Medicine and Surgery (MBBS) undergo 10 days training while registered nurses undergo 14 days. ANMs placed in government facilities of selected districts and staff nurses undergo five days training in medical abortion provision.

Competency-based training manuals and curriculum have been developed. The training curriculum includes instruction in technical abortion procedures, counselling, post-abortion contraception and guidance for improved facility functionality (Samandari et al, 2012). Emphasis is also on values clarification to ensure that women’s rights are protected. Each provider is expected to complete at least 25 procedures independently after the training in order to be certified as an abortion provider.

A health-care facility wishing to provide CAC services needs to be registered with the Department of Health Services under the Ministry of Health. The approved facilities have to fulfil minimum requirements as indicated by the Government, including the presence of a provider who is a trained medical practitioner or health worker. Abortion services are available at primary health care (PHC) and health post level. Providers are permitted to charge for the cost of pregnancy termination, but are required to maintain transparency about price.

As per the national guidelines, the methods recommended for first trimester abortion are vacuum aspiration – MVA or EVA – and medical abortion. For pregnancy beyond 12 weeks, MVA and dilatation and evacuation are recommended. Post-abortion contraceptive counselling is emphasized in the guidelines and providers are encouraged to counsel the woman on different occasions to adopt a method, i.e. before the procedure, at the time of discharge, and when she comes for a follow-up visit if a method has not yet been adopted. The options for contraception offered to women include condoms, IUD, oral contraception, injectables, hormonal implants, tubectomy/ tubal ligation and vasectomy. Emergency contraception is recommended if the woman has unprotected sex.

As far as follow-up is concerned, the guidelines take into account the long distance and hilly terrain that women have to travel to access abortion services. Hence, there is a provision that the follow-up can be done at the nearest health facility by showing the discharge card that records the woman’s details and the clinical procedure performed. A follow-up visit is recommended after 7 days of the MVA procedure and 14 days following MA. The regime followed for MVA and MA is as prescribed by the WHO guidelines. Given Nepal’s difficult terrain, women also are given the option of taking misoprostol at home.
Drugs used for medical abortion (mifepristone and misoprostol) are approved and registered and their availability assured through the drugs department. To date, Nepal has approved four types of combined packaging of mifepristone-misoprostol. MVA syringes are available through local distributors.

PAC is in place and available 24x7 as emergency obstetric care (EmOC) since 2000. Women presenting with incomplete abortion or abortion-related complications are treated according to the CAC guidelines.

A health management information system (HMIS) is in place to measure the progress of abortion services and identify areas for improvement. On a monthly basis, all public-sector abortion care sites aggregate data on the number of PAC clients, induced abortion clients, clients accepting post-abortion contraceptives and clients with complications. Service statistics are reviewed monthly by site staff, quarterly at district review meetings with site facility managers, and annually at both regional and national review workshops. The Family Health Department also regularly reviews indicators on post-abortion complications and post-abortion contraceptive acceptance (Samandari et al, 2012).

Providing safe abortion services is a key element of the reproductive health strategy of the Government of India. Within this context, Guidelines for Medical Officers on Provision of Manual Vacuum Aspiration at PHC Level up to 8 weeks has been published (Ministry of Health and Family Welfare, 2001) as well as Use of RU-486 with Misoprostol for Early Abortion in India—Guidelines for Medical Officers (WHO, AIIMS, 2003). In 2010, Comprehensive Abortion Care guidelines were published to provide safe and comprehensive abortion care services that include not only the clinical aspects of abortion but also other key elements including counselling and PAC and contraception (Comprehensive Abortion Care Training and Service Delivery Guidelines, 2010).

In India, abortion can be provided only by trained and certified physicians. Abortion for pregnancy up to 12 weeks of gestation can be provided by a registered MBBS doctor who has completed MTP training or has a postgraduate degree or diploma in obstetrics and gynaecology. Abortion up to 20 weeks of gestation can be provided only by doctors who have a postgraduate degree or diploma in obstetrics and gynaecology, a practitioner who has completed six months of house residency in obstetrics and gynaecology, or a practitioner who has at least one year of experience in the practice of obstetrics and gynaecology at any hospital having all essential facilities.

MTP training can be held at government accredited training centres in the public or private sector and adequately equipped clinics or hospitals. Training can be provided only by certified trainers. There is no fixed duration of the training because the trainee has to successfully complete a stipulated number of abortions before he/she can apply for certification to the government authorities, that is, 10 (observed), 10 (assisted) and 5 (independently performed).

Training manuals have been adapted for use in Indian settings. The agenda and topics to be covered during training are based on the 2010 CAC Guidelines, and include an overview of abortion, legal aspects, clinical aspects of vacuum aspiration and medical abortion, and counselling, notable on contraception and value clarification (Comprehensive Abortion Care Training and Service Delivery Guidelines, 2010).

Facilities where abortion services can be provided need to be registered. While medical abortion can be provided in the certified provider’s facility provided he/she has access to a registered facility as back-up, MVA can only be provided in facilities established and maintained by the Government, or a place approved by the Government or an Empowered District Level Committee.
Vacuum aspiration – either manual or electric – for MTP can be performed only up to 8 weeks of gestation at PHC centres whereas pregnancies between 8–12 weeks can be terminated only at higher level facilities. Second trimester abortion (up to 20 weeks of gestational age) can be performed only at higher level facilities, like the sub-district, district or rural hospital. In public sector institutions, MTP services have to be provided free of cost. For the second trimester, medical methods or dilatation and evacuation are suggested.

While the MTP Act permits medical abortion up to 49 days, misoprostol was approved by the Drugs Controller General of India in 2006 (DCGI, 2006) for first trimester abortion in combination with mifepristone. In 2008, a combination pack of mifepristone and misoprostol (1 tablet of mifepristone 200 mg and 4 tablets of misoprostol 200 mcg) was approved by the Central Drugs Standard Control Organisation for Medical Abortion up to 63 days gestation (Government of India, 2008). Medical abortion drugs are included in the Essential Drugs List and currently there are about 20 brands of the two drugs available in the market. Equipment and essential drugs for MVA are also registered and available through the government health-care services.

The protocol for medical abortion suggested is a combination of mifepristone (200 mg) orally followed three days later by misoprostol (400 mcg) either orally or vaginally. Women are required to return 15 days later to ascertain the abortion completion status. In cases of incomplete abortion, the woman is advised to undergo vacuum aspiration (Comprehensive Abortion Care Training and Service Delivery Guidelines, 2010).

PAC is an integral part of reproductive health services, particularly maternal health services. Women presenting with incomplete abortion or abortion-related complications are stabilized, provided emergency treatment as necessary as part of Basic EmOC. If needed, they are referred to a higher level facility for treatment.

Post-abortion contraceptive counselling is emphasized for women undergoing abortion both before and after the procedure, and women are offered a range of contraception choices (Comprehensive Abortion Care Training and Service Delivery Guidelines, 2010).

Monitoring Information Systems (MIS) are in place. For example, all approved centres are required to conserve an admission register in the format prescribed for at least five years from the last entry. This is a confidential document and can only be revealed under order of a court. Six-monthly monitoring in a standardized reporting format is required, along with a web-based HMIS for information flow between States and the central ministry. Facilities providing abortion services are also required to maintain details of women presenting for abortion services including monthly information on the total number of terminations conducted by gestational age; religion; number of acceptors of IUD/sterilization and the number of women falling under each of the criterion for which termination is legal.

In Bangladesh, the National Menstrual Regulation Guidelines prepared in September 2011 adapted the latest WHO guidance document (WHO, 2012b) to the Bangladesh setting (Directorate General of Family Planning, 2011). The Guidelines indicate the norms, policy statements and regulations to be adhered to, and offers technical support to providers to make evidence-based decisions and medical management of clients for MR procedures.

Any registered medical practitioner who has specific training on MR procedures, or has working experience in the obstetrics department of a recognized medical institution where MR

---

2 The Comprehensive Abortion Care Training and Service Delivery Guidelines of 2010 suggest that medical abortion is safe and can be provided for a gestational age up to 63 days. The Ministry of Health and Family Welfare is in the process of modifying the MTP Rules in accordance with the approval of the drugs.
procedures are a part of routine work, can provide MR services for up to 10 weeks of gestational age. Additionally, Female Welfare Visitors (FWV) or other categories of paramedical personnel (e.g. Female Sub-Assistant Community Medical Officers, NGO paramedics) who have undergone a formal paramedical training course of at least 18 months in any recognized institution, and thereafter obtained specific training in MR in a government-recognized MR clinic, are also permitted to provide MR services up to eight weeks from the last menstrual period.

The training duration depends on the category of service provider. For example, MR training for FWVs is typically 2-3 weeks. As part of the training, they are expected to perform 20 pelvic examinations and 20 MR procedures under supervision.

MR can be provided as an outpatient procedure at government service centres and at government approved NGOs and private institutes/ hospitals/ clinics that have trained and skilled service providers on MR with appropriate logistics and equipment. MR services are free of charge in all government facilities.

Pre- and post-abortion counselling is given great importance in the guidelines. During counselling, providers encourage women to abstain from sexual intercourse for seven days after the procedure or until bleeding stops. The options for contraception offered to women include condoms, IUDs, oral contraception, injectables, hormonal implants, tubectomy/tubal ligation, and vasectomy. Emergency contraception is recommended following unprotected sex.

The Director General of Family Planning is responsible for procuring the MR kits (syringe and cannulae) and distributing them to the public service centres and NGO clinics approved. Additionally, misoprostol is also available and listed as an essential drug in the 2011 Guidelines (Directorate General of Family Planning, Management Information System, 2010; Directorate General of Family Planning, 2011).

As per a memorandum issued in 1980 by the Government, Deputy Director, Family Planning in the districts must undertake random inspection of the facilities and the performance of trained doctors and paramedics. It also requires regular reporting by the providers of MR services (Government of the People’s Republic of Bangladesh, 1980).

In Bhutan, abortion services can be provided by medical doctors recognized by the Ministry and who have undergone training in obstetrics and gynaecology or have a certificate of required expertise by a competent institution.

The National Medical Standard for Contraceptive Services and Standard Guidelines on Management of Complications of Abortion Manual includes guidelines on medical termination of pregnancy. These serve as a basis for abortion provision requirements and standards to be followed. The Manual gives details on training requirements for abortion provision. In-service training on safe motherhood, including abortion, is available as an attachment course in regional hospitals for about a month. The manual also stipulates that abortion can be provided only in government hospitals.

Methods recommended in the Manual include suction evacuation and dilation and curettage (D&C) for first trimester pregnancy (6-12 weeks of gestational age); vaginal prostaglandin and abdominal hysterectomy for mid-trimester pregnancy termination. The Manual indicates the protocol to be used for medical abortion.

While mifepristone and misoprostol are registered and included in the national Essential Drugs List, they are not available in the market. MVA syringes are available through the government procurement system.
Post-abortion counselling is mandatory and focuses on the risks of unsafe abortion and on appropriate methods of contraception.

MIS systems are in place and require that a report be submitted to the national HMIS on a quarterly basis. Data are also collected through regular Maternal and Neonatal Death Reviews.

In Thailand, no national standards or guidelines are available for provision of abortion services. Only obstetricians, gynaecologists and physicians are permitted to provide abortion services by law. The Government provides adequate funding to run training and service delivery programmes and the Department of Health is responsible for training physicians and nurses on prevention of unsafe abortion, pre- and post-abortion counselling and care, and use of MVA (Country Profiles, Asian Safe Abortion Partnership). Further, in-service training of five days is available in government hospitals undertaken by the Department of Health, Ministry of Public Health.

Terminations of pregnancy in accordance with the regulations can be performed only in specified medical premises. The main providers are private NGOs, general practitioners’ clinics, private hospitals and gynaecologists in private clinics and hospitals.

In the absence of national standards and guidelines, it is not possible to indicate which methods are recommended. The methods suggested for first trimester abortion are mainly MVA or EVA, while misoprostol is used in the second trimester (Country Profiles, Asian Safe Abortion Partnership). A feasibility study is ongoing on the efficacy and safety of medical abortion.

The Government ensures a regular supply of MVA equipment to public health hospitals and there are no restrictions on importing MVA syringes. However, misoprostol is imported and registered for non-obstetric use while mifepristone is not registered.

Post-abortion contraceptive counselling is provided to the women, who are given a choice of contraceptive methods. PAC is limited and provided mainly by NGO service providers.

While there is no formal reporting system in place, all procedures must be reported to the Medical Council of Thailand. Numeric data are collected yearly from government hospitals by the Ministry of Public Health.

Indonesia has no standard national guidelines on abortion provision. Abortion can be provided by a medical doctor or obstetrician-gynaecologist with a certificate given by the Ministry of Health once they have been trained by accredited training providers. They are required to undergo 5 days of PAC training from the Ministry of Health. While training manuals for abortion services are not available, manuals on PAC are available and this training is integrated into the EmOC training package.

Abortion services can be provided in an approved health care facility that fulfils the criteria laid down by the Ministry of Health. In the absence of national standards and guidelines, it is not possible to indicate which methods are recommended. Generally for first trimester abortion, methods used are D&C, EVA, MVA, and medical abortion with mifepristone and misoprostol combination, misoprostol alone, or with methotrexate misoprostol combination. For second trimester, the preferred methods are ethacridine lactate, misoprostol, dilation and evacuation (D&E), and hysterotomy (Country Profiles, Asian Safe Abortion Partnership). MVA syringes are not available through the government procurement system. Misoprostol is registered for anti-ulcer indication but is not included in the National Essential Drugs List.

While there is no MIS system in place, data on maternal mortality caused by abortion are recorded in the annual Maternal and Child Health survey.
In Sri Lanka, with its restrictive abortion laws and absence of national standards and guidelines, it is difficult to get information regarding providers or methods generally used for abortion procedures. Only gynaecologists who are certified by a Board can provide abortion services. Legal abortion services with clear medical indication to save the life of the woman are available at government hospitals that have specialized maternity and gynaecology units. These services are free of charge when certified by two obstetricians/ gynaecologists and/or a psychiatrist.

Without national standards and guidelines, it is difficult to indicate which methods are recommended. Generally, MR through evacuation is the most preferred method since women seeking abortion report at gestational age of 10 weeks or less. The other method used is D&C.

Misoprostol is not a registered drug but is available in the private sector. While a draft policy for PAC is being developed, women presenting with abortion complications are hospitalized and the treatment is free of charge (Country Profiles, Asian Safe Abortion Partnership). PAC includes contraceptive counselling for the woman/couple on family planning, who are informed that all methods are available free of cost at most of the health institutions providing post-abortion care.

In Myanmar abortion can be provided by obstetrics and gynaecology specialists who had abortion as a subject in their postgraduate training and are working in public hospitals. There is no specialized training on abortion nor are there training manuals available. In-service training of 3 days duration is available at township health departments, and obstetrics and gynaecology specialists provide training for doctors in their wards.

Abortion services can be provided only in public hospitals or specialist hospitals at the obstetrics and gynaecology ward. Doctors in private facilities are not authorized to provide services. National standards and guidelines are not available and hence it is difficult to indicate methods that may be suggested to providers. MVA syringes are available, not through the government procurement system but through projects being implemented in collaboration with the Government, especially the Ministry of Health. Misoprostol is registered only for treatment of gastritis and prevention of postpartum haemorrhage/ active management of the third stage of labour (PPH/AMTSL) but not for abortion. It is registered as an essential drug in the sub-national Essential Drug List. Mifepristone is not registered.

Post-abortion contraceptive counselling is undertaken, including birth spacing. PAC is available at all health facilities through health-care providers, including doctors and midwives. HMIS is in place and monthly data are collected at national level.

In Maldives, abortion services are highly restrictive and can be provided only by registered obstetricians/gynaecologists for recommended cases, that is when thalassaemia is diagnosed or in the case of major fetal anomalies. Abortion can be performed only in selected health facilities and the procedure is covered under the national health insurance scheme.

There is no specialized training for abortion. In the absence of national standards and guidelines, it is difficult to indicate which methods are recommended. Misoprostol is registered but is used only in the hospitals. Mifepristone is not registered. MVA syringe is not available through the government system either.

While women undergo post-abortion contraceptive counselling, there is no PAC policy in place. The Vital Registration System captures the total number of abortions performed but there are no studies on actual abortion rates.
There are no national guidelines available in Timor-Leste. Authorised providers of abortion services are doctors or health professionals based in public health institutions or accredited midwives who have undergone training in EmOC. There is no specific training module available but abortion is included as part of the 15 days EmOC training. Abortion services can be provided only at designated public health institutions.

In the absence of national standards and guidelines, it is difficult to say which methods are suggested for abortion. The most used methods are D&C and vacuum aspiration, both electric and manual (Belton S et al, 2009). An abortion care guideline is integrated within the EmOC training package, and EmOC facilities and equipment are used to provide abortion services. Trained EmOC providers at all health facilities provide PAC services, including referral hospitals, community health centres and health posts. MVA is used to remove products of conception after any kind of pregnancy loss.

Post-abortion contraception counselling is provided after the procedure, and the woman is asked to return after her first menstrual period to receive contraceptive services.

Regular reports are submitted both at the local as well as national level on the number of procedures performed, among other information collected.
Unsafe abortion and deaths due to complications arising out of unsafe abortion continue to affect the lives of women in developing countries. The WHO guidance on *Safe abortion: technical and policy guidance for health systems* published in 2012 highlights a direct link between women’s health and women’s rights, and underlines the need for laws and policies that promote and protect both (WHO, 2012b). The current review suggests that even though abortion is legal in all 11 countries in SEAR, access to safe abortion is limited and restricted. Many barriers delay access to safe abortion services, both within the laws binding provision of abortion as well as availability of facilities, trained providers and essential drugs and equipment.

- **Legal barriers:** Abortion laws in many SEAR countries are nested within the penal codes and indicate that abortion is illegal unless it is performed for specific conditions. The law is thus interpreted as abortion being a crime and the exception to the penal code is not considered applicable. In countries where provision of abortion is permissible only to save the life of the woman, access to services becomes extremely restrictive. There is increasing evidence that where abortion is legal, safe and accessible for a broad range of conditions, unsafe abortion-related mortality can be reduced (WHO, 2012b). There is thus an urgent need to make the laws less restrictive within the context of each country and to the extent possible.

- **Third party authorization:** The law stipulates that abortion procedures should be certified by a provider or a team of experts, or require spousal or parental authorization, thereby further restricting access. For example, in Indonesia abortion services can be provided only if they are based on the guidance of a multidisciplinary team of experts, while in India the provider needs to certify the need for abortion – one provider in case of first trimester and two in case of second trimester abortion. In Thailand, a pregnancy terminated on grounds of mental health has to be certified by a medical practitioner other than the one performing the termination and in case of rape, the regulations require evidence that the pregnancy was caused by rape. Mandatory authorization by the spouse/partner or relative is required in Indonesia and Maldives. In India, while the law does not require spousal/parental consent, providers often demand their consent. Third party authorization may deter a woman from seeking safe and legal services and also violates her right to privacy. To enable women to access safe and timely abortion services, it is imperative that such services can be provided on request without being dependent on the certification of providers, and that spousal/parental consent is required only for minors or those who are incapable of giving consent.

- **Access and health system barriers:** Each of the 11 SEAR countries states that abortion can be provided only in specified registered and approved facilities. Only facilities that fulfil the requirements stipulated by the country government can be registered to provide abortion services. This reduces the availability of safe services, since approved and registered facilities are often located in urban centres, thereby restricting access for rural women who may need to travel long distances to reach an authorized facility. Access is also restricted given the limited personnel who can legally provide abortion services. For example, only an obstetrician/gynaecologist can provide abortion services in Maldives, Myanmar, Sri Lanka and Timor-Leste. In India, only obstetricians, gynaecologists and doctors who have undergone MTP training can provide services. Evidence shows that abortion can be safely provided by trained personnel, including non-physicians. Training of other cadres of service
providers, including mid-level providers, is required to increase the provider base (WHO, 2012b).

• **Absence of standards and national guidelines:** Not all SEAR countries have national standards and guidelines to guide abortion services. The methods used range from the now obsolete D&C to vacuum aspiration to medical abortion for first trimester abortion and D&E and hysterotomy, to mention but a few, for second trimester abortion. In countries where standards and guidelines are not available, there is no standard protocol followed for medical abortion or vacuum aspiration. In order to ensure provision of safe abortion services, it is imperative that guidelines be developed within the context of existing laws of the country, and that standards and guidelines be updated and introduced based on new evidence. The recent WHO guidelines (WHO, 2012b) suggest appropriate methods for pregnancy termination based on gestational age, which should be implemented in the countries to the legal extent possible.

• **Lack of availability of essential drugs and equipment:** Essential equipment and drugs, particularly for medical abortion, are not available in all countries under review. Misoprostol is registered for therapeutic use but not for abortion, and mifepristone is not registered in many countries for this purpose, for example, in Maldives, Myanmar, Indonesia, and Thailand. In order to ensure access to safe abortion services, it is essential to introduce new and safer technology into the public health sector as well as ensure regular availability of MVA syringes and essential drugs within the system.

In order to make significant improvements in access to safe abortion and reduce maternal mortality and morbidity associated with unsafe abortion, it is critical to reform national laws and policies (especially in restrictive environments), and set forth more effective principles and guidelines for public information and service delivery, among other changes. It is also important to ensure that services are available and accessible to manage complications arising from unsafe or incomplete abortions and to provide post-abortion counselling, including contraceptive counselling. Abortion services must be expanded to the full extent of the law of the country and make the necessary changes within the existing health system to deal with this public health concern.
Acknowledgements

This review was developed by Ms Shveta Kalyanwala, with the help, support and guidance of numerous professionals who extended their time, expertise and contacts. The contributions of Dr Bela Ganatra, WHO headquarters and Dr Arvind Mathur, WHO Regional Office for South-East Asia in the review of earlier drafts of this paper and their insightful comments and suggestions are greatly appreciated.

Without assistance from colleagues from IPPF, Ipas and SEARO/WHO Country Offices, the information collected would not have been complete and comprehensive. Acknowledgement must be given for the support of the WHO Country Office colleagues Dr Long Chhun, Bangladesh; Mr Kinley Dorji, Bhutan; Dr Nazira Artykova, DPR Korea; Dr Sunanda Gupta, India; Dr Rustini Floranita, Indonesia; Drs Patanjali Dev Nayar and Nazeera Najeeb, Maldives; Professor San San Myint, Myanmar; and Dr Domingas Ângela Sarmento, Timor-Leste. Special thanks go to colleagues from IPPF who also helped in gathering information – Ms Anjali Sen, Dr Karthik Srinivasan, Ms Susmita Das, India; Dr Mark Molina, Malaysia; and Dr Sumithra Tissera, Sri Lanka. Valuable inputs were also received from Sangeeta Batra and Sushanta Bannerjee, Ipas, India.

Thanks also go to all the many other colleagues who helped in different ways in putting this paper together.


Drugs Controller General, India. Number of permissions and date of issue MF-7059/06. New Delhi, Government of India, 2006.


The need to improve maternal health is identified as one of the key Millennium Development Goals, with a target of reducing global levels of maternal mortality by three-quarters between 1990 and 2015. Women lack knowledge of family planning methods and have limited access to family planning services, which results in unwanted pregnancies. Women die because of complications arising as a result of unsafe abortion. An estimated 21.6 million unsafe abortions took place globally in 2008, resulting in 47,000 pregnancy-related deaths and 5 million women suffering temporary or permanent disabilities. Of these, an estimated 10.8 million unsafe abortions were reported to have taken place in Asia. Restrictive legal provisions, non-availability of national standards and guidelines to guide abortion provision, lack of availability of trained service providers and registered facilities are some of the leading reasons for unsafe abortions and the resulting high maternal mortality and morbidity.

Abortion is permitted in all countries of the South-East Asia Region, at least when there is a threat to the pregnant woman's life. Liberal abortion laws alone cannot ensure safe abortion. There are many barriers that delay access to safe abortion services, both within the laws binding provision of abortion as well as health service delivery guidelines, availability of an adequate number of facilities and trained abortion providers. The WHO Regional Office for South-East Asia mapped the legal situation, the existing policies and guidelines regulating abortion service delivery, as well as identified the gaps in making safe abortion a reality for women in the Region.