World Health Organization
REGIONAL OFFICE FOR South-East Asia

Policies, Programme and Services for Comprehensive Abortion Care in South-East Asia Region

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Foreword

Maternal mortality is a major public health problem across the world and in the WHO South-East Asia Region. Globally, an estimated 303 000 women die every year due to complications during pregnancy and childbirth. Most deaths are preventable, including deaths due to complications from unsafe abortions. In the Region and globally, unsafe abortions account for around 8-11% of total maternal deaths.

The Region has in recent years made substantial progress in reducing maternal mortality. Between 2000 and 2017 the Region reduced maternal mortality by 57%, compared with a global reduction of 38.4%. The Region's maternal mortality rate (MMR) is 152 per 100 000 live births, compared with the global MMR of 211. Across the Region, institutional deliveries now average 72%. Skilled birth attendance at the time of delivery averages 78%.

By providing an overview of the legal and policy context of abortion in the Region, this report will help policy-makers design evidence-based interventions that advance access to safe abortions, post-abortion and contraception services, which will in turn help them to sustain and accelerate reductions in maternal mortality.

Currently, all countries in the Region permit abortion to save a woman's life, which in some is the only time an abortion is permitted. In other countries, abortion is permitted in a range of circumstances, including to preserve a woman's physical and mental health, when there is a fetal impairment or abnormality, and when a pregnancy is the result of rape or incest.

Notably, all countries legally require a health care provider to authorize termination, and they restrict the type of provider and facility that can offer abortion services. The standards and guidelines affecting abortion services in the Region vary, impacting the quality of abortion services provided. It is imperative that WHO's guidelines on the provision of sexual and reproductive health services are accessible to all health care providers, including those that provide abortion services.

I am certain that this report will be of great value to Member States in their ongoing quest to reduce maternal mortality. No woman should die from preventable causes while pregnant or giving birth. Together, we must ensure all women in the Region have access to quality reproductive and sexual health services, for a healthier and more sustainable future for all.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia

Abbreviations and acronyms

ANM	auxiliary nurse midwife
CAC	comprehensive abortion care
D&C	dilatation and curettage
D&E	dilatation and evacuation
EML	Essential Medicines List
FP	family planning
MA	medical abortion
MCH	maternal and child health
MMR	maternal mortality ratio
MR	menstrual regulation
MTP	medical termination of pregnancy
MVA	manual vacuum aspiration
NGO	nongovernmental organization
OB-GYN	obstetrician/gynaecologist
PAC	post-abortion care
SEA	South-East Asia
SOP	standard operating procedure
WHO	World Health Organization

Executive summary

Of the estimated 55.9 million abortions that occurred worldwide each year from 2010 to 2014, a large majority (about 49.3 million) were reported in developing countries as compared to 6.6 million in developed countries. An estimated 45% of all women worldwide who terminated a pregnancy had an unsafe abortion, translating to more than 25 million unsafe abortions per year. Unsafe abortion accounts for 8–11% of maternal deaths globally.

Over the past decade, there have been major contextual changes globally. On the one hand, more countries have expanded the legal grounds for abortion. Medical abortion (MA) has revolutionized access to safe abortion by providing a non-invasive alternative to surgical methods of abortion, particularly in countries where abortion services are highly restrictive or not legal. On the other hand, some countries including the United States and several countries in the former Soviet Bloc or zone of influence with broadly liberal laws have added restrictions that hamper access to legal procedures, thereby restricting women's access to safe and legal abortion care.

The overall objective of this exercise is to present an overview of the legal and policy context of abortions in the countries of the World Health Organization (WHO) South-East Asia (SEA) Region, namely Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. For these 11 countries, this report includes:

- an analysis of the laws governing provision of abortion;
- mapping of the current policies and guidelines regulating abortion service delivery;
- summary & challenges based on global technical evidence, primarily the WHO document Safe abortion: technical and policy guidance for health systems, 2012.

All countries of SEA Region permit abortion to save a woman's life. Bangladesh, Myanmar, Sri Lanka and Timor-Leste have very restrictive laws that permit abortion only to save a woman's life. No information is available about the legal context in Democratic People's Republic of Korea. Bhutan, India, Nepal and Thailand probably have the most liberal abortion laws and permit a woman to terminate a pregnancy on a broad range of grounds, including to save a woman's life, preserve a woman's physical health, preserve a woman's mental health, in case the pregnancy is a result of rape/incest and if there is fetal impairment/abnormality. India's abortion law indirectly makes it permissible to seek abortion on economic and social grounds,

while Nepal permits a woman to demand abortion on request up to 12 weeks of gestation. It also includes an additional ground for termination of pregnancy – if a woman is living with human immunodeficiency virus (HIV) or any incurable disease of such nature. The situation varies among other countries – termination of pregnancy resulting from rape/incest or fetal impairment is permitted in Indonesia and Maldives.

All countries include legal requirements of providers authorizing the need for termination, restrictions on the type of provider and facility where these services can be legally provided, or third-party authorizations. These requirements affect the ease with which women can access abortion services as needed. Though MA has been recognized as a safe and effective method of terminating a pregnancy, mifepristone and/or misoprostol are not registered as abortifacient in most of these countries. The status of standards and guidelines also varies, thus significantly impacting the quality of abortion services.

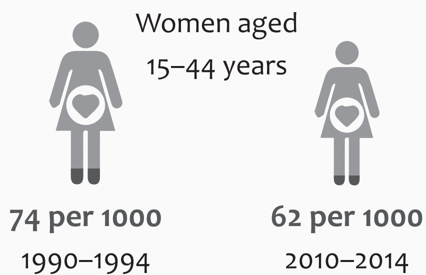
Access to safe abortion care should be universally available for women who want to terminate an unintended pregnancy. There is a growing need to create an enabling environment that respects and protects women who are legally eligible to access safe abortion services and reduce unsafe abortion. Services have to be expanded to the full extent of the laws of the country and can be added to the existing health services at a minimal cost, ensuring that women have access to safe and legal services. Also, as recommended in the WHO guidelines on Health worker roles in providing safe abortion care and post-abortion contraception, safe abortion services in early pregnancy can be provided at primary-care level by trained, mid-level health providers.

Further, it should be recognized that PAC is an integral part of health-care services and plays a crucial role in not only reducing morbidity and mortality due to unsafe abortion but also preventing repeated unwanted pregnancies and thereby the need for subsequent abortions.

1 | Global context

The annual rate of unintended pregnancies across the world declined significantly from 74 per 1000 women aged 15–44 years in 1990–1994 to 62 in 2010–2014 (1). There are many factors resulting in an unintended pregnancy, including non-use or ineffective use of contraception. Other factors include pregnancy resulting from rape or incest, or risk to a woman's well-being including her physical and mental health (2). It is estimated that 44% (99 million) of the world's annual 227 million pregnancies are mistimed or unintended, of which 56% end in abortion, 32% in an unplanned birth and 12% in miscarriage (3).

The annual rate of unintended pregnancies across the world declined significantly

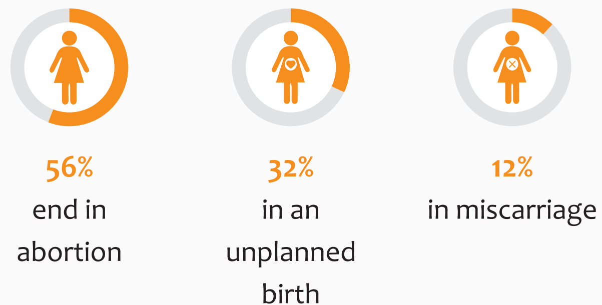


Women aged 15–44 years

74 per 1000
1990–1994

62 per 1000
2010–2014

44% (99 million) of the world's annual 227 million pregnancies are mistimed or unintended

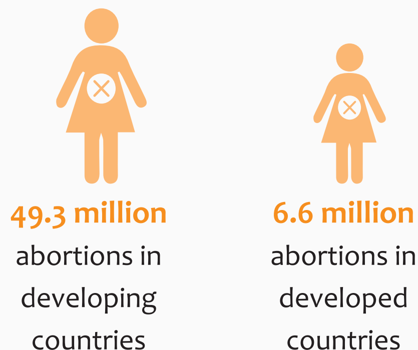


56% end in abortion

32% in an unplanned birth

12% in miscarriage

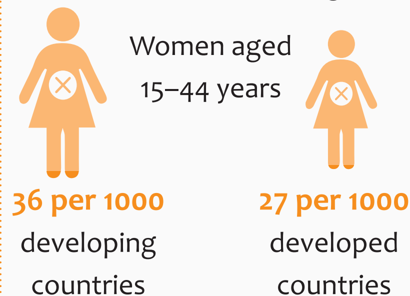
An estimated 55.9 million abortions occurred each year on average from 2010 to 2014



49.3 million abortions in developing countries

6.6 million abortions in developed countries

The rate of abortion is higher

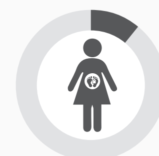


Women aged 15–44 years

36 per 1000 developing countries

27 per 1000 developed countries

8–11% of global maternal deaths are attributed to unsafe abortion



An estimated 55.9 million abortions occurred each year on average from 2010 to 2014, with about 49.3 million abortions reported in developing countries as compared to 6.6 million in developed countries. The rate of abortion among women aged 15–44 years is higher in developing countries (36 per 1000) as compared to developed countries (27 per 1000). In other words, an annual rate of 35 abortions per 1000 women means that a woman would have one abortion in her lifetime (2).

Unsafe abortion continues to pose a significant public health challenge, and 8–11% of global maternal deaths are attributed to unsafe abortion. Countries reporting high unsafe abortions are those with highly restrictive laws and predominantly low-income and middle-income countries located mainly in developing regions (3). Aside from restrictive laws, other barriers include policies that limit provision of abortion, conscientious objection by service providers, requirement of third-party authorization and mandatory counselling and waiting period, to name a few.

Against this global backdrop, the major contextual changes that stand out in the past decade are:

- Some countries with broadly liberal laws have added restrictions that chip away at access to legal procedures.
- Since 2000, 28 countries have changed their abortion laws, all but one expanding legal grounds to allow abortions to protect a woman’s health, for socioeconomic reasons or without restrictions as to reasons.
- Twenty-four countries added at least one to three additional grounds: in cases of rape, incest, or when the fetus is diagnosed with a grave anomaly.
- The recognition of MA (mifepristone and misoprostol, or misoprostol alone) as a safe, effective and acceptable method for termination of pregnancy has revolutionized access to safe abortion by providing a non-invasive alternative to surgical methods of abortion, particularly in countries where abortion services are highly restrictive or not legal. This has had an important impact on abortion-related morbidity and mortality requiring a redefinition of safety and its measurement (2).[a]
- In 2012, WHO updated its technical and policy guidance entitled Safe abortion: technical and policy guidance for health systems. This document included a set of policy recommendations.
- Based on emerging evidence on safety and acceptability of other cadres of service providers, WHO developed recommendations in 2015 indicating that safe abortion services in early pregnancy can be provided at primary-care level and provided guidance on the specified cadres of health workers who can provide this care (4). Trained, mid-level health providers were included to provide abortion services in many countries, thereby increasing the provider base.

This report focuses on WHO SEA Region and aims to map the current abortion-related legal contexts and relevant policies of countries in this Region. The countries included in this report are Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand, Timor-Leste and Nepal.

[a] WHO now uses three categories: safe (done using a recommended method and by an appropriately trained provider); less safe (meet either method or provider criterion); and least safe (meet neither criterion) abortions, which represent a gradient of risk depending on factors including abortion method, provider and gestational age.

2 | Methodology

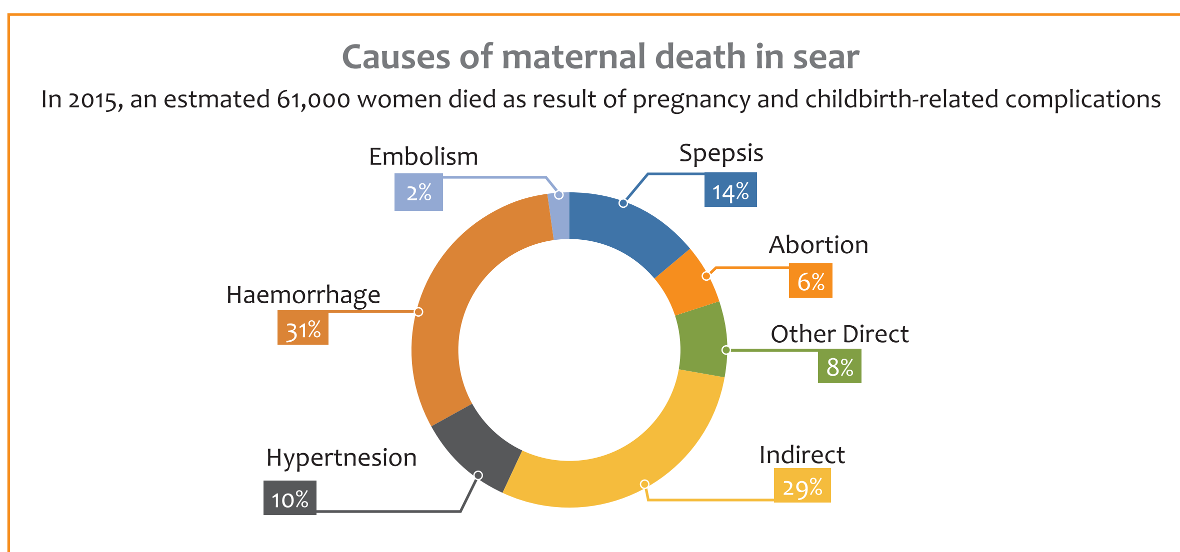
The overall objective of this exercise was to provide an update on the legal situation of abortion in the countries of SEA Region and the existing policies and guidelines regulating abortion service delivery.

An intensive desk review of available documents was undertaken to gather information and data on the legal status of abortion in countries, as well as the national standards and guidelines for providing abortion services, where available. To ensure standardization of information collected and to assess gaps in information, a template was created to populate information for all countries. The literature search was conducted through several search engines. Technical references were accessed from specialized websites such as WHO, United Nations Population Fund, United Nations Development Programme and Guttmacher Institute. Peer-reviewed articles and reports were accessed by typing keywords in the search engine such as abortion, PAC, family planning, and so on.

To confirm the information collected, and in some cases to build upon the same, country-wise information was compiled into factsheets and drafts were sent to the countries for their feedback and inputs. Further revised factsheets were prepared for review by WHO country focal points at a regional workshop in October 2019. The data and information were finally vetted and have been consolidated into this report and 11 country factsheets.

3 | Regional context

In Asia, during 2010–2014, an estimated 35.5 million induced abortions occurred each year. The annual rate of abortion declined (though not significantly) from 41 per 1000 women in the reproductive age (15–44 years) in 1990–1994 to 36 per 1000 women in 2010–2014 (5).



Source: Say L, Chou D Gemmill A Tuncalp Ö Moller AB, Daniels JD, et al. Global causes of maternal death: a WHO systematic analysis . Lancet Global Health 2014;2: e323-e33

In Asia, laws governing abortion vary from being liberal to highly restrictive. Even where broadly legal, women face several barriers in accessing safe and legal services. Health system barriers include lack of trained providers for abortion–even when trained, many providers are not willing to perform abortions due to legal barriers. The condition of health facilities to provide safe abortion services is not standardized. Lack of awareness about legality of abortion among women as well as service providers, and the stigma attached to abortion, further impede access to safe abortion services.

The sociopolitical context of the countries in the SEA Region is very diverse. The countries also vary in their reproductive health profile. Maternal mortality rate (MMR) ranges from 36 per 100 000 women in Sri Lanka to 250 per 100 000 women in Myanmar. Similarly, one sees a variation in the unmet need for family planning as well as contraceptive prevalence rates. For instance, contraceptive use (any method) was reported by just 19% of women in Maldives compared to 79% in Thailand. Unmet need for family planning was reported by only 6% women in Thailand, while 25% women in Timor-Leste reported so (Table 1). The total fertility rate also varies in these countries, ranging from 1.5 in Thailand to 4.2 in Timor-Leste (data not shown).

Table 1: Key reproductive health indicators

Country	Maternal mortality rate (MMR) (2017) UN MMIEG 2019	Number of maternal deaths	Unmet need for family planning (%)	Contraceptive prevalence (%)
SEA Region	152	61 000		
Bangladesh	173	5500	12	62
Bhutan	183	20	11.7	65.6
Democratic People's Republic of Korea	89	300	7	78
India	145	32 000	12.9	53.5
Indonesia	177	12 000	11	64
Maldives	53	5	31	19
Myanmar	250	1700	16	52
Nepal	186	1500	24	53
Sri Lanka	36	127	7.5	64.6
Thailand	37	270	6.2	78.4
Timor-Leste	142	94	25	26

Source: Collated from various sources

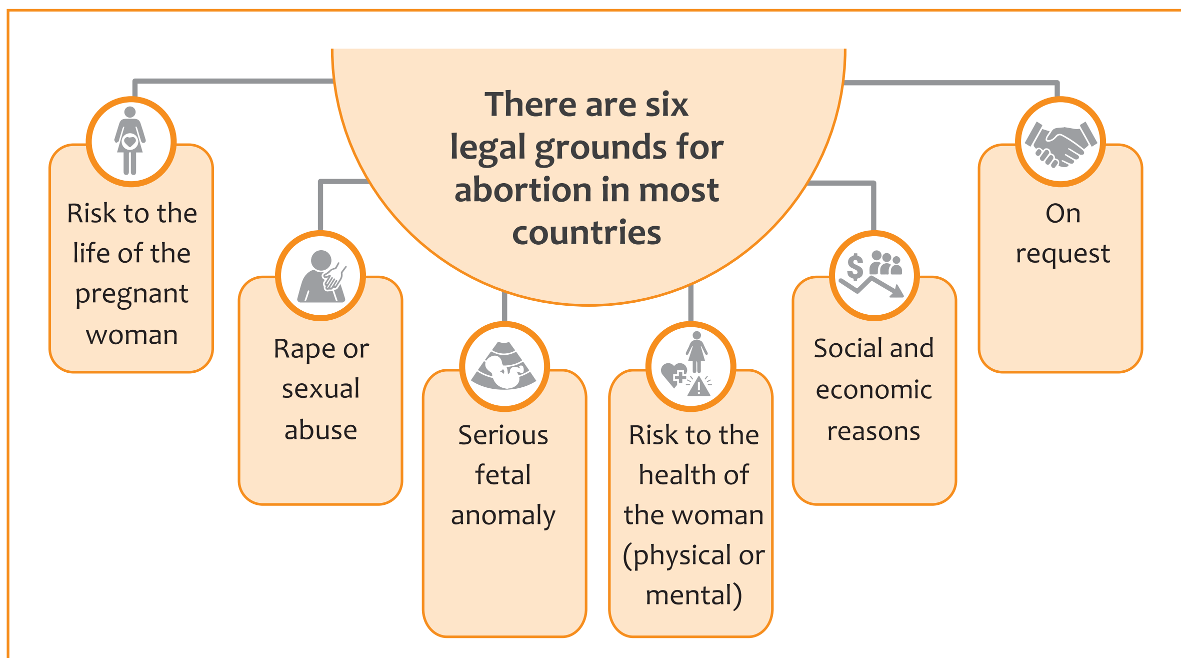
There is a dearth of country-specific data on maternal deaths resulting from complications of abortion or unsafe abortion. However, available data indicates that maternal mortality due to unsafe abortion is high in the countries of SEA Region, ranging from less than 1% in Bangladesh to 13% in Timor-Leste. In Timor-Leste, 13% of maternal deaths are attributed to complications of abortion. On the other hand, Bangladesh Maternal Mortality Survey reports that less than 1% of maternal deaths in Bangladesh are due to unsafe abortion (6).

4 | Abortion-related laws

To compile information for this section, relevant laws of countries or decrees or orders as applicable – documents that bring abortion into the legal ambit and/or guide the provision of services–were studied.

Evidence indicates that the average rate of unsafe abortions is more than four times higher in countries where abortion access is restricted as compared to countries where it is less restricted. Countries with restrictive abortion laws report on average a three times higher MMR (223 maternal deaths per 100 000 live births) as compared to countries with less restrictive laws (77 maternal deaths per 100 000 live births) (7). These deaths could have been prevented with provision of sexuality education, family planning services and availability of safe and legal abortion services.

The number of countries that legally permit abortion has increased over the years. The laws range from prohibiting abortion to allowing it without restrictions. The majority of women of reproductive age (42%) live in countries where abortion is highly restricted – either prohibited altogether or permitted only to save the woman's life or protect her health. Further, 125 countries (93%) with highly restrictive laws are in developing regions. Since 2000, changes in laws governing abortion were implemented in 27 countries; these countries expanded the law to include health and socioeconomic grounds under which a woman can access abortion services. Additionally, 24 countries added one or more of the three grounds under which abortion is legal, including pregnancy resulting from rape or incest or detection of fetal anomaly (8).



Between 1996 and 2013, United Nations Department of Economic and Social Affairs (UN DESA) reported that the percentage of national governments permitting abortion has increased gradually for all legal grounds. In the SEA Region, Bhutan, Nepal and Thailand legalized abortion to preserve a woman's mental health. Nepal added preservation of a woman's physical health as an additional ground for permitting abortion (*10*).

4.1 Laws governing abortion in SEA Region

WHO recommends that a country's laws and policies on abortion should aim to protect women's health and rights. To the extent possible, an enabling regulatory and policy environment should be created that ensures that women have access to safe and timely abortion services (*11*).

In countries where abortion is legal and available, the procedure is generally safe. However, unsafe abortions tend to be higher in countries where it is legally restricted. Almost all countries in the world have one or more legal indication for provision of abortion services. Where it is restrictive, abortion service is limited to the management of complications of unsafe abortion, post-abortion care (PAC) . Though treatment of post-abortion complications reduces maternal mortality and morbidity arising from unsafe abortions, a woman's right to access safe and legal abortion services is necessary to save her life.

In the past two decades, a number of declarations and resolutions have been passed and signed by countries across the world. There is a growing consensus that unsafe abortion contributes significantly to maternal mortality, and that it can and should be prevented through provision of sexuality education, family planning services and safe abortion services. PAC is unanimously recognized to be an important component of the health delivery system irrespective of the countries' legal status on abortion.

The 11 countries of SEA Region are also signatories to these international declarations that aim to build consensus on increasing access to safe abortion, and support governments to take appropriate opportunities to create a legal and policy environment to save more women by preventing them from choosing an unsafe abortion.

Laws in these 11 countries range from being very restrictive to not restrictive. Though legal, laws governing provision of abortion are nested within penal codes of all countries of SEA Region. Thus, if a woman accesses abortion outside of the legally permitted domain, she is likely to be punished along with the abortion provider.

As seen in Table 2, all countries under review permit abortion to save a woman's life. Bangladesh, Myanmar, Sri Lanka and Timor-Leste have very restrictive laws that permit abortion only to save a woman's life.

Table 2: Grounds on which abortion is permitted in SEA Region countries

Country	To save a woman's life	To preserve a woman's physical health	To preserve a woman's mental health	Pregnancy resulting from rape or incest	Because of fetal impairment	For economic or social reasons	On request	Other reasons
Bangladesh	X							
Bhutan	X	X	X	X	X			In cases of intellectual and cognitive disability of the woman
DPR Korea	No information available							
India	X	X	X	X	X	X		
Indonesia	X			X	X			
Maldives	X			X	X			
Myanmar	X			X				
Nepal	X	X	X	X	X		X	In cases of women suffering from HIV or other incurable disease of such nature
Sri Lanka	X							
Thailand	X	X	X	X	X			
Timor-Leste	X							

Source: Various

Among the countries of SEA Region, Bhutan, India, Nepal and Thailand probably have the most liberal abortion laws and permit a woman to terminate a pregnancy on a broad range of grounds including to save a woman's life, preserve a woman's physical health or mental health, if pregnancy is a result of rape or incest and if there is fetal impairment/abnormality. India's liberal abortion law mentions that providers should consider the economic and social conditions of the woman seeking abortion, thus indirectly making it a permissible ground for abortion. Nepal also permits a woman to demand abortion on request up to 12 weeks of gestation. The country includes an additional ground for termination of pregnancy – if a woman is living with HIV or any incurable disease of such nature.

In Bangladesh, abortion is illegal. The term used for abortion is "menstrual regulation", which is defined as the "procedure for regulating the menstrual cycle when menstruation is absent for a short duration". This permits a woman to access an abortion up to 12 weeks of gestation provided the abortion is deemed necessary to save her life.

Among countries other than Bhutan, India, Nepal and Thailand, the situation varies. In addition to these four countries, termination of pregnancy resulting from rape/incest or fetal impairment is permitted in Indonesia and Maldives.

4.2 Legal requirements and conditions for accessing abortion

Despite access to safe, standardized abortion services even under broad grounds, it is not always possible for women to terminate an unwanted pregnancy. Most countries have legal requirements – to certify the need for abortion, gestational age limits, certification of the service provider and listing facilities that can provide services. These often act as barriers to timely and safe access to abortion services. Each country has laws that regulate provision of abortion services. The guidelines and standard operating procedures (SOPs) depend upon the country's context and the actual situation regarding provision of abortion in the country. The guidance document developed by WHO provides several guidelines aimed at increasing the availability of safe abortion services. For example, task-sharing and task-shifting aim to reduce the burden on the health system. WHO Guidance on task-shifting advocates provision of abortion by trained mid-level providers at primary-level facilities (*12*). MA is a good provision that can be provided with minimum infrastructure in primary-level facilities or at a physician's clinic, though access to back-up services is essential to manage abortion-related complications.

4.2.1 Provider certification

A woman cannot demand abortion on request, except in Nepal where a woman can request for abortion within 12 weeks of gestation. Service is provided without consent from the husband or guardian except in the case of minors. In Bangladesh, no authorization of a doctor is required; this may be so because the procedure is called menstrual regulation and not termination of pregnancy.

Even if a woman's life is in danger and she is in need of a termination urgently, in Timor-Leste a panel of three doctors, excluding the doctor performing the procedure, needs to sign before providing safe abortion services. The country also suggests that there should be a delay, where possible, of at least two days between the consent from service providers and performance of the procedure.

To provide safe abortion even when it is legally permissible, the number of doctors required to sign off a termination varies from country to country. In Bhutan, two medical doctors need to certify that termination is essential for all conditions for legal abortions and is limited to a gestation period of 180 days.

India's liberal laws also require one doctor to certify the need for abortion during the first trimester and two doctors for a second-trimester abortion. It also limits access to abortion up to 20 weeks unless the procedure is required to save a woman's life.

In Nepal, accessibility of services is affected by the requirement of a licensed doctor to provide services in listed sites for termination of pregnancy for a very wide range of indications with the woman's consent, to save the life of a woman or preserve her physical and mental health or in case of fetal impairment. No authorization is required for pregnancies resulting from rape/incest or when a woman is suffering from HIV or other incurable diseases of such nature. Recently, the gestation limit for legal abortions in the country has been increased to 28 weeks.

Thailand does not require an authorization if the abortion is performed to preserve a woman's physical health. However, in cases where abortion is sought to preserve a woman's mental health, a medical practitioner other than the one providing termination of pregnancy needs to authorize the procedure. For pregnancies caused by rape, there needs to be evidence or fact leading to a reasonable belief that the pregnancy is caused by the offence. This may take time, resulting in increase in weeks of pregnancy followed by higher chances of complications during the abortion procedure. Women seeking abortion for fetal impairments are required to undergo genetic counselling and require a written certification by at least one medical practitioner other than the one performing the termination.

Indonesia requires medical indications and prescriptions for termination of pregnancy even when it is being performed to save a woman's life or if there is fetal impairment. Additionally, pregnancies as a result of rape need to be proved before a woman can receive an abortion service.

Maldives also requires doctors' certification of fetal impairment or congenital anomaly before planning for termination of pregnancy. There is also a limit of gestation age of up to 120 days.

4.2.2 Third-party authorization

Third-party authorization is the consent given by the husband, guardian or any legally bona fide person to obtain legal abortion services for a woman. Requiring the consent of a spouse or partner can limit a woman's ability to access services on her own. Based on the principles of reproductive rights, laws in Bangladesh, India, Nepal, Sri Lanka and Thailand only require consent from the woman undergoing the procedure. On the other hand, Maldives and Timor-Leste require the spouse/partner to sign off along with the woman undergoing termination. Indonesia also requires spousal consent except in cases of pregnancy resulting from rape. There is no mention of a requirement for spousal consent in Bhutan's law, but this is indicated in their Medical and Health Council Regulations. However, it is not included in the standard guidelines for management of complications of abortion.

The WHO document Safe abortion: technical and policy guidance for health systems, second edition suggests the recognition of a woman seeking termination as an autonomous adult who is mentally competent to take a decision about her body and health. Third-party authorization from partner, spouse, parent or guardian should not be a requirement for provision of abortion services.

In case of a minor or mentally challenged person, consent of the parent/guardian is required in

all countries for which data were available.

The current law and policy in Nepal recognizes that in the case of a woman below 18 years of age, safe abortion services shall be provided keeping in mind her best interests.

4.2.3 Abortion as a penal offence

There is an increasing demand from women's groups and advocates of abortion to decriminalize abortion. In all 11 countries of SEA Region, provision of abortion , including self-abortion, is a criminal offence if not provided under the laid down legal stipulations. Although varied across countries, penal codes prescribe punishments for the woman seeking abortion, any person providing abortion services, including physicians, midwives, pharmacists or any other person and any person who provides information on abortion. The punishment ranges from three to ten years with or without fine, depending on the gestational age of the pregnancy.

5 Abortion-related guidelines

With the objective of increasing availability of safe abortion across the world, WHO released updated the abortion-related guidelines in 2012 (11). In addition, WHO Guidance on task-shifting advocates for provision of abortion by trained mid-level providers at primary-level facilities (*13*). The target audience for the guidelines is policymakers, programme managers and providers. The guidelines aim to enable evidence-based decision-making with respect to safe abortion care and suggest that the clinical recommendations be individualized to each woman, with emphasis on her clinical status and the specific method of abortion to be used while considering each woman's preferences for care.

While the law provides a broad framework for access to abortion services, it is expected that details of service delivery, including standards of service delivery, will be translated to the people through policies, regulations, complementary guidelines and SOPs. WHO recommends that standards and guidelines should cover the following–types of abortion services; who can provide those services safely and in which facilities; what abortion services can be provided; essential equipment, drugs and supplies; and referral mechanisms with linkages. Respect for a woman's autonomy, independence in decision-making and maintaining confidentiality and privacy are to be ensured while providing these sensitive services. Special attention and provision for adolescents and women who are victims of rape/incest, and conscientious objection by providers (11) are also included as an important recommendation in WHO Guidelines.

Not all countries of SEA Region have national guidance and standards for induced provision of abortion or PAC. In the absence of guidelines, some countries depend on the laws for guidance on who can provide abortion and at what kind of facilities. The guidelines will facilitate standardized services, train service providers and improve access to safe abortion and PAC.

Table 3 gives the availability of abortion-related technical standards and guidance in SEA Region.

Table 3: Availability of abortion-related technical standards and guidance

Country	Induced abortion	Post-abortion care
Bangladesh	Available	Available
Bhutan	Available	Available
Democratic People's Republic of Korea	Not Available	Not Available
India	Available	Available
Indonesia	Not Available	Not Available
Maldives	Not Available	Not Available
Myanmar	Not Available	Available
Nepal	Available	Available
Sri Lanka	Available	Available
Thailand	Available	Available
Timor-Leste	Available	Available

Available Not Available

5.1 Who can provide abortion services

WHO has provided evidence-based recommendations in a guideline on health workers' role in providing safe abortion care, PAC and contraceptives to deliver evidence-based recommended services. It highlights the range of health workers who can provide abortion services, depending upon the availability of appropriate human resources in a country. It recommends task-shifting and task-sharing to address staff shortages and improve equity in accessing health services and increasing acceptability of health services for those receiving it (13).

Despite availability of broad grounds for abortion, legal requirements on who can provide abortion and where to obtain services from can be a barrier to accessing safe abortion services.

The legal requirement of countries that only medical practitioners can provide abortion services acts as a barrier to accessing safe services. For example, Bhutan, Maldives, Myanmar and Timor-Leste permit only obstetricians/gynaecologists (OB-GYNs) to provide abortion services, even though the existing number of specialists (OB-GYNs) in all countries are insufficient and deployed centrally. India includes general practitioners who have obtained training and are certified as abortion providers by appropriate authorities. Indonesia and Thailand permit only licensed practitioners, though the law does not specify the cadre of the practitioner.

Bangladesh and Nepal are two countries in the Region that have implemented task-shifting and include mid-level providers as abortion service providers. Bangladesh permits this cadre to provide abortion services for up to 8 weeks of gestation and Nepal up to 12 weeks.

5.2 Where can abortion be provided

Legal requirements on the place of abortion can also restrict or facilitate access to services. Myanmar and Timor-Leste indicate that abortion can only be provided at public health facilities, including at medical colleges and hospitals.

Bangladesh, India and Nepal also permit primary health posts and government-approved private facilities and nongovernmental organization (NGO) clinics to provide abortion services. In India, MA can be provided at an unapproved clinic, provided the clinic has a referral linkage to a facility approved under the law to manage complications, if any.

The laws controlling the place where abortion services can be provided are very restrictive in Bhutan and Thailand. Bhutan specifies that abortion can be provided only where there is blood transfusion facility available and Thailand permits only those hospitals or infirmaries that have provisions for overnight stay.

Indonesia and Maldives do not specify the level of facility but require certification of facility.

Sri Lanka does not specify where abortion can be provided.

5.3 How can abortion be provided

WHO Guidance recommends MA or vacuum aspiration as a desirable method of abortion for pregnancies ≤ 12–14 weeks gestation age. For pregnancies >12–14 weeks, MA and dilatation and evacuation (D&E) are the preferred methods (12).

Information on recommended methods of induced abortion is available for only four countries of SEA Region–Bangladesh, Bhutan, India and Nepal.

For first-trimester-induced abortions, standards and guidelines of all four countries recommend surgical and medical methods–although the use of MA is limited to a maximum of 10 weeks' gestation age in Nepal. It may be noted that standard guidelines in Bhutan continue to mention use of dilatation and curettage (D&C) for induced abortion.

Only India and Nepal allow termination of pregnancies in the second trimester. Indian service delivery guidelines, in line with the WHO Guidelines 2014, recommend surgical methods (including vacuum aspiration and D&E) and include the MA drug protocol (although the Drug Controller General of India limits the use of MA drugs for abortion up to 9 weeks of gestation). Nepal includes both medical termination and surgical methods of abortion in second-trimester abortion in listed comprehensive emergency obstetric care (CEmOC) sites. The service providers – OB-GYN and medicine in general practice–are certified to provide second-trimester abortion services after undergoing standardized competency-based training.

A compilation of country-level guidance on provision of abortion services is given in Table 4.

Table 4: Country-level guidance on provision of abortion services

Country	Cadre of provider	Where abortion services can be provided	Method used for abortion
Bangladesh	Up to first trimester: specialist, non-specialist Up to 8 weeks: paramedics	Government medical institutes, medical colleges & hospitals, district hospitals, mother & child welfare centres, maternal and child health (MCH)-family planning (FP) clinics, union health & family welfare centres, government-approved private and NGO clinics	Combination of mifepristone and misoprostol for menstrual regulation of pregnancy up to 9 weeks and vacuum aspiration for pregnancy between 6 and 12 weeks
Bhutan	OB-GYN	Hospital with blood transfusion facility	Mifepristone and prostaglandin; vacuum aspiration; D&C
Democratic People's Republic of Korea	No information available		
India	Specialists (OB-GYN); general physicians certified as abortion providers	Up to first trimester: all public facilities, approved private clinics and NGO facilities Second trimester: secondary- & tertiary-level facilities; approved private clinics	Up to 9 weeks: MA using a combination of mifepristone and misoprostol; vacuum aspiration. Second trimester: comprehensive abortion guidelines of 2018 includes drug protocol for second-trimester abortion as per WHO 2014 Guidance
Indonesia	Health personnel certified by ministry	Facility approved by ministry	No information available
Maldives	Registered OB-GYNs	Selected health facilities (not specified)	No information available

Country	Cadre of provider	Where abortion services can be provided	Method used for abortion
Myanmar	Gestational age of 12 weeks: specialist (OB-GYN); non-specialists can provide abortion under the guidance of OB-GYN	Station hospitals, township hospitals, district hospitals and higher	Misoprostol alone, manual vacuum aspiration (MVA) and D&E
Nepal	First trimester: non-specialist; nurse including auxiliary nurse midwife (ANM) Up to second trimester: specialist (OB-GYN)	Primary health centre, district health centre, specialized public facility, private facility, NGO clinics	For 9 weeks of gestation, MA using mifepristone–misoprostol combination. For 12 weeks of gestation MVA is recommended. No method is specified for second-trimester abortion
Sri Lanka	Not specified	Not specified	No information available
Thailand	Registered and licensed medical practitioner	Government hospital with overnight stay facility or medical infirmary with beds for overnight stay Up to 12 weeks: medical clinic in accordance with Medical Premise Act	Includes two methods, i.e. MA and MVA (MVA subject to gestational age)
Timor-Leste	OB-GYN	Public health facility	No information available

5.4 Availability of MA drugs

Availability and regular supply of drugs and equipment are indicators of access to safe abortion services. Mifepristone and misoprostol are registered and part of the Essential Medicine List (EML) only in India and Nepal. Combination of both drugs as a single pack is listed only in Nepal. Misoprostol is used for other gynaecological indications and is registered in Bangladesh (2), Bhutan, Myanmar and Timor-Leste. It is not indicated as a drug to be used for termination of pregnancy. Maldives includes both mifepristone and misoprostol in its EML but indicates that it is for restricted and hospital use only. Indonesia, Sri Lanka[b] and Thailand do not include either

mifepristone or misoprostol in their EML. No information is available for Democratic People's Republic of Korea.

Recommended drugs for medical methods of abortion in countries are given in Table 5.

Table 5: Medical methods of abortion – drugs recommended (combi-pack, mifepristone + misoprostol or miso alone), registration of drugs, mention in essential drug list

Countries	Misoprostol		Mifepristone		Combi-pack of mifepristone and misoprostol	
	Registered for use	Included in EML	Registered for use	Included in EML	Registered for use	Included in EML
Bangladesh	X!	X!	X*	X		
Bhutan	X!	X!				
Democratic People's Republic of Korea	No data available					
India	X	X	X	X	X#	X#
Indonesia						
Maldives	X!	X!	X!	X!		
Myanmar	X!	X!				
Nepal	X	X	X	X	X##	X##
Sri Lanka!!						
Thailand						
Timor-Leste	X!	X!				

! Registered for use only for gynaecological purposes

* Mifepristone is not on the 2008 List of Essential Drugs but the Bangladesh National Menstrual Regulation Services Guidelines indicate that it has been registered.

Medical abortion by MTP Act is legal up to 49 days. Comprehensive Abortion Care Guidelines, 2018, have a footnote indicating that it is safe up to 63 days. Combi-pack (1 tablet of mifepristone 200 mg & 4 tablets of misoprostol 200 mcg) approved for up to 63 days gestation in December 2008.

Up to 9 weeks

!! Although misoprostol is not listed in the Sri Lanka 2009 Essential Medicine List, the Sri Lankan Post-Abortion Care guidelines (Document 2) provides some general guidance for the use of misoprostol. Additionally, the ministerial directive also details and authorizes the use of misoprostol.

Source: WHO human reproduction programme – country profiles

[b] Although misoprostol is not listed in the Sri Lanka 2009 Essential Medicine List, the Sri Lankan Post-Abortion Care guidelines provides some general guidance for the use of misoprostol. Additionally, the Ministerial directive also details and authorizes the use of misoprostol.

6 | Guidelines on PAC

PAC includes management of complications of both spontaneous and induced abortions. Complications vary from simple incomplete abortion to life-threatening severe conditions. Post-abortion complications continue to be of concern. Nearly 7 million women in developing countries are treated for complications from unsafe abortions annually, and at least 22 000 die from abortion-related complications every year (*14*).

In countries where abortion laws are restrictive, women undergo abortion from unsafe providers or locations resulting in severe complications and maternal mortality or morbidity. Even in countries with less restrictive laws, if services are difficult to obtain, women choose abortion self-care, often procuring MA drugs from pharmacists. In all these situations, women may seek care at facilities that can only provide incomplete abortions and may need additional care in cases of complications.

Based on emerging evidence on increasing use of MA, WHO has redefined measures of safety in abortion. Three categories are used to define abortion – safe (done using a recommended method and by an appropriately trained provider); less safe (meeting either method or provider criterion); and least safe (meeting neither criterion) abortions, which represent a gradient of risk depending on factors including abortion method, provider and gestational age.

[Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model.]

No national guidelines are in place for PAC in Indonesia, Maldives and Timor-Leste (Table 3). However, women presenting themselves with complications are required to be treated at public facilities.

In Bangladesh, PAC is mentioned as an integral component of the Menstrual Regulation programme, but there is limited guidance available on treatment of complications, including use of misoprostol for the same.

Bhutan, India, Myanmar, Nepal and Sri Lanka have in place guidance for treatment of post-abortion complications that can be treated at different levels of facilities.

Key country-level highlights include the following:

- Bangladesh permits facilities at primary health-care level to provide PAC.
- Standard guidelines for management of complications of abortion in Bhutan state that if a woman comes in with complications after an illegal abortion, she should be treated with respect and without any bias. These services can be provided by general practitioners or specialists.
- India has in place standards and guidance for provision of comprehensive abortion care (CAC) including PAC. These guidelines were revised in 2018 and are aligned with the latest recommendations of WHO *Safe abortion: technical and policy guidance for health systems.* However, only OB-GYNs or medical practitioners who fulfil training criteria as specified in the Medical Termination of Pregnancy (MTP) Act and Rules can provide PAC.
- Myanmar Strategic Plan (2013–2018) on Reproductive Health prioritizes strengthening management of miscarriage and PAC as an integral component of reproductive health services. The national Post Abortion Care Guidelines, 2015, reflect WHO recommendations regarding uterine evacuation technologies–for the first time, PAC using medical methods (misoprostol) was included.
- In Nepal, comprehensive abortion services can be provided by a range of providers including OB-GYNs (specialists), non-specialist physicians and nurses (including staff nurses and senior ANMs). It can be provided at facilities that meet the specifications of infrastructure including providing 24x7 emergency services, having designated spaces for registration and counselling and a procedure room.
- Sri Lanka permits a woman who has undergone illegal abortion to access care from any government facility without fear of prosecution. Though the guidance says that emergency PAC services should be available even at the most basic rural health posts, this is largely located in specialist gynaecology units. At the primary health-care level, medical officers are required to initiate treatment before referring the woman to a higher-level facility. For management of incomplete abortion, the guidelines recommend using misoprostol. Other methods include manual vacuum aspiration (MVA) and D&E.

7 | Summary

Based on country-level mapping, this chapter summarizes the policy highlights and gaps for all 11 countries that are part of this report.

In Bangladesh, while induced abortion is permissible only to save the life of a woman, menstrual regulation has been available free of charge in the government's family planning programme since 1979. In recent years, the government introduced policy reforms including increasing the time frame for menstrual regulation from 10 weeks to 12 weeks; approved the use of menstrual regulation through medication (MRM) up to 9 weeks; and allowed trained nurses to offer menstrual regulation. However, mifepristone or the kit containing the combination of MA drugs are not part of the EML. Notably, the National Menstrual Regulation (MR) service delivery guidelines mention the confidentiality of services and emphasize the importance of upholding the dignity and autonomy of women undergoing MR. The country has also ensured initiation of PAC at primary health-care level, even though limited guidance is available on PAC including on the use of misoprostol for PAC.

In Bhutan, abortions are guided by the *Standard guidelines for health workers on management of complications of abortion.* The guidelines clearly acknowledge the lack of family and social support for women undergoing abortions and urge providers/facilities to treat women seeking treatment for complications of abortion with the same respect as they would treat any other client. In addition, abortion care is mentioned as an intervention, especially for adolescents in the National Health Promotion Strategic Plan. However, the country's policy documents do not uniformly describe abortion and MTP. While the documents say that abortion is illegal, and termination of pregnancy is permitted under certain conditions, the penal code clearly legalizes abortion under certain circumstances. This is also probably a reason why methods of abortion are not described in detail in the guidelines or elsewhere – they are mentioned as treatment of abortion complications.

The Democratic People's Republic of Korea issued a directive in 2015 banning medical professionals from performing birth control procedures and abortions to reverse the country's falling birth rate. As a result, there are no documents on abortion laws and policies and the indicators related to it.

India now endorses the CAC programme that recognizes abortion as more than just a medical procedure. In addition to the liberal legal provisions for abortion, India follows the national *Comprehensive abortion care training and service delivery guidelines* to ensure standardized

practices across the country. The national CAC guidelines were revised in 2018 and aligned with recommendations of the latest WHO *Safe abortion: technical and policy guidance for health systems.* MA drugs are included in the essential drugs list, and MVA equipment and essential drugs for MVA are registered and available in public sector facilities. In recent years, there has been increased focus on integration of CAC with post-abortion contraception, with key guidance documents by the national government including a technical update and operational guidelines on post-abortion contraception. However, the Drug Controller General of India limits the use of MA drugs up to 9 weeks of gestation; and the Indian abortion law permits only allopathic doctors to provide abortion services, excluding a range of other potential providers – doctors of complementary systems of medicine, nurses and ANMs.

In Indonesia, the Health Law permits abortion only for limited conditions. Despite its limitations, the law emphasizes the need to provide safe high-quality services . However, the country's operational guidelines stipulate several preconditions, hampering access to services; Indonesia does not have any standards and guidelines for provision of services. Further, neither misoprostol nor mifepristone are part of the country's EML.

In Maldives, advocacy efforts, particularly with the religious groups, led to amendment in the country's penal code. This resulted in the expansion of conditions under which abortion can be provided. However, even though abortion is permitted for several indications, there is no legal clarity. National standards and guidelines for induced abortion and PAC are not available. Abortion-related drugs and supplies are not part of the registered product list, and approval status is ambiguous.

In Myanmar, the 5-Year Strategic Plan for Reproductive Health (2014–2018) clearly prioritizes strengthening of management of miscarriage and PAC as an integral component of reproductive health services. In 2015, the national PAC guidelines reflected WHO recommendations regarding uterine evacuation technologies – for the first time, PAC using medical methods (misoprostol) was included. However, while the contents of the essential package of reproductive health interventions in the 5-Year Strategic Plan talk about counselling, including on dangers of unsafe abortion, there are no policies for making abortion safe.

In Nepal, abortion provisions are included in the Right to Safe Motherhood and Reproductive Health Act, enacted in September 2018. Since the legalization of abortion less than two decades ago, the country has made significant progress, including introduction of a task-shifting mechanism to ensure availability of safe abortion services up to the community level through ANMs, increased access to MA by ensuring supplies and availability of drugs, and practice of a one-visit protocol for MA compared to a two/three-visit protocol. However, safe abortion services were excluded from the *Nepal Health Sector Strategy 2015–2020* that includes maternal health-care services, family planning services and PAC. Free abortion services were later addressed through the separate *Safe Abortion Service Guidelines* of 2016.

Sri Lanka has a restrictive abortion environment, which stipulates that abortion is illegal unless the life of the mother is at risk. In 2013, the Law Commission proposals called for legalization in the case of rape and fetal impairment; but this was not taken forward.

In Thailand, abortion is legalized (under limited circumstances) by the Criminal Code and further guided by the Medical Council Act. Given the religious context of the country, it is notable that the Thai Civil and Commercial Code clearly states that the fetus, while inside the mother's womb, is not considered as having any legal right as a person until it is delivered alive. The law and policy documents do not recognize conscientious objections, even though providers refuse to perform abortion due to their religious beliefs and the assumption that abortion is illegal. The Standard of Practice for Comprehensive Safe Abortion Care for health-care providers was made available in 2018 and service providers are updated. Provision of safe abortion services in Thailand include two methods, i.e. MA and MVA (MVA subject to gestational age). In addition, combination of Mifepristone and Misoprostal was approved by the Thai FDA in 2014, and officially included in the National Essential Drug List in 2018.

In Timor-Leste, although a penal code was adopted in 2009 that permitted abortion to save a woman's life and health, abortion was made highly restrictive through a Decree Law 19/2009. The law lays down several preconditions (for example, gaining agreement from three doctors in addition to the one performing the abortion) and allows termination of pregnancy only when it is the only means to save the pregnant woman's life. The country has no focus on access to contraception and no strategy to tackle unsafe abortion although it is recognized as a direct cause of maternal mortality.

Table 6 presents an overview of available policies and legal documents in the 11 countries.

Table 6: Snapshot of policies and legal sources related to abortion in SEA Region countries

	BAG	BHU	DPRK	IND	INO	MDV	MMR	NEP	SRL	TLS	THA
Reproductive health act								■			
General medical health act					■						
Constitution											
Criminal/penal code	■	■		■	■	■	■	■	■	■	■
Civil code											
Ministerial order/ decree				■		■					
Case law											
Health regulation/ clinical guidelines	■	■		■			■	■	■	■	■
EML	■	■	■	■	■	■	■	■	■	■	■
Medical ethics code											■
Documents relating to funding											
Abortion specific law				■							
Law on medical practitioners											
Law on health-care services											
Others				■				■		■	

Source: WHO Global Abortion Policies Database

■ **Available documents**

* Section 416, The Penal Code, 2014 https://www.law.upenn.edu/live/files/4203-maldives-penal-code-2014

** Fathwa released by the Fiqh Academy of Maldives (Government's Council of Religious Scholars) that currently guides abortion service provision in the country

BAN – Bangladesh; BHU – Bhutan; DPRK – Democratic People's Republic of Korea; IND – India; INO – Indonesia; MDV – Maldives; MMR – Myanmar; NEP – Nepal; SRL – Sri Lanka; THA – Thailand; TLS – Timor-Leste

7.1 Legal grounds for abortion

Evidence suggests that where abortion is legal, safe and accessible for broad indications and upon a woman's request, mortality and morbidity related to unsafe abortion are reduced.

The WHO Guidance document recognizes that there is a global trend towards liberalization of abortion laws with nearly a third of UN Member States permitting abortion upon informed request of the pregnant woman. Restricting access to abortion does not decrease the need for abortion but is likely to increase the number of women seeking illegal or unsafe abortions (*15*).

Among the countries of SEA Region, Bhutan, India, Nepal and Thailand have the most liberal laws governing provision of abortion and permit a woman to terminate a pregnancy on a broad range of grounds.

Bangladesh, Myanmar, Sri Lanka and Timor-Leste have very restrictive laws that permit abortion only to save a woman's life.

Nepal is the only country that permits abortion upon request of the pregnant woman up to 12 weeks of gestation.

7.2 Third-party authorization

WHO Guidance document states that the requirement of spouse/partner or parental or hospital authorization may prevent women from seeking safe and legal services.

7.2.1 Requirement of spousal/partner consent

Requirements of spouse/partner consent vary across countries of SEA Region. Bangladesh, India, Nepal, Sri Lanka and Thailand only require consent from the woman undergoing the procedure. However, Indonesia, Maldives and Timor-Leste require the spouse/partner to sign off along with the woman undergoing termination.

Requiring the consent of a spouse or partner can limit a woman's access to services on her own.

7.2.2 Evolving maturity and guardian consent

All countries of SEA Region require that parents/guardians sign off a consent form in cases of termination of pregnancy for minor girls.

In all countries of SEA Region, the law requires the parent's/guardian's consent when a pregnancy termination is sought for a woman with any mental illness.

There is a need to acknowledge the evolving maturity or mental capability of a woman to take an independent decision for her own health and well-being.

7.2.3 Provider certification

WHO Guidance document states that laws, policies and practices that restrict access to abortion information and services can deter women from seeking safe and legal abortion services. One of the key barriers is requirement of certification by one or more medical professionals or hospital committees (*16*).

In the SEA Region, all countries require that one or more medical practitioners certify or

approve the need for termination even when such termination is legal on broad grounds. When applied to cases where a woman's life needs to be saved, it impinges on her right to life, as is seen in Timor-Leste.

Indonesia and Thailand place additional barriers where a doctor needs to certify that an abortion is being sought on mental health grounds or fetal impairment. These countries also require proof that the pregnancy to be terminated is the result of rape/incest. This poses a barrier and particularly affects young women who either may not access legal services or are denied abortion outright.

7.3 Access and health system barriers

The WHO Guidance document suggests that restricting the range of providers (e.g. gynaecologists only) or facilities (e.g. tertiary level only) that can legally provide abortion reduces the availability of services and equitable geographical distribution. This results in women having to travel long distances for care, thereby increasing costs and delaying access. Regulation of facilities and providers should be evidence-based to protect against over-medical, arbitrary or otherwise unreasonable requirements. Facility and provider regulation should be guided by criteria currently required for provision of safe abortion services (*17*).

7.3.1 Facilities for provision of abortion services

Each of the 11 countries of SEA Region have restrictions on the type and level of facility that can provide abortion services. These services can be provided only in approved and/or registered facilities that fulfil the requirements stipulated by the government of that country.

Bangladesh, India and Nepal permit abortion services starting at the primary level and government-approved private and NGO clinics. Bhutan and Thailand have a requirement of blood transfusion facility and overnight stay, respectively. These laws restrict availability of abortion services since the approved and registered facilities are largely located in urban areas, thereby restricting access for rural, marginalized women and those who live in hard-to-reach geographical areas.

It is well known that permitting home administration of misoprostol after provision of mifepristone at the facility can improve privacy, convenience and acceptability of services without compromising on safety. This option is not available in most countries of SEA Region.

7.3.2 Providers of abortion services

The WHO Guidance document states that abortion care can be safely provided by any trained health-care provider, including mid-level providers. This cadre of mid-level providers includes non-physician clinicians, midwives, nurses, family welfare visitors, etc. who are trained in providing basic clinical procedures related to reproductive health service.

It recognizes that in many contexts, training of mid-level providers will be required in order to increase service availability (*18*).

Bangladesh and Nepal are the only two countries that permit non-specialists, nurses and paramedics to provide menstrual regulation and abortion after they have undergone the requisite training. In all other countries, a termination can be performed only by gynaecologists or doctors who have been trained and certified for provision of abortion. Designating only specialized doctors, mainly OB-GYNs, as abortion service providers limits access, especially for women who live in rural and difficult, hilly terrain.

7.3.3 Gestational age

Laws and policies guide limits of gestational age within which abortion can be performed. This has negative consequences for women who have exceeded this limit, forcing them to seek abortion services from unsafe or illegal sources or self-induce with misoprostol or less safe methods – in some cases forcing them to seek services in other countries (*19*).

When a termination is sought to protect a woman's life, the countries of SEA Region do not impose gestational age restrictions except for Maldives (120 days).

For other grounds of termination, the limits on gestational age vary from 120 days (Maldives) to 28 weeks (Nepal). Women who discover their pregnancy later or are unable to access timely services are often denied services, resulting in unsafe terminations.

It is a challenge in most of the countries of SEA Region to make services available at the primary-care level with a referral linkage to higher facility and to expand the range of service providers by including mid-level service providers.

7.4 Standards of service and national guidelines

Bangladesh, Bhutan, India and Nepal are the only four out of 11 countries of SEA Region that have in place national-level standards and guidelines for provision of abortion and PAC.

PAC standards and guidelines are in place in Myanmar and Sri Lanka. Timor-Leste has drafted a PAC guideline, which is in the process of finalization.

In countries where standards and guidelines are not available, no standard protocol is used for providing vacuum aspiration or MA.

In countries of SEA Region, methods used vary from the now obsolete D&C to vacuum aspiration and MA.

MA using a combination of mifepristone and misoprostol is used in Bangladesh, Bhutan, India and Nepal for termination of pregnancies of up to 10 weeks (9 weeks in India and Bangladesh, and 10 weeks in Nepal). WHO Guidance states that MA is a safe and effective method for second-trimester abortion.

Essential equipment and drugs, particularly for MA, are not available in all countries of SEA Region. Misoprostol is registered for gynaecological use but not for abortion in Bangladesh, Bhutan, Maldives, Myanmar and Timor-Leste.

India and Nepal are the only two countries that have registered a combi-pack of mifepristone and misoprostol for first-trimester pregnancy termination. Mifepristone is not registered in Bhutan, Indonesia and Myanmar.

7.5 Country-level challenges

Bangladesh: In Bangladesh, abortion is termed as illegal and is permitted only to save a woman's life. However, a woman can access menstrual regulation services up to 12 weeks after missing a menstrual cycle. A major challenge is listing MA drugs in EML for abortion and ensuring availability of quality MA drugs that are registered.

Bhutan: Though there is no mention of requirement of spousal consent in Bhutan's law, it is indicated in the Medical and Health Council Regulations. The country does not have an expanded base of abortion providers. It specifies that abortion can be provided only where blood transfusion facility is available.

Democratic People's Republic of Korea: In the Democratic People's Republic of Korea, standards and guidelines on abortion and PAC do not exist, thereby hampering evidence-based practices.

India: Given its population size and the current doctor–population ratio, the country struggles to meet the needs of women. The country lacks an expanded provider base for abortion services.

Indonesia: The requirement of spousal/partner consent and proof of rape lead to delays in termination of pregnancy. Misoprostol and Mifepristone are also not registered as MA drugs, but only for gynaecological purposes.

Maldives: Task-shifting for abortion services has not been considered, which could have played a crucial role in improving accessibility of indicated abortion care. Also, abortion and PAC technical standards and guidance are not available.

Myanmar: Capacity-building of service providers to manage legally permitted abortions and post-abortion services is a challenge. Absence of technical standards and guidance for abortion care hampers delivery of quality services

Nepal: Nepal's laws governing termination of pregnancy are very liberal. However, provider authorization restricts a woman's access to abortions.

Sri Lanka: Misoprostol is not registered in the country. Also, in 2013, the Law Commission proposals called for legalization in the case of rape and fetal impairment. However, this was not taken forward.

Thailand: Thailand has in place provider authorization requirements for terminations sought on grounds of mental health or pregnancy resulting from rape or fetal impairment – these pose challenges for women seeking abortions for these conditions. The country has also not taken steps to include expanded cadres of providers to be trained as abortion providers. Further, abortion services can be provided only at hospitals or infirmaries that have provision for overnight stay to be service providers . Misoprostol and mifepristone are not registered as MA

drugs, but only for gynaecological purposes.

Timor-Leste: Abortion services are highly restricted in Timor-Leste. The country requires that a panel of doctors approve termination even if a woman's life is in danger. It permits only OB-GYNs to provide abortion services while there are very limited specialists in the country. Absence of technical standards and guidance for abortion and PAC hampers delivery of quality services.

In conclusion, access to safe and legal abortion should be universal. Women should have the right to decide freely and responsibly whether and when to have children without coercion, discrimination or violence (*20*). An enabling environment with policies that respect, protect and fulfil human rights would ensure that every woman who is legally eligible has access to safe abortion services. Abortion services must be expanded to the full extent of the law of the country and necessary changes made within the exiting health system. Further, where abortion is legal, there is a need to ensure that services are accessible in practice. Abortion services can be added on to existing health services at a minimal extra cost, ensuring that women have access to safe abortion at public health facilities. PAC is an integral part of health-care services. It is essential to ensure that services are available and accessible to manage complications arising from unsafe or illegal abortions.

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