World Health Organization
REGIONAL OFFICE FOR Europe

IPPF International Planned Parenthood Federation
European Network

Improving access to safe abortion care and related reproductive health services in the European Region

Meeting report
Riga, Latvia 30–31 May 2012

ABSTRACT

Despite progress in improved access and quality of family planning services, access to good-quality abortion services and post-abortion family planning remains a challenge in many countries of the WHO European Region. This meeting disseminated new WHO recommendations on safe abortion care and encouraged participating Member States to act on their responsibility for the health in providing adequate health and social measures and respect for human rights.

WHO has updated the Guidance on Safe Abortion. This publication could serve as an effective process in analysis of technical and legal barriers in improving access to safe abortion care and improving the health of women in the European Region.

Keywords

Abortion, Induced - methods - standards
Maternal and Child Health
Prenatal care - organization and administration - standards
Reproductive health services
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Women's health

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Background

Access to safe, legal abortion services has been critical in reducing the maternal mortality and morbidity in the European Region. However, there are countries where women continue to be harmed and die from unsafe abortion.

Objectives of the meeting

1. Share country experiences and results from applying the WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes related to safe abortion;
2. Introduce participants to the WHO guidelines from 2012 on the provision of safe abortion;
3. Discuss non-technical barriers (e.g. legal, social, economic, value- and rights-related) to accessing safe abortion care, particularly for vulnerable groups of the population;
4. Develop recommendations for concerted action to improve access to comprehensive safe abortion care.

Opening session

Welcome addresses

Ingrida Circene, Minister of Health of Latvia, welcomed participants and opened the meeting noting the seriousness of the issue not just for participants but as an issue of global human rights.

The rate of induced abortions in Latvia has gradually decreased yearly, resulting in a five-fold reduction over 30 years.

Latvia has declared 2012 as the national Year of Maternal and Child Health. The significant policy planning document *Public Health Strategy for 2011- 2017* placed additional importance on safeguarding mother and child health the Ministry of Health has developed a working party to monitor through an auditing system and implement the WHO "Beyond the Numbers" approach. Attention must be paid to education of youth.

The rate of induced abortions in Latvia has gradually decreased yearly, resulting in a five-fold reduction over 30 years. If a woman has decided to have an abortion, she must have access to safe and high quality treatment and care.

Zsuzsanna Jakab, WHO Regional Director for Europe, extended her thanks for efforts to improve women's maternal health in Latvia, and for declaring 2012 as Year of Maternal and Child Health. Thanks to partners and international organizations in particular IPPF European network for support in improving women's health issues was given. Together with partners, WHO has made remarkable progress. There are substantial declines in abortion rates, however, many women still do not have access to safe abortion services. Limited access to means of preventing unintended pregnancies, and to safe abortion services results

in about 22 million unsafe abortions globally, and causes close to 50 000 maternal deaths each year. There is a need for a better understanding of barriers and ways to reach vulnerable groups, such as migrants and adolescents.

WHO analyses the data and provides evidence to governing bodies. The newly developed WHO guidelines *Safe abortion: technical and policy guidance for health systems* show that we know what needs to be done – together we will work to make abortion rare, accessible and safe.
Link to guidelines:
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/index.html

Bert Van Herk, IPPF European Network Regional Treasurer, introduced the IPPF European Network as a lead advocate for the right to safe abortion. Also today abortion must remain a key priority in our work, as many women still do not have access to effective family planning and safe abortion, and the rights of women are often still disregarded. Implementation of the WHO guidelines will be a key tool and IPPF European Network is ready to assist and support the implementation of the guidelines at the national level, focusing both on women and health service providers. Bert Van Herk confirmed the joint aim of the hosts of the meeting – that women of the Region should have access to abortion care whenever and wherever they need it.

Sandra Roelofs, First Lady of Georgia and WHO Goodwill Ambassador in the European Region for health-related Millennium Development Goals (MDGs), addressed participants regarding the priorities for achieving MDGs and improving maternal health in the Region. Although we are close to the goal, there are still too many maternal deaths. Especially in the Eastern part of the European Region there is still progress to be made.

The First Lady expressed health as a public good and a fundamental human right. Without proper registration and universal access to reproductive health it is not possible to achieve progress. This shows the importance of internationally approved guidelines. In addition, it is essential to provide guidance on family planning and prevention of unwanted pregnancies to adolescents.

Gauden Galea, Director of Noncommunicable Disease and Health Promotion WHO Regional Office for Europe, emphasized that the issue of safe abortion is not just about numbers, but about justice. Maternal deaths do not represent a large number of the public health burden but the issue is about the fundamental right to health. Unsafe abortion must be dealt with as part of Millennium Development Goals. There is a need to develop national strategies from the global strategy.

Maternal mortality and morbidity is underreported in many countries and although maternal deaths have decreased, women still die from unsafe abortions. Health systems are well developed in countries of the European Region and not a single woman should be dying from abortion complications. However, the best way is to avoid unwanted pregnancies. In some countries there is still a limited knowledge about modern contraception. Several countries are revising their legislation and

look to WHO for guidance – the outcome of this meeting will be part of this guidance.

Gauden Galea identified three actions needed to accelerate progress – we must:

- tackle inequalities
- strengthen health systems
- strengthen health information systems.

Discussion

The discussion that followed with members of the opening panel focused on whether countries felt they had made progress in tackling unsafe abortion since the meeting held in Riga in 2004. Following are some of the main points raised by the panel:

- In Latvia statistics show that the rate of induced abortions has decreased. One of the challenges is the quality of the sexuality education programme in schools that is currently under discussion with the Ministry of Education.
- WHO Regional Office for Europe noted that progress has been made: maternal mortality has declined and the number of induced abortions has been reduced. The aim is to prevent the need for abortion. Good and accurate reporting including complications due to abortion is essential. In several countries an awareness of the available, evidence-based guidelines for safe abortion, and how to of implement them is missing.
- WHO Regional Director described this as a complex problem where it is paramount to address the issue of equity. WHO promotes universal coverage to provide safe and high quality services in addition to avoiding unintended pregnancies.
- IPPF EN illustrated progress by noting that in some countries abortion has been legalized and access has improved, like in Portugal. At the same time, other laws are becoming more restrictive and it is therefore crucial to keep safe abortion on the political agenda.

Points raised by participants of the meeting included:

- Despite obvious achievements there is a need to work on furthering **equitable access to contraceptives** for rural and urban populations.
- **Progress has been made** both medically and in terms of national legislation.
- One should be aware that sometimes there is a misunderstanding between **clinical guidelines and technical guidance**. It is important to clarify the difference when WHO tools are presented in the countries.
- Important not to focus on reducing the numbers of abortions reported but more on preventing **unintended pregnancies**. Although we know how effective contraception is and we have health systems in place, **contraceptive prevalence rates are still low** in many countries.
- Use of **alcohol and drugs influence unsafe sexual behaviour,** and is one reason abortion rates are high despite the availability of contraception.
- **Mifepristone and misoprostol** has made a big impact on the severity of unsafe abortion – for example, it can now be bought in markets, but without

proper knowledge about it use it can be ineffective and even harmful. Ways to prevent incorrect use should be explored.

Using the WHO Strategic Approach to improve access to and quality of abortion care in the European Region

Panel discussion

The panel members represented countries where the strategic approach has been implemented:

Brankica Mladenovik /TFYRM,

Arsen Askerov/Kyrgyzstan,

Rodica Scutelnic/Republic of Moldova,

Ekaterina Yarotskaya/Russian Federation,

Mihai Horga/Romania,

Vladislav Kaminsky/Ukraine

Ronald Johnson from WHO headquarters facilitated the session and described the huge inequities in the WHO European Region – the Western part of Europe has the lowest abortion rates in the world and the Eastern part has the highest. This is due to poverty coupled with unavailability of safe services, stigma and lack of confidentiality.

The *Strategic Approach to strengthening sexual and reproductive health policies and* programmes is a strategic planning and policy and programme implementation tool that consists of three stages: (1) a strategic assessment to identify a country's reproductive health needs and priorities; (2) introduction of interventions on a small scale to address priority needs; and, (3) scaling-up proven interventions to expand their benefits to more people and to strengthen institutional capacities. Key features of the strategic approach are:

- country owned and country led;
- multidisciplinary and participatory;
- systems focused;
- grounded in a philosophy sexual and reproductive health and human rights;
- strategic and qualitative.

The Western part of Europe has the lowest abortion rates in the world and the Eastern part has the highest. This is due to poverty coupled with low rates of safe services, stigma and lack of confidentiality .

The Strategic Approach can be used for different areas of reproductive health but relevant for the meeting objectives are those guided by three strategic questions:

- How to reduce unintended pregnancies?
- How to improve access and availability of safe, legal

abortion care?
- How to improve quality of abortion care?

The strategy for policy and programme strengthening is built around key partners and the interplay of their individual roles and relationships.
Member State: brings political authority, ownership, leadership and national standards.
WHO: brings global health authority/credibility, evidence-based guidelines, technical support and political cover for addressing sensitive issues
NGO/Civil society: brings accountability, local coordination, training and implementation.
Development partner: brings financial resources, provide inputs on governance and strategic direction.

The chronology of events and activities in the Republic of Moldova was given as an illustration of the process.

The panel discussion which followed centred around three questions:

1. What was greatest benefit and challenge of conducting a strategic assessment?
2. What one piece of advice would you give to a neighbouring country's Minister of Health considering conducting a strategic assessment?
3. What key follow up actions can you attribute to the strategic assessment?

The following is an overview of the main discussion points by theme.

Raising awareness:

- The greatest benefit from conducting the strategic assessment was the opportunity of making reproductive and sexual health issues more visible in society and focusing awareness on illegal, unsafe abortions. In addition, the strategic assessment provided different perspectives (patient, service provider, etc.) on the complex issue of abortion.

- A comprehensive approach is needed as it is important that both decision-makers and service providers are engaged. Scaling up at the national level resistance is a logistical and managerial challenge, so participation and support from all levels is important.

Forming alliances and developing leadership:

- The main benefit of a strategic assessment is the development of key national leaders in this field. People who participated in the assessment play a crucial role at national level in communicating with government officials in improving access and quality of services and in maintaining access to abortion services.

- The strategic assessment managed to bring together key stakeholders at the highest possible level. This made change more sustainable – exchanging

information at policy and population level as people and positions move around.

- Importance of working very closely in cooperation with partners in family planning became clear. The alliances made it possible to counter opposition and protect women's rights.

- Creating and developing broad coalitions involving for example health care insurance companies which could support accessibility of safe abortion could be investigated.

Change in attitudes:

- The strategic assessment allowed to demonstrate to policy-makers (Ministries of Health and other policy-makers) the facts beyond the figures, it made them listen to the attitudes of people and to look at the abortion issue as something that could be much safer and more accessible. It led to moving forward with practical steps, such as revising the national standards to make them in line with international evidence-based guidance.
- The community started to perceive abortion as a necessary procedure and now female clients began to have better access.
- The greatest challenge was the fear and resistance to change among health-care providers.
- The changing of attitudes of the providers is a good marker of success.
- The assessment revealed that there is a negative attitude to abortion in many post-Soviet countries.
- The best indicator of the quality of abortion services in pilot health facilities was the increased demand for these services. This also reflected the population's trust and satisfaction with the services.

Objective information:

- The strategic assessment gives an objective picture and provides information for policy-makers to understand the real situation.
- The strategic assessment was essential in promoting evidence-based protocols implemented in clinical training.
- Objective information supports the legislative process. In one country, data from a strategic assessment was presented in a Parliamentary hearing and convincing to lawmakers.

Usefulness of the WHO guidance at country level in developing national guidelines:

- The WHO guidance proved helpful in developing good-quality (national?) standards.
- The guidance was useful in describing how to provide safe abortion.
- It was useful in various policy levels as it provides evidence-based guidance in developing policies and programmes.

Problems identified through strategic assessments:

- Resistance among some groups of population and policy-makers.
- Revelation of gaps in training providers especially in counselling.
- Despite conducting monitoring, the reports on numbers of abortion presented to the Ministries of Health were not always based on accurate numbers.

When participants in the assessment were asked if some steps could have been bypassed in implementation they responded that the process should take time, as through strategic assessment we are changing the perception of the community towards abortion. It is not just a medical problem, but involves human rights, behaviour, and the attitude of the whole community not just the medical profession. Political will should be invoked not only by respected professionals but by civil society understanding that their rights can be repressed by restrictive abortion legislation. We are should involve gender movements, and NGOs dealing with human rights. There is a good result after the first phase, but no limit to scaling up. The topic of safe abortion on pre- and post-graduate level and involving national experts and authorities as speakers at universities will help reduce the time required for training.

Defining goals:

Following the presentation of the country experiences, discussion continued in plenary regarding the definition of common goals regarding pregnancy-related mortality and morbidity.

There was a plea for caution in articulating a goal – it should not be to “have no maternal deaths” but rather “ to reduce maternal deaths”. We all must accept that some deaths will occur regardless of the safeguards in place and thus we should not raise the expectations of policymakers beyond realistic levels.

It is the responsibility of the medical community to explain the complexity of maternal deaths and morbidity, which includes a range of environmental factors such as access, availability of services, and parental consent, as well as quality of care. Although the ultimate goal is to reduce maternal deaths, it is important to bear in mind that the issue is about quality of care, respect, dignity and confidentiality.

There is also a need to address the fact that when speaking about maternal deaths sometimes real numbers are hidden. Regarding management of abortion, countries should follow the recommendations of the WHO.

Tools in improving access to and quality of safe abortion service

Plenary session – Updated WHO tool "Safe abortion: technical and policy guidance for health systems"

A panel of three experts presented the **WHO safe abortion: technical and policy guidance for health systems 2nd edition:**

Nathalie Kapp – Medical Officer, WHO headquarters
Maria Rodriguez – Medical Officer, WHO headquarters
Eszter Kismodi – Human Rights Adviser WHO headquarters

Almost ten years after the launch of the WHO Safe abortion guidance: "Safe Abortion: Technical and Policy Guidance for Health Systems", the guidelines are still one of most downloaded documents from WHO's Department of Reproductive Health and Research web site. In developing the updated version, stakeholders and health professionals were asked what the key questions are in abortion care which need to be addressed. Systematic reviews were done for each of these questions and resulted in evidence-based recommendations.

A clinical handbook for safe abortion care was created in parallel. This was created based on feedback from the field and is intended to be a practical, easy-to-follow guide for practitioners. It reflects the clinical recommendations from the Technical and Policy Guidance.

Key recommendations

Pain management
All women should be offered pain medication. When undergoing either surgical or medical abortion, general anaesthesia should not be routinely applied.

Surgical abortion
Vacuum aspiration is the recommended technique of surgical abortion for pregnancies up to 1214 weeks gestation.

Surgical versus medical
Both methods are recommended in the first trimester of pregnancy. Women should be able to choose between them when ever possible.

Medical abortion
For all medical methods the recommendation is for mifepristone followed by misoprostol. Recommended regimens are given for the various gestational age ranges.

Postabortion-care
There is no medical need for a routine follow-up visit after uncomplicated surgical or medical abortion. Hormonal contraception may be started immediately after abortion initiated.

Ongoing next steps
The new clinical recommendations will be distilled into a journal article for publication in 2012. There will be a compilation of recommendations for guidelines on use of misoprostol as well as presentations on the guidance at large international conferences. Dissemination workshops are planned for at least three regions, with the possibility of follow-up with strategic assessments and other country work in collaboration with partners.

The key issues for establishing and strengthening abortion services include:

- The need for evidence-based standards and guidelines;
- Service provision at primary care level;
- Equipping facilities and training providers to deliver WHO recommended methods;
- Quality assurance and improvement (indicators for safe abortion, registration, monitoring and evaluation);
- Ensuring that cost is not a barrier for women or adolescents.

National standards and guidelines should cover what types of services can be offered when and by whom, equipment, medication, referral mechanisms. It is key that there is respect for informed decision-making also among adolescents. WHO has developed indicators for safe abortion care that focus on:

- availability
- information
- quality
- outcome/impact.

Safe abortion is dependent on there being a good network of trained providers. Abortion should be provided at the primary level; when this is not the case, referral to services at higher levels is essential. Also, primary-care-level provision of contraception should be available to all women and adolescents. Primary care providers are expected to provide contraception, vacuum aspiration up to 12–14 weeks gestation and medical abortion up to 9 weeks gestation.

Abortion should never be denied due to the financial circumstances of a woman or adolescent.

A systematic approach to strengthen abortion services is needed together with guidelines to promote easy access and good quality. Primary level delivery of abortion care should be strengthened and outcomes monitored.

Eszter Kismodi presented an overview of the legal regulatory and policy considerations related to safe abortion
Her introduction underscored the need of understanding the issue of safe abortion as a matter of human rights and equality.

Where abortion is legal and safe services are accessible, morbidity and mortality are reduced.

According to the ICPD Programme of Action "In circumstances in which abortion is not against the law, such abortion should be safe." Legal restrictions on abortion do not result in fewer abortions nor do they result in increased birth rates. On the contrary this leads to an increase in illegal and unsafe abortions, leading to increased pregnancy-related morbidity and mortality. Where abortion is legal and safe services are accessible, morbidity and mortality are reduced.

Recent data show that contraception alone does not eliminate the need for abortion services. No method of contraception is 100% effective.

Legal restrictions also lead many women to seek services in other countries, which is costly, delays access and creates social inequities.

The legal grounds for abortion were outlined as follows:

- when there is a threat to the woman's life;
- when there is a threat to a woman's health;
- when pregnancy is the result of rape or incest;
- when there is fetal impairment;
- for economic and social reasons;
- on request.

Laws, policies and practices can deter women from seeking care. These barriers include:

- prohibiting access to information on legal abortion services;
- censoring, withholding or intentionally misrepresenting health related information;
- requiring mandatory waiting periods;
- failing to protect against abuse of conscientious objection by not ensuring referral;
- restricting available methods of abortion;
- restricting the range of health-care providers and facilities that can safely provide services;
- excluding coverage for abortion services under health insurance, or failing to eliminate or reduce service fees for poor women and adolescents;
- failing to guarantee confidentiality and privacy;
- requiring third-party authorization;
- restrictive interpretation of legal grounds.

In an enabling policy environment, policies should aim to

- promote and protect the health of women;
- respect, protect and fulfil the human rights of women;
- prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications;
- minimize the rate of unintended pregnancy by providing good-quality contraceptive information and services;

- reduce maternal mortality and morbidity due to unsafe abortion, by ensuring that every woman entitled to legal abortion care can access safe and timely services including post-abortion contraception;
- meet the particular needs of women belonging to vulnerable and disadvantaged groups.

An interagency statement OHCHR, UNFPA, UNICEF, United Nations Women and WHO "Preventing gender-biased sex selection" http://www.who.int/reproductivehealth/publications/gender_rights/9789241501460/en/index.html
was issued on effective methods to eradicate sex selection. Restriction of abortion is not proven to reduce this practice. Countries were recommended to consult with this evidence-based statement. The issue of sex selection is complex as the real agenda is often trying to limit and restrict access to reproductive health services using the language of promoting gender equality. An interagency statement refers to what works and what does not in terms of limiting sex selection.

Participants shared their country experience in the plenary discussion which followed:

Experience from Portugal regarding abortions performed at primary care level showed that when introduced in primary care it worked as well as when carried out in hospitals.

The Netherlands had experienced a rise in abortions since 1981 documented from the international process registration database. Discussion is now whether doctors that work at local level should be able to perform abortions. There is such a high standard of abortion care in hospitals that it is problematic to lower standards at local level. The Netherlands has a lot of experience of monitoring quality of care.

In Kyrgyzstan, both gynaecologists and family doctors can perform an abortion but in practice, abortions are not provided at primary care level due to limited training of professionals and financing – financing is per capita not by case. So, capacity and competency to perform abortion at the primary care level is underdeveloped in performing safe abortions.

Often primary health-care personnel are not interested in providing abortion as there is no financial incentive. However, it is imperative that health care is driven by the needs of clients and not by financial incentives.

The issue was raised regarding appropriateness in the region that medical nurses and midwifes can perform abortion care. This should be based on the need for expanding availability of services and providers being able to demonstrate key competencies to provide safe abortion care. Women should be asked what they prefer and design care accordingly people.

Tools for improvement of quality of care

IPPF – Tools for improvement of quality of care

Manuelle Hurwitz presented a series of tools available for access on the IPPF web site at:
http://www.ippf.org/en/Resources/Reports-reviews/

- *Law and obstacles tool*–The IPPF 'Law Tool' encourages the exploration of national abortion laws to inform advocacy activities and ensure access to the maximum possible level of services. *Abortion legislation in Europe* – This publication gives a complete overview of the abortion legislation in European countries where IPPF EN has member organizations.
- *I Decide!* – I decide is a collection of stories about young people accessing abortion services from different cultural and social backgrounds – it is an awareness raising and advocacy tool which includes information on abortion and family planning.
- *Comprehensive Abortion Care: Guidelines and Tools for Clinics*– This manual includes practical steps according to WHO and IPPF guidelines on how to set up and run clinics, ensure infection prevention, manage logistics, monitor quality of care, assess clinic performance and use data for programme management. It is currently being translated into Russian.
- Tools are available *in Russian*: http://www.ippfen.org/rus

Ipas – Tools for improvement of quality of care

www.ipas.org/resources

Dalia Brahmi outlined the Ipas' mission to reduce abortion related mortality and morbidity and to increase women's ability to exercise their sexual and reproductive rights. A common misperception in many parts of the Region is that abortion is unsafe. Ipas has a series of tools to communicate that abortion care can be provided safely.

- *COPE for CAC* (Comprehensive Abortion Care) the importance of assessing client perspectives – those women who seek and do not seek the services;
- *Abortion Attitude Transformation* – addresses negative provider attitudes a values clarification toolkit for global audiences;
- *Safe abortion care (SAC) toolkit.*

Ipas is intent on a moving away from a system of blame and uses root cause analysis and responds by for example developing checklists and systems that are responsive to providers and poor outcomes. Adverse events are addressed – not as an inspection, but as a means of improving a situation and quality of care.

Ipas strengthens policies by providing technical assistance and abolishing non-evidence-based policy barriers.
Ipas has training curricula in Russian.

Marie Stopes International – Tools for improvement of quality of care

Kate Worsley presented the work of Marie Stopes International. The organization provides services for family planning and reproductive health services in Europe, South America, Africa and Asia. Given the nature of a service, the challenge for quality is constant, each time a client presents – the quality of service that they receive must be high. Teams must be well positioned to provide constant levels of high quality service to all clients. MSI also tries to ensure that the high standards of service provision are maintained to the same high level across all of its networks. Assessing the level of adherence to qualtiy standards globally is difficult. One way that MSI does this, is by using a process of Quality Technical Assistance (QTA) which aims to improve quality in programmes through regular external visit to the centre using checklists that evaluate the adherence to the set of minimum standards. These visits try to make the improvements during the visit, and where improvement can't be made immediately draw up action plans on what to improve and when. As a general principle, following up on these action plans is key, but are the difficult aspects for MSI programmes.
This assessment is used as a platform for discussion with management of what resources are needed. Often the clinical team already has an idea of what needs to change to improve and the assessment helps take the time to identify these issues further and present to the senior management what needs to change.

Discussion points:

- Tajikistan has developed national standards, has only just started strategic assessment and faces a lot of questions and financial barriers. Legislation is good but there are barriers that need to be changed. Progress has been achieved and the situation is sustainable, but there is a large young population which requires more attention. The WHO guidelines are good but must be adapted to national values and human resources.

- Participants from Ukraine mentioned that many international organizations develop their own tools to improve monitoring and evaluation. There is a need to bring all this experience and tools together and provide to countries one evidence-based comprehensive way to monitor, preferably available in Russian. There is a general need to adapt and use rather than to duplicate as there are similarities in all tools.

- A word of caution from the panellist was that tools are not enough if you do not change the punitive culture towards adverse outcomes, you will not get valid data or a reliable situation analysis and will have barriers in implementing the tools.

Legal and human rights considerations to strengthening access to safe abortion

Panellists Johanna Westeson and Mihai Horga gave an overview of legal grounds for abortion, regulatory barriers to access to abortion and enabling policy

In Romania when abortion and contraception was banned, maternal mortality through abortion rose dramatically.

environment and service delivery. The panel was facilitated by Ezster Kismodi who introduced the session stating that the European Court of Human Rights has firmly established that where legal, abortion must be available and accessible. Participants were urged to look at *Access to safe and legal abortion* in Europe Council of Europe resolution 1607 (2008) http://assembly.coe.int/main.asp?Link=/documents/adoptedtext/ta08/eres1607.htm

Public health impact of restrictive abortion laws

The developments regarding abortion in Romania were presented as a tragic social experiment. When abortion and contraception was banned, maternal mortality due to abortion rose dramatically. This is seen as evidence that legal restrictions do not limit abortions and achieve higher birth rates, but move it into clandestine provision.

Conscientious objection

The discussion on the freedom of conscience and religion under human rights law raised the following issues:

- The right to conscientious objection has to be balanced against other rights, such as the right to access health services and information, and that one right cannot be invoked as a way of violating the rights of others.
- The claim that life starts at conception is a legally flawed argument, disregarding women's rights which reduces women to a mere vessel, an instrument of procreation.
- A service that is legal must also be available in practice (European Court of Human Rights). If a doctor objects, it is the obligation of the state to ensure that other doctors are available and that referral takes place in a timely manner, respectful of the woman's health needs and preferences.
- In a life-threatening situation, the right of the woman to life takes precedence over the right to conscientiously object to providing services.
- Only individuals can object, not institutions – freedom of conscience is an individual right. Institutions do not have a soul.

Waiting period

From a public health point of view a waiting period means delaying the intervention. Complications due to abortion are linked to gestational age, and – increasing gestational age – increases the risk of complications. Waiting periods also increase costs for women (related to transportation, child care, lost income etc. due to repeated visits) which may be burdensome and result in some women being unable to access services. Delay may also mean that a woman exceeds the legal gestational age limit. Adolescents may reject official services and choose self-induced abortion.

Human rights and legal implications regarding parental authorization

Globally pregnancy is the main cause of death among women aged 15-19 due to complications in child birth.

- Adolescents have the same reproductive rights as adults and, due to their special vulnerability, deserve special protection.
- *Principle of evolving capacities*. Instead of treating all young people under 18 as children the law must recognize that adolescents have evolving capacity to make decisions related to their health, which includes their sexual and reproductive health, without consent of parents or guardians.
- Requirement of parental consent may deter adolescents from seeking care and consulting illegal abortion.

Discrimination / funding abortion

Socioeconomic values are one of main issues hindering universal access. Poor women do not have same access to health services. Denying abortion funding risks real and hidden costs both to women, family and tax payers. Illegal abortion is costly for society as well.

- Fees and costs are two main issues – the fees of service and the opportunity costs of obtaining services can be prohibitive and prevent seeking services.
- The argument that the state should not cover costs of abortion is not valid and cannot be compared to cosmetic surgery as pregnancy is time sensitive and has long term implications.
- The argument that abortion is a life style choice and not medically required is countered by the argument that so is child birth and that is free to the woman.
- Abortion is one of the areas where human rights and public health are clearly linked– denial of services in reproductive health has an aspect of gender discrimination. Only women need these services.

Age of consent

In the discussion about adolescents under the age of 16 who are sexually active, concern was raised whether medical providers become complicit in sexual abuse if they treat under 16s. Advice was that criminal law should be separate from access to services and that health providers should never be criminally liable for providing legitimate health services.

Barriers to accessing safe abortion care – particularly to vulnerable groups and ways to overcome

This session was moderated by Iveta Kelle, participants included Lena Luyckfasseel, Ann Svensén, Galina Grebinnikova, Manuelle Hurwitz and Danielle Gaudry.

Lena Luyckfasseel outlined the barriers in three groups – cultural and social norms, quality of services and health systems:

1. **Cultural and social norms**

In many countries and cultures in the region, it is not accepted that young women are sexually active. Hence, when confronted with an unwanted pregnancy they face multiple barriers in accessing safe abortion services. They often need to travel to other areas to ensure confidentiality, they lack comprehensive, unbiased sexuality education and information and are stigmatized for being sexually active, for being pregnant and for having an abortion. Language and gender issues, including gender based violence, are other cultural barriers.

2. **Quality of services**

The quality of abortion services, or rather the lack of high quality services, constitutes multiple access barriers to safe abortion services. These can be a limited or no choice of abortion method, often outdated abortion methods such as D&C are used. Other barriers to access are the lack of confidentiality, limited availability of services, no or biased counselling, the lack of integrated contraceptive services in the abortion services, a judgemental attitude of service providers or unskilled service providers.

3. **Health system**

The third group of barriers exists within the health system:

- cost/affordability of the abortion procedure
- under the table payment
- limited number of abortion service delivery points
- lack of:
    - drugs, equipment
    - training of service providers
    - sharing and lifting

Ann Svensén, Director of External Relations of the Swedish organization for sexual enlightenment (RFSU), an IPPF Member Association, talked about RFSU's work on improving access to safe abortion services for refugees and migrants. She cautioned against the risk of the "fat cat syndrome" in Sweden and underlined the importance of having civil society support. RFSU launched a campaign on the grounds of the principle of solidarity and human rights as it was clear that not all citizens are treated equally in Europe. This was a push towards having services free of charge for all in Sweden, including migrants and refugees. The targeted advocacy campaign was focused on giving women from outside of Sweden access to safe abortion in Sweden under the Swedish law, which was not the case. The campaign created more awareness of Swedish abortion law, and resulted in the

most conservative members of Swedish parliament changing their views. RFSU's efforts led to a change in the law.

Galina Grebennikova, Executive Director of Kazakhstan Association on Sexual and Reproductive Health (KMPA) an IPPF Member Association, presented the situation in her country and the work done by KMPA on the integration of abortion services in the primary health care level.

In Kazakhstan, 30% of 16 million people are women of reproductive age. Every third pregnancy ends in abortion and there is no decreasing trend. Abortion is legal in Kazakhstan and is free of charge. Before 12 weeks abortion is provided on request of the woman, from 13 to 22 weeks abortions are provided only in case of social or medical indications. Adolescents up to 18 years need parental consent. Vulnerable groups are under-informed and there are a lot of misconceptions regarding safe abortion.

Women from low income groups use medications purchased on the black market which is facilitated by the country's proximity to China where medicine is produced.

The main challenge was to see how their association could make abortion services more accessible and move them from secondary to primary care level. KMPA is currently implementing a pilot project, where they set up comprehensive abortion care cabinets in three community medical centres and in one youth clinic.

Danielle Gaudry, Mouvement Français pour le Planning Familial (MFPM), an IPPF member assocation, presented *Access to safe abortion for vulnerable groups in France.*

- Since 2001 the law provides for access to safe abortion before 12 weeks of gestation (14 weeks LMP), including foreigners and underage girls without parental consent.
- Abortions for teenagers and poor women are covered by the national health insurance. Migrants have to apply for financial assistance from the national health service.
- Many hospitals and abortion centres have disappeared since 2001. Budget cuts introduced by the previous French government have led to the merger of hospitals, resulting in less service delivery points.
- Women are now obliged to wait 2–3 weeks for an appointment, often travelling up to 60- 80km to access surgical or medical abortion.

Mouvement Français pour le Planning Familial claims the following for women:

- proximity
- specialized counselling
- support for women's autonomy
- support for young people's empowerment
- financial aid
- dedicated professional provider.

The organization has worked with feminist partners to build a case for government and ministry officials, explaining medical issues and women's rights: no woman should be obliged to continue an unwanted pregnancy. This was supported through campaigns in newspapers, radio programmes and street meetings for closed hospitals to be re-opened. Women must be able to get an abortion with their doctor or in family planning centres.

As a result, since 2004 medical abortions have been legal outside hospitals, doctors in private practice who want to provide medical abortion services are required to have an agreement with the health institute.
Since 2005, MFPF is providing abortion services in its family planning centres. In 2009, medical abortion also became legal in family planning centres. Surgical abortion remains illegal outside hospitals. The organization will continue a national campaign to destigmatize abortion and to improve surgical abortion outside hospitals.

Global view of barriers – IPPF
Manuelle Hurwitz presented the obstructions to reproductive freedom both in terms of legal requirements and other barriers:

Main legal barriers:
- time limits
- abortion only provided in certified medical institutions
- approval of abortion by 2 or more physicians
- approval by judiciary in case of rape
- mandatory counselling
- parental consent
- mandatory reflection period

We must be creative in how we facilitate access to safe abortion services. Success can only be reached by adaptability to needs of women.

Other barriers:
- high cost of services
- unskilled and/or unsupportive provider
- abortion services not advertised
- unregistered and unavailable drugs
- protesters outside services
- duties in relation to conscientious objection not applied.

After her overview, Manuelle Hurwitz provided examples of how these can be addressed:

Removing barriers to accessing safe abortion services

- ✓ Reaching the poor and the marginalized
  - o Operating a 'no refusal policy'
  - o Running "open days" (free services)
  - o Sliding fee systems
  - o Targeted distribution of referral coupons enabling clients to claim free services
  - o Extending clinic opening hours
- ✓ Taking services to the community
  - o Outreach workers providing referrals and accompanying clients
- ✓ Implementing harm reduction initiatives
  - o Accurate information on safe medical abortion
- ✓ Increasing access to medical abortion
- ✓ Ensuring the youth friendliness of abortion programmes
  - o Peer educators providing referrals
- ✓ Identifying referral partners in the event a client cannot be served at a clinic
- ✓ Establishing referral partnerships with pharmacists, community health workers and NGOs
- ✓ Ensuring the highest standards of care through ongoing provider training and support
- ✓ Working to liberalize abortion laws and update safe abortion protocols
  - o Increasing access to second trimester abortion services
  - o Registration of medical abortion drugs
  - o Authorizing mid-level providers to perform safe abortion services
  - o Adopting liberal interpretation of laws

Discussion after these presentations centred on the following issues:

- One should not forget about women who have a sympathetic view towards prolonging period of reflection pre-abortion.
- The provision of misinformation to young women in school sexual education that abortion makes you infertile.
- UNESCO and WHO Regional Office for Europe guidelines on sexuality education – are strong on evidence and human rights standards and should be used by governments in guidelines for sexuality education.
- The IPPF network works to strengthen the public health system through advocacy, addressing barriers to young people, training providers, encouraging the development of national protocols, and other actions to strengthen quality of care in public sector facilities. We must however recognize that some marginalized groups will not access government based services – this is why NGOs are needed in addition to a strong public sector.
- It is important to raise awareness of decision-makers to the need of advocating for good salaries for service providers. This is to counter the soliciting of informal payments for abortion.

Participants worked in one of three working groups according to their preference.

Group 1 – Governance in the area of women's health and abortion

This working group discussed the following three questions:

- Were there any recent changes in the legislation and national policies in your country related to access to reproductive health services?
- Who are the main stakeholders in the area of sexual and reproductive health and rights in your country?
- Government initiatives in improving access to safe abortion in the country.

The group presented these recommendations to WHO:

- **WHO** should finalize the Safe abortion guidance as soon as possible and should look into further disseminating the guidelines on national level.
- **WHO** should organize sessions at different meetings of professional organizations (e.g. FIGO, FIAPAC., etc.) to further disseminate the guidelines.
- **Regulations on conscientious objection** have to be very clear and precise and include follow up and control mechanism with the purpose that access to services that women are entitled to are guaranteed. States should establish and implement a well-functioning referral system and control and monitoring mechanisms to ensure timely access to services.
- **Professional organizations are to be reminded that conscientious objection cannot be exercised by institutions** and should remain on an individual level only for those directly involved in abortion procedures.
- To use the **WHO strategic approach and strategic assessment as a starting point** for coalition building between civil society, academia, government, professional organizations and other experts.

Recommendations to the government

- In countries where abortion is legal we need to ensure that there is access to abortion services and we urge **governments** the use the newly updated WHO guidelines to update national protocols and regulations.
- Governments should ensure that the same standards apply to private and public service providers.
- Governments should consider the recommendations of health care providers.

Recommendations to health care providers

- Health care providers should make them selves more visible and advocate for their evidence-based suggestions to improve the health care systems through professional associations, unions, medical chambers, trade unions, ethical committees, and international associations (e.g. FIGO, FIAPAC).

Recommendations to other stakeholders

- Look into involving an ombudsperson (for human rights) to mediate in national abortion issues.
- Build stronger coalitions between actors that want to advance a pro choice agenda.
- Work in coalitions that can act as a watchdog for governmental activities.

- Strengthen research and involve researchers to provide evidence bases for regulations and national abortion protocols, which also can inform advocacy activities of non-governmental actors.

Group 2 – Registration monitoring and analysis of national data on abortion

The group addressed the following questions:

- Describe abortion registration and monitoring of the data in your country.
- Which are the main factors that influence the reliability of the available official statistics on abortion in your country?
- The government initiatives in improving access to safe abortion in your country.

After discussion, the group presented the following statements and recommendations to the plenary

1. Important to **recognize the different realities across countries and the importance of identify problems and constraints in each country.**

2. **Standardize what to document** (in some countries medical abortions are not registered):
- necessary to have uniform criteria for national and international comparison;
- training on data collection – how to register and what to register;
- analysis should be done by a team that includes statisticians and clinicians and understands the meaning of what is being registered.

3. **Different culture of registration** – The goal should be on support and not on punishment – *motivate for registration of abortions without punitive measures.*

4. **Data collected should be available for facilities, regional offices, governmental (on different levels) –** *not just kept as national data so information can be used at different levels in different ways.*

5. **Linkage to family planning services:**
- to have information on contraception (use, no use, incorrect use) of that unplanned pregnancy;
- to have contraception after abortion.

6. **Additional assessments and periodical qualitative analysis with assistance of international agencies and academia**

It was noted that it was important to include under these points that women's privacy and identity is respected in data collection.

Group 3 – Prevention and management of unintended pregnancies in adolescents

The third group addressed the following questions related to unintended pregnancies:

- What are the challenges in countries to ensure access to safe abortion and post abortion counselling, contraception and care to adolescent girls?
- What are the good practices that countries may share in overcoming the identified challenges?

Challenges to ensure access to safe abortion and post abortion counselling and care to adolescent girls encompass:

- not proper setting designed for adolescents
- lack of quality of services
- affordability of contraceptives
- reaching minority groups
- low level of information on sexuality education
- human rights not taking into consideration
- abortion laws existed for more than 30 years and needs for revision/ parental consent
- not trained service providers
- lack of statistics
- reaching vulnerable groups
- no standards on Youth Friendly Services
- donor dependence
- gender stereotypes.

Good practices:

- offering comprehensive sexuality education in schools
- government support to and collaboration with NGOs
- referral system
- youth friendly services
- engaging youth in advocacy
- use of social media, hotline, online counselling, web sites,
- peer education.

Group recommendations:

- research on evaluation the benefits of ensuring access for comprehensive abortion for young people and other qualitative research;
- government support to NGOs by to ensure increased funding for offering services for safe abortion for young girls;
- allocation of budget within the Reproductive Health budget for more support towards safe abortion and free contraceptives for youths;
- medical insurance to include youth services;
- transfer of knowledge among different countries;
- increase of condom distribution and use;
- support of international agencies through projects, statistics;
- WHO and IPPF support for further technical assistance in favor in introducing youth friendly services (YFS) in countries where YFS do not

exist -YFS should become low cost and a one-stop shop. A comprehensive package, not just abortion counselling;
- better coordination and communication with the country WHO offices;
- more support for promotion of linkages between SHRH and HIV/AIDS;
- WHO to recommend/support the government through policy papers/statements in favour of safe abortion policies.

Group 4 – Medical abortion

Group four discussed the following issues regarding medical abortion:

- Is medical abortion available in your country?
    - If NOT – what are the main obstacles?
    - If YES – were/are there any challenges related to medical abortion use in your country?

Group members shared good practices in improving access to safe medical abortion in their countries and presented the present situation in countries represented and recommendations. Some countries lack an adopted protocol for registration of the drugs used. In some countries they are registered but there is a black market where they can be bought more cheaply. The challenge is to ensure the safe route of a pill from manufacturer to woman to make medical abortion safe.

Protocol of medical abortion: although all participants are familiar with the WHO protocol and try to apply in their countries, there are issues related to dosing and the schedule of use of medications

Actions to be taken further by governments and health professionals to ensure equal access to medical abortion:

- Good monitoring and better registration of complications should be introduced to monitor quality of care and to create increased demand from the population. Countries should introduce transparent monitoring systems. Quality of care indicators should be included.
- The problems related to abortion in the society are to be discussed openly and this will help to solve them.

It was recommended:

- to activate partnerships between public organization and government structure and professional organizations to improve abortion services;
- to ensure sustainable comprehensive abortion care implementation, to introduction on pre and post –graduated and service training curricula on safe abortion and to address to IPPF, Ipas and other to organizations to provide training materials;
- to request country offices of United Nations agencies to include issues related to access to safe abortion in the training programmes on reproductive health and in their work plans.

Recommendations to WHO, IPPF EN and other international partners:

- to share successful country experiences on good models of service delivery and distribution of the medical abortion drugs;
- to encourage governments to support/introduce policy changes which would allow midwifes and general practitioners to provide medical abortion services;
- to ensure support on monitoring of the use of medical abortion and it's complications;
- to develop advocacy materials, tools and to work with policy-makers;
- to work with pharmaceutical companies to ensure quality of medical abortion drugs;
- to urge Concept Foundation to accelerate registration of Medabon in all EE countries .

Plenary agreed on following **action points**:

- Regarding tools to improve monitoring and evaluation: it seems there is a need to bring all this experience and these tools together and to provide them to countries in a comprehensive way (in Russian). There is a general need to adapt and use rather than to duplicate as there are similarities in existing tools.
- WHO to support in introducing a modern, transparent non-punitive monitoring system.
- To compile publications on abortion that could be used by countries for reference.
- WHO country offices should take active part in the initiating projects on implementation of WHO guidance recommendations.
- WHO to continue the implementation of the WHO Strategic Approach in countries of Eastern and central Europe to better address existing problems on abortion.
- Support from all partners at the local and global level is crucial: to address other United Nations agencies they need to include access to safe abortion, including promotion of medical abortion in their agenda.
- Capacity development of civil society/NGOs involved in the field of reproductive health on the recommendations of the WHO guidance on safe abortion.
- WHO to influence other international agencies United Nations organizations to include in their agenda advocacy for safe abortion.
- To assist translation of WHO guidance into local languages.
- NGOs, agencies can provide experience on making coalitions for safe abortion and suggest proposals for constructive progress.
- The importance of having more evidence-based figures when speaking to politicians was stressed, to convince politicians and help them make reasonable decisions.
- We need more publicity, and better opportunities to publish data and protocols. Protocols should be amended and updated and regional offices should provide new protocols so updates can be provided on time to provide quality services.

- To disseminate the report of the meeting to WHO country offices and national decision-makers and opinion leaders.
- To consider replication of this meeting to be carried out in the countries. Participants were urged to go back and arrange a national meeting based on new guidelines launch and to think about what they can do in their respective countries, for example, by reaching out to relevant agencies.
- To advocate for the outcomes of the meeting during the WHO European Regional meeting on Commission on Information and Accountability planned to be organized in October 2012.
- A pool of experts should be established to assist WHO and other international organization in improving quality of abortion services. All participants were encouraged to contact their national experts and WHO Regional Office for Europe.
- Bert Van Herk/Netherlands offered the possibility for some training on clinical practice in their clinics.

Mapping partners' areas of intervention and potential for assisting countries in improving access to safe abortion

Isabel Yordi facilitated this session with representatives from FIGO, Ipas, MSI, UNFPA, EPF, ICMA, EEARC, and the Concept Foundation. Main points covered:

European Parliamentary Forum on Population and Development (EPF):

- EPF is a parliamentary network that serves as a platform for cooperation and coordination for 30 All-Party Parliamentary Groups in Parliaments throughout Europe working on improving sexual and reproductive health and rights. We will inform our members: Parliamentarians and Secretariats about the guidelines, paying particular attention to the Chapter 4 on Legal and Policy Considerations. These will be of particular help when drafting the relevant legislation and formulating arguments in favor of ensuring access to safe abortions.
- EPF is one out of two sexual and reproductive health and rights organizations (together with IPPF) that have a participatory status at the Council of Europe. While attending the sessions of the Parliamentary Assembly of the Council of Europe in Strasbourg we will ensure that Members of Parliament at relevant parliamentary committees, staff of the Assembly secretariat as well as political groups are informed about the new guidelines and use them in their relevant legislative work.

International Federation of Gynecology and Obstetrics (FIGO):
As a global professional organization implementing initiatives on reducing unsafe abortion at country level, FIGO will ask associations to include in the program of their national and regional congresses sessions dedicated to abortion and related problems, to discuss WHO guidelines and use guidelines produced by FIGO. This includes a consensus statement on uterine evacuation (by vacuum aspiration and medical abortion, not sharp curettage), guidelines on use of combination of mifepristone and misoprostol for the termination of pregnancy and a joint FIGO, ICM, ICN and USAID statement on postabortion contraception. Countries where professional associations of obstetricians and gynaecologists are not established were urged to unite professional knowledge and experience and to become members of FIGO.

Ipas:
Ipas outlined four areas of policy and advocacy where they can support efforts:

- Remove barriers such conscientious objection.
- Ipas has several training curricula and tools for clinics to use and free service training.
- Ipas has developed an abortion kit specific to adolescent abortion.
- Ipas is involved in dissemination of WHO guidelines. Russian and English. Although Ipas mainly works in Asia, Africa and Latin America, training materials are still applicable to European Region.

Marie Stopes International (MSI):
The mission of MSI is "Children by choice not chance".
The main focus is on service delivery. MSI is developing a new strategy for the European Region. MSI clinic networks do high quality medical abortion and manual vacuum aspiration.
MSI is willing to include training space in these centres if needed and network with private practitioners. Supplies catalogue, training materials etc can facilitate access to all this. MSI is very interested in collaborating – and participants were urged to contact MSI if interested in involvement in development of MSI's European strategy.

UNFPA eastern Europe and Centra Asia (EECA) Regional Office:
A global survey several Regional meetings are underway.

UNFPA priorities in EECA are to:

- expand partnership and collaborative relationships with stakeholders;
- strengthen legislation and policies in line with ICPD PoA;
- improve quality of service provision in RH area;
- promote national ownership reproductive health commodity security;
- support programmes tailored towards prevention of unwanted pregnancy among young women and vulnerable population.

International Consortium for Medical Abortion (ICMA)
ICMA works at global and regional level but mainly in Africa and Asia (due to donor decision). They have built a powerful web site and brought together hotline

groups at conference recently. The web site provides an information package on medical abortion – in translation to English.

Activities:

- training of trainers related to WHO Guidelines;
- later in 2012 – Promoting women's right to access for safe abortion – launched movement to oppose growing threats.

ICMA would like to create a unified force and voice – open to civil society. The objective is to promote WHO guidelines on safe abortion and women's autonomy on when to have children without risk to their lives. ICMA will send a letter to all participants to become partners in this campaign as follow up.

The eastern European Alliance for Reproductive Choice (EEARC):
The EEARC is a group of highly dedicated professionals in the field of reproductive health and reproductive rights. EEARC aims to help protect women's reproductive health by advocating for their right to reproductive choice and access to safe abortion.

The alliance underscores the importance of presenting countries on regional and international levels in related policy development and decision-making process, to participate at national and international meetings on safe abortion. The main activities connect with developing information and educational materials and organizing educational programmes on safe abortion, networking and advocacy training.

EEARC promotes timely and efficient day-to-day management of activities through a Coordination Office in Kiev (coordinator: Dr Galina Maistruk, Ukraine). The Coordination Office implements the policies of the Steering Committee, coordinates the implementation of agreed activities, and develops and supports the EEARC web site and news. The alliance is open to collaborate with any organizations and individuals, who work at the field of reproductive health and reproductive rights.

EEARC believes knowledge sharing, networking and advocacy to be critical components of a holistic approach to sustaining women's right to reproductive choice and safe abortion. To this end, the Alliance collaborates with similar networks in Asia, Africa, and Latin America and welcomes mutually beneficial partnerships

Concept Foundation:
Over recent years the Concept Foundation, a not-for-profit organization, has worked with its pharmaceutical partner, Sun Pharmaceutical Industries Ltd, Mumbai, India to make the high quality, affordable mifepristone-misoprostol product, Medabon® available for the termination of early pregnancy.

The Concept Foundation works in collaboration with governments and national and international NGOs on the introduction of Medabon® into health systems in several countries to make it a safe and accessible choice for women. Until now, Medabon® has been approved in 20 countries, including 14 countries in western

Europe, and Concept Foundation is interested in working also with East-European countries.

Discussion

The chair opened the floor for discussion and questions indicating the broad range of opportunities for collaboration including innovative ways of dealing with franchising, public partners, private partners, etc.

- More partners: Royal College of Obstetrics and Gynecology, Reprostat Intl Scientific Board of FIGO, WHO CC in Karolinska were not present. BzGA is present – standards of sexuality education.
- European Society on Contraception and Reproductive Health (ESC&RH) has become a partner of WHO Regional Office for Europe in promoting effective family planning and access to safe abortion. It the 12th Congress of ESC&RH in Athens in June 2012 safe abortion in included in the programme.
- Russian language of WHO Guidelines is prioritized for translation.
- Royal College of Obstetricians and Gynaecologies is developing training course on clinical guidelines handbooks accompanying Guidance will be helpful. A master class is planned to be organized in London next year.
- Knowledge in operations research obtained during the 2 weeks training in Kaunas Lithuania organized by WHO should be used in developing research proposals and carrying out implementation research.

Closing remarks

Lena Luyckfasseel on behalf of IPPF EN and Gunta Lazdane on behalf of the WHO Regional Office for Europe closed the meeting by outlining the topicality and good timing of the issue.

It was emphasized that despite a lot of achievements in improving access to and quality of family planning and safe abortion services, challenges remain. The updated WHO safe abortion guidance will for sure provide an excellent tool to address some of the existing problems, decreasing maternal mortality and morbidity and improving quality of life of women in the European Region and beyond.

Annex 1 – List of participants

Improving access to safe abortion care and related reproductive health services in the European Region

Organized by WHO and IPPF European Network

30-31 May 2012, Riga, Latvia

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Annex 2 – Programme

Wednesday, 30 May

8.30-9.00	Registration	
9.00-10.30	Opening session Chair: Gauden Galea & Lena Luyckfasseel	
	Welcome by Ingrīda Circene, Minister of Health of Latvia	
	Welcome by Zsuzsanna Jakab, Regional Director, WHO Europe	
	Welcome by Bert Van Herk, IPPF EN Treasurer on behalf of the IPPF European Network	
	Priorities for achieving Millennium Development Goals: improving maternal health in the European Region	Sandra Roelofs, First Lady of Georgia, WHO Goodwill Ambassador in the European Region for the Health-related Millennium Development Goals
	Health 2020 and reproductive health in the European Region Objectives of the meeting	Gauden Galea, Director of Noncommunicable Diseases and Health Promotion, WHO Regional Office for Europe
	Questions and answers	
10.30-11.00	*Coffee Break*	
11.00-12.30	Using the WHO Strategic Approach to improve access to and quality of abortion care in the European Region Panel discussion • What was the greatest benefit and challenge of conducting a strategic assessment? • What one piece of advice would you give to a neighbouring country's Ministry of Health, considering conducting a strategic assessment? • What key follow-up actions can you attribute to the strategic assessment?	Facilitated by Ronald Johnson Participants from countries where strategic approach has been implemented: Arsen Askerov/Kyrgyzstan Rodica Scutelnic/Republic of Moldova Ekaterina Yarotskaya/Russian Federation Mihai Horga/Romania Valentyna Kolomeychuk/Ukraine

12.30-13.30	*Lunch*	
13.30-15.30	Plenary session Tools in improving access to and quality of safe abortion service	Facilitated by Gunta Lazdane
	WHO Safe abortion guidance 2nd edition	Nathalie Kapp Maria Rodriguez Eszter Kismodi
	Questions and answers	
15.30-16.30	*Coffee Break/* Market place	
16.30-17.30	Plenary session Tools for improvement of the quality of care (cont.) - IPPF - Ipas - Marie Stopes International	Manuelle Hurwitz Dalia Brahmi Kate Worsley
17.30	Closing of the day	
17.30-18.30	Reception hosted by IPPF European Network and WHO Regional Office for Europe	

Thursday, 31 May		
8.30-9.30	Legal and human rights considerations to strengthening access to safe abortion Panel discussion on: • Legal grounds on abortion • Regulatory barriers to access to abortion • Enabling policy environment and service delivery	Facilitated by Eszter Kismodi Participants: Johanna Westeson Mihai Horga
9.30-11.00	Plenary session Barriers to accessing safe-abortion care particularly to the vulnerable groups and ways to overcome	Moderator: Iveta Kelle Lena Luyckfasseel Ann Svensén Galina Grebennikova Manuelle .Hurwitz Danielle Gaudry
	Introduction to the working group session	Sarah Standaert
11.00-11.30	*Coffee Break*	
11.30-13.00	Working group session on improving access to and quality of care and developing goals and targets for 2020	
	Working group 1: Governance in the area of women's health and abortion Facilitator: Lyubov Erofeeva	
	Working group 2: Registration, monitoring and analysis of national data on abortion Facilitator: Anastasiya .Dumcheva	
	Working group 3: Prevention and management of unintended pregnancies in adolescents Facilitator: Elona G.Hoxha	

	Working group 4: Medical abortion Facilitator: Rodica Commendant	
13.00-14.00	*Lunch break*	
14.00 – 15.30	Feedback from the working groups	Facilitated by Sarah Standaert
15.30 – 16.00	*Coffee break*	
16.00- 17: 00	Mapping partners' areas of intervention and potential for assisting countries in improving access to safe abortion Panel discussion	Facilitated by Isabel Yordi Representatives of FIGO, Ipas, MSI, UNFPA,EPF, ICMA, EEARC, Concept Foundation
17.00-17.30	Closing session Chair: Lena Luyckfasseel & Gunta Lazdane	