by the conspicuous absence of family planning from the Millennium Development Goals.[13]

Unsafe abortion is a major cause of maternal mortality,[14] and every year, 5 million disability-adjusted life-years are lost by women of reproductive age as a result of unsafe abortion.[15] Abortion is illegal in Burkina Faso, except to save the mother's life or in cases of rape or incest, which suggests that nearly all abortions are unsafe. In Filippi and colleagues' study, 4·7% of women who had had severe obstetric complications and 25% of women who had had an early pregnancy loss were suspected or confirmed to have undergone an induced abortion. Women who died before arriving at hospital or during their hospital stay were not included, which prevents inferences about abortion-related maternal mortality. In this context, unsafe abortion and its maternal consequences are probably under-reported or misclassified. Provision of safe abortions can have a substantial effect on the primary prevention of maternal morbidity and mortality. A broad focus on the prevention of maternal morbidity and its short-term and long-term physical and mental health consequences is needed. Better health care during pregnancy and at delivery should go hand-in-hand with efforts to prevent unwanted pregnancies.

Michelle J Hindin
Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA
mhindin@jhsph.edu

I declare that I have no conflict of interest.

1 Filippi V, Ganaba R, Baggaley RF, et al. Health of women after severe obstetric complications in Burkina Faso: a longitudinal study. *Lancet* 2007; **370:** 1329–37.
2 Ronsmans C, Graham WJ, on behalf of the Lancet Maternal Survival Series steering group. Maternal mortality: who, when, where, and why. *Lancet* 2006; **368:** 1189–200.
3 WHO. The world health report 2005: make every mother and child count. Geneva: World Health Organization. 2005. http://www.who.int/whr/2005/whr2005_en.pdf (accessed Oct 2, 2007).
4 Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Effects of birth spacing on maternal health: a systematic review. *Am J Obstet Gynecol* 2007; **196:** 297–308.
5 DaVanzo J, Hale L, Razzaque A, Rahman M. Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. *BJOG* 2007; **114:** 1079–87.
6 Measure DHS Statcompiler. ORC macro. 2007. http://www.measuredhs.com. (accessed Sept 28, 2007).
7 Geller SE, Adams MG, Kominiarek MA, et al. Reliability of a preventability model in maternal death and morbidity. *Am J Obstet Gynecol* 2007; **196:** 57–56.
8 Graham WJ, Hussein J. Ethics in public health research: minding the gaps. A reassessment of the challenges to safe motherhood. *Am J Public Health* 2007; **97:** 978–83.
9 Campbell OM, Graham WJ. Strategies for reducing maternal mortality: getting on with what works. *Lancet* 2006; **368:** 1284–99.
10 Geller SE, Rosenberg D, Cox SM, et al. The continuum of maternal morbidity and mortality: factors associated with severity. *Am J Obstet Gynecol* 2004; **191:** 939–44.
11 Singh S, Darroch JE, Vlassoff M, Nadeau J. Adding it up: the benefits of investing in sexual and reproductive health care. 2004. http://www.guttmacher.org/pubs/covers/addingitup.html (accessed Oct 2, 2007).
12 Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *Lancet* 2006; **368:** 1810–27.
13 UN Development Programme. Millennium Development Goals—MDGs. 2007. http://www.undp.org/mdg/ (accessed Sept 28, 2007).
14 Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PF. WHO analysis of causes of maternal death: a systematic review. *Lancet* 2006; **367:** 1066–74.
15 Grimes DA, Benson J, Singh S, et al. Unsafe abortion: the preventable pandemic. *Lancet* 2006; **368:** 1908–19.

Eliminating unsafe abortion worldwide

See Editorial page 1283
See Articles page 1338

In today's *Lancet*, Gilda Sedgh and colleagues report new findings about abortion that are both good and bad news.[1] The absolute number and rate of abortions globally have slightly declined since 1995. Yet these findings mask increases in much of the developing world and virtually no change in the rate of unsafe abortion. Each year, millions of women and girls risk their lives, health, and dignity to terminate their pregnancy where abortion is not safe and legal. Governments, donors, health practitioners, and civil society have the capacity to substantially reduce maternal mortality and morbidity related to unsafe abortion.

The continuing high incidence of unsafe abortion in developing countries represents a public-health crisis and a human-rights atrocity. In such places, the need for contraceptive services and supplies to prevent unwanted pregnancies is far from being met[2] and abortions are done in dangerous conditions—even where legal. This year, tens of thousands of women will die, more than 5 million will be admitted to hospital, and a substantial number will become infertile as a result of unsafe abortion. Preliminary estimates suggest that more than US$1 billion yearly could be needed to treat complications from abortion.[3]

In 1994, governments declared for the first time that addressing unsafe abortion was a public-health imperative.[4] Since then, many countries have broadened the circumstances under which abortion is legal,[5]

and medical care for postabortion complications has improved.[6] Only last year, African governments set a bold plan of action to address unsafe abortion explicitly among a comprehensive set of goals to promote and protect sexual and reproductive rights and health.[7] The path to progress is clear.

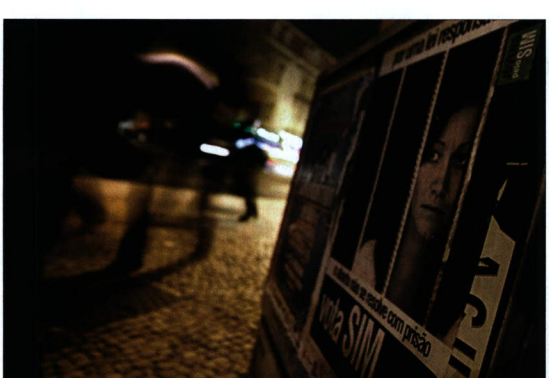
Legal and policy reform is required. The legal status of abortion has never dissuaded women and couples who, for whatever reason, seek to end pregnancy, and research shows that the more restrictive a country's abortion law, the higher are the rates of unsafe abortions and related mortality.[6] Conversely, Guyana saw a 41% reduction in hospital admissions for septic and incomplete abortion in the first 6 months after making abortion legally available in 1995.[8] Governments should also consider following the example of Nepal, which banned child marriage and polygamy, and granted women some property rights, at the same time as abortion was legalised.[9]

Donor governments, such as that of the USA, exacerbate legal restrictions on abortion with policies like the global gag rule, which mandates that foreign organisations receiving US governmental assistance for family planning must deny information to women about the option of legal abortion or where safe services can be obtained. This policy has very real detrimental effects on public health[10] and should be unanimously rejected. Repealing harmful policies is not sufficient, however—donors and national governments must also ensure access to reproductive health services, including contraception.

Reform must also be supplemented by technical assistance to health systems and health-care providers, which is especially important in settings such as Colombia, Portugal, and Mexico City, where laws that allow increased access to abortion have recently been enacted. Examples such as Guyana, India, South Africa, and even the USA prove that legalisation is not sufficient to ensure women's access to safe services.[8,11-13] In each setting, players must carefully consider women's preferences and ensure access to services accordingly, including through mid-level providers and an appropriate mix of medical and surgical technologies (eg, manual vacuum aspiration). Outreach and support to providers in countries where abortion remains highly restricted is also necessary to ensure access to family-planning services and postabortion care, as well as provision of abortion to the full extent allowed by law. WHO's technical guidance, available in several languages, is key to designing effective policies and programmes.[14]

Investment in developing and sustaining robust advocacy for access to safe abortion is the final priority. Broad coalitions of advocates at local and national levels can help to change, implement, and protect laws. They can also document and expose consequences of unsafe abortion, reach women with crucial information, and work to address the additional and underlying challenge of gender and socioeconomic inequality that can compromise women's right to make decisions about their health, even after abortion is legalised.[15]

In all the available data, one fact stands out: safe and legal abortion saves women's lives and protects their health.[16] There is no acceptable reason to allow women to die, fall ill, or become infertile as a result of unsafe abortion when the world community has both the knowledge and the means to prevent these deaths.



AP

"The abortion problem is not solved with jail, vote Yes"
Poster in Portugal before February, 2007, referendum on legalising abortion.

Beth Fredrick
International Women's Health Coalition, New York, NY 10001, USA
bfredrick@iwhc.org

I declare that I have no conflict of interest.

1 Sedgh G, Henshaw S, Singh S, Åhman E, Shah IH. Induced abortion: rates and trends worldwide. *Lancet* 2007; **370:** 1338–45.
2 Sedgh G, Hussain R, Bankole A, Singh S. Occasional report: women with an unmet need for contraception in developing countries and their reasons for not using a method. New York, NY: Alan Guttmacher Institute, 2007.

3 Vlassoff M. The economic impact of unsafe abortion. *id21 health focus* August, 2007. http://www.id21.org/focus/unsafe_abortion/art03.html (accessed Oct 1, 2007).

4 UNECOSOC, UNFPA. Programme of Action, Para 8.25, September 1994. International Conference on Population and Development; Cairo, Egypt; September 5–13, 1994. http://www.unfpa.org/icpd/icpd_poa.htm (accessed Oct 2, 2007).

5 Center for Reproductive Rights. Briefing paper: abortion worldwide: twelve years of reform. 2007. http://www.reproductiverights.org/pdf/pub_bp_abortionlaws10.pdf (accessed Oct 2, 2007).

6 Berer M. National laws and unsafe abortion: the parameters of change. *Reprod Health Matters* 2004; **12** (suppl): 1–8.

7 Special Session of the African Union Conference of Ministers of Health, Maputo, Mozambique. Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010, Sept 2006. http://www.south-south-ppd.org/doc/Maputo_Plan_of_Action.pdf (accessed Oct 4, 2007).

8 Nunes F, Delph Y. Making abortion law reform work: steps and slips in Guyana. *Reprod Health Matters* 1997; **9**: 66–76.

9 Cohen S. Nepal reforms abortion law to reduce maternal deaths, promote women's status. *Guttmacher Rep Public Policy* 2002; **5**: 13.

10 Center for Reproductive Rights. Breaking the silence: the global gag rule's impact on unsafe abortion. 2003. http://www.reproductiverights.org/pub_bo_ggr.html (accessed Oct 4, 2007).

11 Hirve S. Abortion law, policy and services in India: a critical review. *Reprod Health Matters* 2004; **12** (suppl): 114–21.

12 Dickson K, Jewkes R, Brown H, Levin J, Rees H, Mavuya L. Abortion service provision in South Africa three years after liberalization of the law. *Stud Fam Plann* 2003; **34**: 277–84.

13 Boonstra H. The heart of the matter: public funding of abortion for poor women in the United States. *Guttmacher Policy Rev* 2007; **10**: 12–16.

14 WHO. Safe abortion: technical and policy guidance for health systems. 2003. http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf (accessed Oct 4, 2007).

15 Shakya G, Kishore S, Bird C, Barak J. Abortion law reform in Nepal: women's right to life and health. *Reprod Health Matters* 2004; **12** (suppl): 75–84.

16 Grimes D, Benson J, Singh S, et al. Unsafe abortion: the preventable pandemic. *Lancet* 2006; **368**: 1908–19.

A better future for women and children

Over the past century, the risk of maternal and infant death and of injury associated with childbirth has decreased substantially in developed countries.[1] Sadly, the benefits of these advances are not accessible to all throughout the world.

Why does one woman die every minute from complications related to pregnancy and childbirth? 99% of such deaths occur in developing countries, and the reasons are basic. Women haemorrhage to death; they do not have access to antibiotics to prevent infection; or they do not have the option of a caesarean section.[2,3] Why do nearly 10 million children die each year before their fifth birthday (more than the number of adults who die from AIDS, malaria, and tuberculosis combined), if most of these deaths are preventable?[4,5] Why, when contraception is cheap and effective, do 200 million women still have an unmet need for family planning?[6]

The answers are known: poverty and poor health go hand-in-hand. Poor health is closely related to inequities in resources and power. The health status of individuals and communities is linked to lack of access to clean water, nutritious food, secure shelter, economic opportunity, education, and health care. These determinants of wellbeing are mostly denied to poor people, and women and girls typically have least access to resources and power. That nine out of ten women in sub-Saharan Africa will lose a child during their lifetimes,[7] or that the highest mortality rates for children aged under 5 years are concentrated in countries in or emerging from conflict is no coincidence.[7]

With effort and resources, large-scale improvements in public health are achievable. Sri Lanka's long-term commitment to safe motherhood services has, over four decades, decreased maternal mortality from 486 deaths per 100 000 livebirths to 24 per 100 000.[8] In Egypt, a national campaign promoting oral rehydration therapy helped to reduce infant diarrhoeal deaths by 82% between 1982 and 1987.[8] China's national tuberculosis programme helped to reduce prevalence of that disease by 40% between 1990 and 2000, and translated directly into social and economic benefits: for each US dollar invested in the Chinese programme, $60 was generated in savings from treatment costs and the increased earning power of healthy people.[8]

But, too often funding for health interventions flows inefficiently through independent and issue-specific channels. Today's health threats almost never occur in isolation. The same communities in which individuals live with AIDS are also those in which women are at very high risk of dying during childbirth from lack of family planning and basic obstetric care. The same young children who sleep under bednets to guard against malaria are no less likely to die from diarrhoea or pneumonia. The laudable objective of fighting specific diseases has become confused with the fundamental goal of saving and bettering lives, and crucial investments are undermined by an excessively narrow perspective.