

From choice, a world of possibilities



Her in charge

Medical abortion and women's lives
A call for action

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals, made up of 164 member associations and collaborating partners. In 2017, IPPF delivered 208.6 million sexual and reproductive health services.

IPPF works towards a world where people of all ages everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; and free to pursue healthy sexual lives without fear of unintended pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We are committed to advancing the rights of all women and girls to access safe abortion. Access to reproductive technologies that help women to have full control over their reproductive destinies is a human right, and denial of these technologies – including access to safe abortion – is reproductive coercion.

Access to safe abortion is a fundamental bedrock of sexual and reproductive health and rights and of women's ownership of their own bodies. IPPF will continue to work to ensure that abortion care is safe, legal and accessible for all women, everywhere. IPPF's strategic framework is committed to advancing the rights of all women and girls to choose and obtain safe abortion, increasing access to comprehensive abortion care, and raising awareness of the public health and social justice impacts of safe abortion. We are committed to reducing the number of injuries and deaths of women and girls who are forced to turn to unsafe abortion methods.

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Key abbreviations

CSE	Comprehensive sexuality education
CSO	Civil society organization
ICPD	International Conference on Population and Development
MISP	Minimum Initial Service Package
NGO	Non-governmental organization
PSI	Population Services International
SRHR	Sexual and reproductive health and rights
UNFPA	United Nations Population Fund
WHO	World Health Organization

Foreword

Early in my career, as a young doctor in Ghana, I saw first-hand the impact when women who did not want to progress through a full pregnancy were barred from accessing safe abortion. I saw women who, in desperation, had resorted to unsafe abortions that caused injury, severe haemorrhaging and even an untimely death. I saw the impact that their disabilities and deaths had on their children and families.

As Minister of Health in Ghana, it was clear to me then, as it still is now, that the compassionate, reasonable response to the public health scourge of unsafe abortion is to allow women the freedom to access the life-saving care and services that they need.

During my tenure as Ambassador of Ghana to the Kingdom of the Netherlands, where abortion is relatively unrestricted and women have access to safe services including to medical abortion drugs, I was struck by the stark contrast of a very low maternal mortality rate, high uptake of contraceptive services and the resultant low levels of unintended pregnancy and need for abortion. When a woman chose to opt out of an unintended pregnancy, she had access to a safe procedure with negligible levels of complications. And hardly ever death!

In contrast, the unacceptably high rates of maternal mortality and morbidity from unsafe abortion in most of the developing world, and particularly in Africa, are not an accident. They are the direct result of governments' – as well as society's – decision to deny women access to safe abortion through restrictive laws, which also criminalize providers and perpetuate the stigma around abortion. Over 40,000 women dying every year from complications of unsafe abortion is totally unacceptable in our modern world!

Medical technologies are fast improving, and in recent years increasing access to medical abortion drugs has transformed women's ability to take control of their reproductive decisions, and, consequently, other areas of their lives, including education. Medical abortion can be used without significant facility space or medical equipment and with a wide range of trained providers, which makes it suitable for even the lowest resource settings and the most local levels of care.

More excitingly, medical abortion has the potential to offer a complete paradigm shift for women as it puts the power in women's hands. Even in the most restrictive settings, women have been able to access the drugs for medical abortion and opt out of their pregnancies where other options have not been available.

Unfortunately, legal, economic and knowledge barriers currently in force in many countries and especially in Africa prevent many women from being able to widely access medical abortion with the current medicines: mifepristone and/or misoprostol. The coercive reproductive laws and policies that limit women's access to information, critical healthcare and services, as well as essential medications, also limit their ability to plan their reproductive lives, determine their futures and realize their full developmental potential.

Every woman must be able to decide for herself whether or not to carry a pregnancy to term and be fully informed and supported in her options by laws, policies, and programmes.

National reproductive health programmes must incorporate medical abortion into safe abortion services and post-abortion care. A full range of providers must be mobilized and trained. Above all, there is a need to ensure that medical abortion drugs are available and affordable to all women.



Photo: IPPF / Jon Spaul / Nepal

It is our expectation that as these abortion medications become more broadly available, their use will represent a step forward in reducing the thousands of deaths and countless injuries that result every year from unsafe abortion and, indeed, other pregnancy-related complications. No woman anywhere should die from an unsafe abortion when we have the technologies and medicines to provide safe abortion services to all women everywhere.

This excellent report, *Her in Charge* and IPPF's increasing and laudable leadership in the area of safe abortion is a huge step in the right direction and shows the huge possibilities that medical abortion offers.



Ambassador Dr Eunice Brookman-Amissah

Special Advisor on African Affairs, *ipas*, and former Minister of Health of Ghana

Foreword

All women should be able to decide if and with whom they want children. We must ensure access to comprehensive sexual and reproductive services for all. Ensuring access to safe and legal abortion is a central part of this agenda.

This report, *Her in Charge*, examines the opportunities, challenges and risks of providing access to medical abortion.

Every year, it is estimated that 56 million induced abortions take place worldwide. Of these, 25 million are performed unsafely. Almost all unsafe abortions (97%) take place in the developing world – causing a significant number of maternal deaths and other serious health and social problems. The burden of unwanted pregnancies, and illegal and unsafe abortions increases social disparities.

Promoting sexual and reproductive health and rights is a priority for the Norwegian government. It is an essential aspect of protecting human rights. It is vital for gender equality. It contributes to reducing disparities between rich and poor. And it is essential to reach the Sustainable Development Goals. That is also why Norway continues to increase our already large support to sexual and reproductive health and rights. Norway believes that access to comprehensive sexuality education, contraceptives, family planning and safe and legal abortions is central to giving women and girls control over their own bodies and lives.

Medical abortion is a safe method of terminating pregnancy and could significantly reduce injury

and death if it was more widely available.

Unfortunately, access to medical abortion is limited for many women and girls across the globe due to legal restrictions, stigma, limited supply or high costs.

The International Planned Parenthood Federation (IPPF) is a key partner for Norway. I commend this report because it provides valuable insights into how access to safe abortions can be improved. I hope you will read, learn from and debate the findings of the report, and that we can move the SRHR agenda forward together. Norway remains committed.



Nikolai Astrup

Nikolai Astrup

Norway's Minister of International Development



Photo: IPPF / Omar Havana / Cambodia

Executive summary

Each year, IPPF publishes a landmark policy report that explores a theme from its *Vision 2020 Manifesto*.

While recognizing that access to all abortion methods must be vastly expanded to enable each woman to choose the method most suitable to her, this report specifically explores the promise, challenges, risks and practical steps that governments should take to improve access to safe abortions by maximizing the potential of medical abortion. It recognizes that millions of women in need of safe abortion care are still being left behind.

Medical abortion – the use of the medicines misoprostol alone or in combination with mifepristone to opt out of a pregnancy – is safe, cheap and simple to administer. Yet, nearly one in every two abortions that occur is unsafe.¹ As a result of the barriers put in their way, over 25 million women each year are forced to find their own,² often dangerous, solutions to an unintended pregnancy. While the majority of these women will have a complete abortion with no major complications,³ some will suffer acute and sometimes lifelong damage to their health, particularly when they need additional medical care but lack access to a skilled provider. Many even die: between 8% and 11% of all maternal deaths globally are due to unsafe abortion.⁴ Tens of thousands of women each year lose their lives and nearly seven million more have to seek medical care for complications from unsafe abortions.⁵

The steps women are forced to take when they decide not to go through a full pregnancy can be extreme. An estimated eight million women take drastic measures,⁶ including drinking bleach, inserting sticks or wires into their bodies, or turning to an unskilled person to induce an abortion. The World Health Organization (WHO) categorises these as 'least safe' abortions.

An estimated 17 million more women find ways to not continue with a full pregnancy that avoid this extreme harm but may still pose some risk: having an abortion performed with an obsolete method,ⁱ or using a safe method, such as a medical abortion misoprostol, but with inadequate information or support.⁷ In the face of extremely restrictive abortion laws that give them no official options for safe abortion, women in Latin America have long led the way in obtaining abortion medications through online services or other non-traditional routes, self-administering misoprostol on their own.^{ii, 8}

i The WHO considers dilatation and curettage, or D&C, to be an obsolete method of surgical abortion that should be replaced with vacuum aspiration or medical abortion. World Health Organization (2012) *Safe abortion: technical and policy guidance for health systems*. Geneva: WHO.

ii This report uses the term 'self-use' of medical abortion as defined by researchers in Ipas, et al (2017): provision of drugs from pharmacies, drug sellers or through online services or other outlets, without a prescription from a clinician, followed by a woman's self-management of the abortion process, including care-seeking for any complications.



Photo: IPPF SAAF / Tommy Trenchard / Uganda

Other women are jailed on suspicion of having had an unsafe abortion or even as a result of miscarriage, as in El Salvador.ⁱⁱⁱ And untold numbers lose the opportunity for health in the fullest definition of the term – a complete state of physical, mental and social well-being, not merely an absence of disease.⁹

The knowledge, the technology, and the experience to make all abortions safe abortions exist. Yet tens of millions of women each year still lack access to completely safe abortions.

Women deserve better. They should not be forced to take risks with their health when a solution – medical abortion – is in their hands.

It is time for all governments to put in place the supportive structures and systems to enable women to use medical abortion legally, safely and without fear of sanction or ill health.

This report is a call for action to dramatically expand medical abortion as one of the options for women who decide not to progress through a full

pregnancy. This urgently requires a coordinated effort to build the evidence needed to allow women to self-manage medical abortion. To enable women to do this, health systems must be supportive of women's needs, providing information and support mechanisms, and ensuring the quality, availability and accessibility of medical abortion drugs, as well as post-abortion care.

This report recommends that the work to end unsafe abortion should take place across health systems and political structures. Legal frameworks must support access to safe abortion by removing abortion from national penal codes. Health systems must be equipped to provide comprehensive abortion care by ensuring the

25
million
abortions a year are unsafe



ⁱⁱⁱ In El Salvador, for example, where abortion is completely forbidden by law, 129 women were prosecuted between 2000–2011 for crimes related to abortion, and many more were accused of having had an abortion; 17 of these women were serving prison terms for murder in 2014. Center for Reproductive Rights (2014) *Marginalized, persecuted, and imprisoned. The effects of El Salvador's total criminalization of abortion*. New York: CRR.

availability, affordability and accessibility of quality medicines through the registration of mifepristone, misoprostol and combi-packs; the training of health providers; and expanding the roles of a range of health workers in abortion care through a task-sharing approach.¹⁰ Community and lay health workers should be authorized and trained to provide abortion medications, administer pregnancy tests, provide referrals and dispense contraceptives; this can have a transformative effect in expanding access to safe abortion, and build a pathway for women to self-manage their abortion. Governments can promote more equitable gender relations through comprehensive sexuality education programmes that include accurate information about contraception and abortion, and support women and men in forming healthy relationships.

Join us in taking practical steps together to eliminate abortion-related deaths and injuries, protect and promote women's health, enhance gender equality and end reproductive coercion.

Together, we can realize women's human right to make decisions about their own bodies and lives. The evidence for the consequences of unsafe abortion is clear: what is now needed is action.



Photo: IPPF WHR / Martin Gutierrez / Mexico

Introduction

Despite the polarizing headlines, the passionate marchers and the challenging arguments in parliaments and the halls of the UN, abortion is more than a political topic for debate.

Abortion is, at heart, a critical decision and essential health need for nearly 56 million women, girls, and their families' each year.¹¹ Deciding whether and when to have children – *and having the options and means to act on that decision* – is a fundamental human right for all people. Indeed, the ability of a woman or girl to safely decide not to continue through a full pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health.

Political momentum

Abortion is a core element of reproductive and social justice. A worldwide movement rooted in the principle that individuals and communities should have the resources and power to make decisions about their bodies, genders, sexualities, and lives is gaining momentum once more. International, regional and national movements such as the International Campaign for Women's Rights to Safe Abortion, Catholics for Choice, PINSAN and Women on Web have undertaken

decades of persistent, committed work in the face of enormous opposition.

These efforts have raised public awareness and prompted landmark changes in law and public policy. In 2018, for example, Ireland liberalized its abortion legislation and a million women demonstrated in the streets in Argentina, demanding their right to safe abortion and bodily autonomy. New forces for change, including SheDecides and youth movements that take a 'digital first' approach, are further energizing this work.

Oppressive laws

But in too many countries around the world, it remains the case that governments, community heads and religious leaders still deny women access to the full range of health rights and information, while gender inequality, discrimination and violence further limit women's abilities to make decisions about their lives.

As a result, women and girls are not legally or socially permitted to make decisions on their own about whether or not to continue with a pregnancy. Millions of adolescent girls are denied

ⁱ In several places, this report refers to 'women and girls' who have abortions. Although the vast majority of abortions globally are provided to individuals who identify themselves as women or girls, IPPF acknowledges that other people who do not identify themselves as 'women' (such as trans men/transmasculine people and non-binary people) can also experience pregnancy and abortion.

information about sexuality and reproduction and then punished when they become pregnant. Health professionals are harassed and even threatened with violence if they provide abortions, leading fewer and fewer to offer services. Governments in many countries fail to ensure that safe abortion services are available, accessible and affordable. Some politicians even debate how to make abortion more difficult to access, rather than how to ensure that laws respect women's right to self-determination while protecting their health.

Expanding care through access to safe medical abortion

Abortion can be done by two methods: surgical methods or medical methods using misoprostol alone or in combination with mifepristone.^{ii,12} All health system protocols for first trimester abortion currently call for the first medicines in a medical abortion to be given in a health facility by a trained health professional. Some countries have authorized women to self-administer the second dose of medication at home or in a place of her choosing. No countries have yet approved the administration of medical abortion without some direct oversight by a health professional.

Yet women are increasingly self-using medical abortion safely, without any medical oversight. It may hold particular promise for or be the only viable option for those who are unable or unwilling to get care from a health facility. Non-governmental organizations (NGOs) and civil society organizations (CSOs) have long offered creative support to women seeking medical abortion, ensuring that they can find high quality affordable medicines, medical evaluation and guidance about the procedure through telemedicine and telephone hotlines, and virtual or in-person accompaniment through the process.

These efforts have a positive impact: evidence shows that women's use of misoprostol rather than harmful or invasive methods to self-induce abortion has likely made abortion safer overall.¹³

But laws and policies that restrict abortion, the presence of pervasive abortion stigma, and a lack of political will to address the need for safe abortion mean that many of these efforts are 'workarounds' – ad hoc solutions to abortion access issues that governments and societies have been unwilling or unable to address despite their duty to respect, protect and fulfil the health rights of all citizens.

Medical abortion supports women to break free from restrictive gender norms and empowers them to decide if, when and whether to move through a full pregnancy. It enhances women's ability to exercise their full reproductive rights.

Radically scaling up progressive abortion laws and policies expands access to safe medications, accurate information and support, and strengthens links to the health system for information and follow-up. Through these measures, high rates of unsafe abortion can be dramatically reduced.¹⁴ health systems should play a leading role in making them happen.

This report brings together the evidence on abortion around the world and makes a case for expanding access to medical abortion as an option for women's reproductive healthcare. It calls on governments and organizations to take practical steps to ensure the right systems and structures are in place so that women can determine the path of their own lives and their futures.

ii Medical abortion using only misoprostol has slightly lower effectiveness rates than the two-drug combination.



Photo: IPPF / Omar Havana / Cambodia

Abortion care in the workplace, Cambodia

Far from home and the support of their families, the female migrant workers who make up the vast majority of Cambodia's garment sector workforce tend to be denied the opportunity to opt out of an unintended pregnancy safely.

Many come to Phnom Penh from poor rural areas and lack high levels of education, making them more vulnerable to coercive policies. Many are unclear on abortion law and are unaware of what care they are entitled to. In the absence of reliable information, they take matters into their own hands and risk illness, injury and death.

But when 31-year-old garment worker Ty decided not to go through with her third pregnancy, she knew she would be in safe hands when she turned to the Reproductive Health Association of Cambodia (RHAC).

"I came to the clinic to buy the medication for an abortion," she says. "I need[ed] to do it because of my family's financial situation."

Ty, who is married with two children, earns a base monthly salary of US\$160 training other workers in sewing techniques. Her husband, a tuk tuk driver, has a fluctuating income: some days he earns US\$20, others US\$4, and occasionally, nothing at all. "It's not enough to cover my family's expenses," Ty says.

She says she trusts the doctors and nurses at RHAC and had listened when they told her about the range of family planning options that are available. This equipped her with the knowledge to make an informed choice when she became pregnant for a third time.

Understanding abortion

When an unintended pregnancy occurs, a woman's ability to have a safe abortion can be transformational—the key that unlocks opportunities for her education, employment, good health and well-being.

Facts about abortion are plentiful and well-documented but not always adequately used in policymaking. Abortion is a common experience: nearly 56 million women and girls^{i,15} each year decide not to move through a full pregnancy. Yet in much of the world, gender inequality and discrimination limit women's options for safe abortion, and stigma keeps it from being openly included as a core element of sexual and reproductive health and rights (SRHR) care.



i In several places, this report refers to 'women and girls' who have abortions. Although the vast majority of abortions globally are provided to individuals who identify themselves as women or girls, IPPF acknowledges that other people who do not identify themselves as 'women' (such as trans men/transmasculine people and non-binary people) can also experience pregnancy and abortion.

Safe abortion methods recommended by the WHO include surgical methods of vacuum aspiration and dilatation and evacuation, and medical methods using misoprostol alone or in combination with mifepristone. Vacuum aspiration uses an electric or hand-held vacuum source, while medical abortion involves the use of medications to induce an abortion, with an effect similar to that of a spontaneous miscarriage.

The medicine used for medical abortion, mifepristone and misoprostol, are both on the WHO essential medicines list. Misoprostol, a prostaglandin analogue that is widely available and inexpensive, results in a complete first trimester abortion 75–90% of the time, when used correctly. When paired with mifepristone, which is less widely available and more expensive than misoprostol in many countries, effectiveness for complete abortion at nine weeks of pregnancy is between 95–98% when used correctly – an effectiveness rate that is comparable to a surgical abortion.^{ii,16}

ii Safety and effectiveness have been proven for medical abortion using a mifepristone-misoprostol combination up to 9 weeks (63 days), with some limited evidence for safety and effectiveness between 9–12 weeks. When medical abortion is used beyond 12 weeks, the WHO recommends that it be facility-based only, and that women remain under direct supervision until the procedure is complete. While this report discusses abortion primarily for first trimester pregnancies, unsafe abortion beyond 12 weeks is disproportionately responsible for the majority of global abortion-related death and illness and is an important element of comprehensive SRH care. WHO-recommended dosages for medical abortion beyond 12 weeks can be found at Safe abortion: technical and policy guidance for health systems

Abortion is safe when done correctly by skilled providers under hygienic conditions using WHO-recommended methods.¹⁷ It can be performed by a wide range of health workers, including at the primary level.

Evidence increasingly shows that women can use abortion medications safely without direct supervision of a health professional when they have the correct information and access to a health facility should they need or want it.¹⁸

Medical abortion has revolutionized the delivery of safe abortion care. For decades, women have used misoprostol on their own, a practice which has likely replaced more dangerous methods of self-inducing and increased the safety of abortion overall, for example in Latin America where there is a lower case fatality rate than in regions with higher rates of least safe abortion using more dangerous methods.^{19, 20} Women have found that taking at least one of the abortion medications at home offers benefits of privacy and convenience, and is often cheaper.²¹ It is also likely these traits have made it appealing to women who have limited access to health facilities for physical, financial or social reasons.

WHO definition of abortion safety

Safe abortion: Provided by healthcare workers and with a WHO-recommended method appropriate to the gestation.

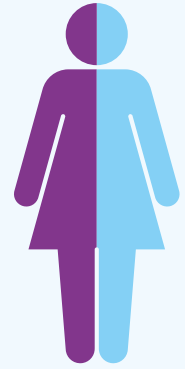
Less safe abortion: Use of an outdated method by a trained provider OR self-use of medical abortion drugs without adequate information or support from a trained person.

Least safe abortion: Use of dangerous, invasive methods, such as ingestion of caustic substances, insertion of foreign bodies or use of traditional concoctions, by untrained persons.

Ganatra, B, et al (2017) Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet*. 390, pp.2372–81.

About half

of adolescent pregnancies are unintended



However, when women are barred from accessing safe abortion and instead seek help from an unskilled person, or swallow caustic substances or insert foreign objects into their bodies to disrupt a pregnancy, significant complications and even death are often the result.²² Based on data from 2010–2014, approximately eight million of the 56 million abortions that take place annually are done using extremely harmful, invasive methods and characterized by WHO as 'least safe'.²³ The Guttmacher Institute reports that these least safe abortions "are estimated to account for much higher proportions of procedures among poor and rural women (62% and 55%) than among non-poor and urban women (36% and 38%)."²⁴

Approximately 17 million more women opt out of pregnancies by using abortion methods that avoid the greatest harm but may include some risk, for example by using proven abortion medications but without adequate information or support.²⁵

Together, these 25 million women – 97% of them in low- and medium-income countries²⁶ where safe abortion options are extremely limited – have been forced to seek out abortion mostly on their own.

Access to safe abortion is inequitable

Young women and very young adolescents

Very young adolescence (10–14 years old) is the period when young people enter their reproductive years. Making up 8% of the world's population, the vast majority of these young people live in low- and middle-income countries where health systems are weak and already unable or unwilling to meet the need for abortion-related

care.²⁷ Older adolescents – between 15 and 19 years old – also face barriers to abortion care.

Every year, 21 million young women in low- and middle-income countries become pregnant. Half of these pregnancies are unintended²⁸ and as many as 65% of these young women decide to seek abortion, often under unsafe conditions.^{iii, 29, 30}

Women in humanitarian settings

Over 100 million people are currently in need of humanitarian assistance, one in four of whom are women or girls of reproductive age.³⁷ These women and girls have been displaced, lack regular access to healthcare and face high risk of sexual and gender-based violence and unintended pregnancy. They are often located in camps or settings ill-equipped to provide abortion, including post-abortion care services. An assessment of humanitarian crisis sites found that safe abortion services are rarely provided, even though the Minimum Initial Service Package (MISP) for reproductive health in emergency settings

Adolescents and young women face barriers to contraception and safe abortion:

- Most very young adolescents live in countries where abortion is legally restricted.³¹
- Young people often lack the financial resources and transportation needed to access abortion care.
- Young people face double stigma – social and religious condemnation of pre-marital sex, as well as the stigma associated with abortion.³²
- Comprehensive sexuality education (CSE) may fail to address abortion or may include it in an inaccurate or stigmatizing way.^{33, 34, 35}
- Young women are less able to negotiate safer sex, and of the 60% of adolescents who want to avoid pregnancy, most are not using any method of contraception.³⁶

97%

of the world's unsafe abortions occur in low- and middle-income countries



recommends that services are available to the full extent allowed by law.^{38, 39}

Women living in poverty

Women living in poverty and rural women are more likely than better-off and urban women to turn to unqualified practitioners and unsafe methods or to try to induce their own abortions and therefore to experience health complications. They are also less likely to receive post-abortion care. As in every aspect of reproductive health, the women most likely to die or suffer lifelong disability are the poor.⁴⁰

Women living with disabilities

People with disabilities represent 15% of the world's population,⁴¹ yet they are grossly underserved and neglected by sexual and reproductive health and rights services. Women living with disabilities who have unintended pregnancies face multiple layers of discrimination: they are women, they are more likely to be victims of physical abuse and rape, they are more likely to be forced or coerced into sterilization or abortion,⁴² and health systems are rarely equipped to meet their needs.

People with diverse sexual orientations, gender identities and expression, and sex characteristics

The reproductive rights of people with diverse sexual orientations, gender identities and expressions, and sex characteristics, including lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) individuals, are often overlooked and actively threatened in many contexts, particularly in settings where they are criminalized. Those seeking sexual and reproductive health

iii In Africa, Latin America and the Caribbean about half of unintended adolescent pregnancies result in induced abortion. In Asia, 65% of unintended adolescent pregnancies result in induced abortion. Starrs, AM, et al (2018).

services often face stigma and discrimination which limits their access to healthcare and places them at risk of abuse and violence. Providers that are judgemental provide poor quality care, and the lack of comprehensive medical guidelines prevents health professionals from being able to respond appropriately to the SRHR needs – including abortion – of these populations.⁴³

Survivors of sexual and gender-based violence (SGBV)

Violence against women is a clear result of gender inequality and discrimination. More than one in every three women experiences physical or sexual violence in her lifetime, including 29%

of adolescent women aged 15–19 years, with damage ranging from physical or psychological trauma to death. Women who experience violence during pregnancy are more likely to have unintended pregnancies, abortions, miscarriages and stillbirths.⁴⁴ The link between SGBV and reproductive coercion is clear: women who experience SGBV are less likely to have reproductive autonomy and are at greater risk of being coerced to move through a full pregnancy or have an abortion against their will. These women need specialized and tailored care to ensure their needs are met.

Supporting sex workers to make informed choices, Uganda

The Safe Abortion Action Fund (SAAF), hosted by IPPF, was set up in 2006 to help grassroots organizations increase access to safe abortion. The SAAF-funded Lady Mermaid's Bureau is a project that supports sex workers in Uganda to stay safe, advocate for legal protection and access health services. Over the last three years, it has worked with sex workers in towns across Uganda, providing information on their rights, what not to do in cases of unintended pregnancy, and ensuring that they are aware of how they can protect their health.

Access to abortion is highly restricted for most women in Uganda, particularly those living in poverty. As a result, women turn to dangerous methods. No one knows this better than Pretty Lyn. A student living on the poverty line, she has become pregnant twice during her time involved in sex work. Both times, as a result of her circumstances, she decided not to move through the full pregnancies. Unaware that abortion medication is available, she used what she called 'local methods'.

"One time I used local herbs and I was successful," Pretty says. "Then the other time I used Omo [local washing detergent] and tea leaves but it was really hard for me. I nearly died."

Pretty Lyn is not alone. Many sex workers in Uganda end up having unintended pregnancies and then being forced to turn to dangerous services. Myths about contraception, as well as lack of access, mean that most sex workers rely on condoms for contraception. However, "men don't want to use condoms and female condoms are really rare and they are expensive," Pretty explains.

Like Pretty Lyn, the last time Deborah, another sex worker involved in the Lady Mermaid's Bureau project, became pregnant she used local herbs and nearly died.

"They didn't work," she says. "I was totally disturbed and was bleeding a lot. So they rushed me to hospital and it was really challenging. Doctors asked me many questions [such as] why I was doing such a thing but luckily enough they helped me."

Following an intervention by the Lady Mermaid's Bureau, Deborah understood that abortion does not have to be dangerous. The next time she became pregnant, she used the medical abortion drug misoprostol instead.

"I wish they [could] sensitize everywhere in our society, even if you are not a sex worker," Deborah says.

A brief recent history of abortion in international policy

It was not until 1994 at the International Conference on Population and Development (ICPD) held in Cairo that the world's governments first openly acknowledged the existence and dangers of unsafe abortion as a matter of public policy.

The ICPD Programme of Action gave long overdue recognition to the need for all women to have access to post-abortion care to treat complications from unsafe abortion. Governments also reached a political compromise to ensure that where abortion is not against the law, it should be safe.⁴⁵

This landmark agreement opened the door for progressive action to make abortion safer. But by calling for abortion to be safe only where it is legal (see paragraph 8.25 of the ICPD Programme of Action), governments with restrictive laws had an excuse not to increase access to abortion, leaving

Post-abortion care

Post-abortion care is an integral component of comprehensive abortion care and includes five essential elements:

Treatment of incomplete and unsafe abortion and complications

Counselling to identify and respond to women's emotional and physical health needs

Contraceptive and family planning services to help women prevent future unintended pregnancies

Reproductive and other health services that are preferably provided on site or via referrals to other accessible facilities

Community and service provider partnerships to prevent unintended pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs

Maureen R. Corbett and Katherine L. Turner. 2003. *Essential Elements of Post-abortion Care: Origins, Evolution and Future Directions*. International Perspectives on Sexual and Reproductive Health: Vol. 29, Issue 3.

behind the hundreds of millions of women living where abortion was, or was perceived to be, against the law.

Despite this restrictive interpretation, the decades after the ICPD saw a major shift in safe abortion provision.^{46, 47, 48, 49, 50, 51, 52, 53} Healthcare training and service delivery improvements in abortion and post-abortion care took place in many countries. Advocacy groups flourished and concrete policy changes established standards and regulatory guidance for health systems and abortion providers. Research documented the incidence and magnitude of unsafe abortion and the most effective approaches for reaching women with services. Since 1994, more than 30 countries have liberalized restrictive abortion laws, while only a handful have added restrictions⁵⁴ and the WHO has issued technical and policy guidance on safe abortion.

In the 2000s and 2010s, regional government and programme agreements and treaties built on the ICPD language and provided political underpinnings for progressive action at a more local level (see box).⁵⁵ Human rights treaty monitoring bodies continue to issue guidance that recognizes the right to safe abortion.⁵⁶

This progress generated a backlash by anti-rights groups that oppose abortion and modern contraception. These groups, many of them supported by mainstream religions and active in national and international fora, promote narrow patriarchal views on the roles of women and advocate against incorporating safe abortion into SRHR programmes. Pressure from them has limited progressive commitments at the global level and strengthened the reluctance of many governments to address abortion.

The treatment of abortion by conservative donor governments as a political tool, rather than a woman's right and critical public health need, and due to the imposition by the United States (US) of the Global Gag Rule under Republican administrations (see box) has starved recipient governments and foreign NGOs of funds to offer SRHR care and denied life-saving services to women. Some private foundations are also reluctant to provide funding for abortion as part of their SRHR package of services. As a result, abortion care has remained fragmented and limited, and is offered separately from other services or not at all.

Sample regional agreements on abortion

The **Maputo Protocol** is a legally binding protocol to the African Union Charter on Human and Peoples' Rights, adopted in 2003. It recognizes reproductive rights and requires that signatories "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus."

The revised **Maputo Plan of Action 2016–2030** is a continental framework for universal access to comprehensive sexual and

reproductive health rights and services in Africa, and follows on from the Maputo Plan of Action 2007–2015.

The **Montevideo Consensus on Population and Development** is a 2013 regional agreement adopted by Latin American and Caribbean governments at the First Regional Conference on Population and Development. It calls on governments to revise restrictive abortion laws, among other progressive actions to advance sexual and reproductive health and rights.

Unsafe abortion around the world



Sam, USA*



"I personally do not want children and always said I would go this route if I ever did become pregnant. Later the next day, I called Planned Parenthood in my town. They truly could not have been more helpful or reassuring... These ladies were really angels and I'm glad we have a system put in place for moments like these... I have two friends who have done the same and honestly, a surgical abortion didn't seem the right choice for me."

Maria, Uruguay



"Although abortion is legal in Uruguay, it's not legal in people's minds... It's not about defending abortion. It is about defending women's freedom to decide when to have a baby."

Maria was 20 years old when the condom that her and her boyfriend were using broke. She took the morning after pill about 50 hours later. It did not work, and Maria found herself unintentionally in the first stages of a pregnancy. She spoke with her boyfriend and parents. She decided not to move through the full pregnancy because she felt it wasn't the right thing to do: she didn't have a fixed income and didn't know what the future held for her and her boyfriend.

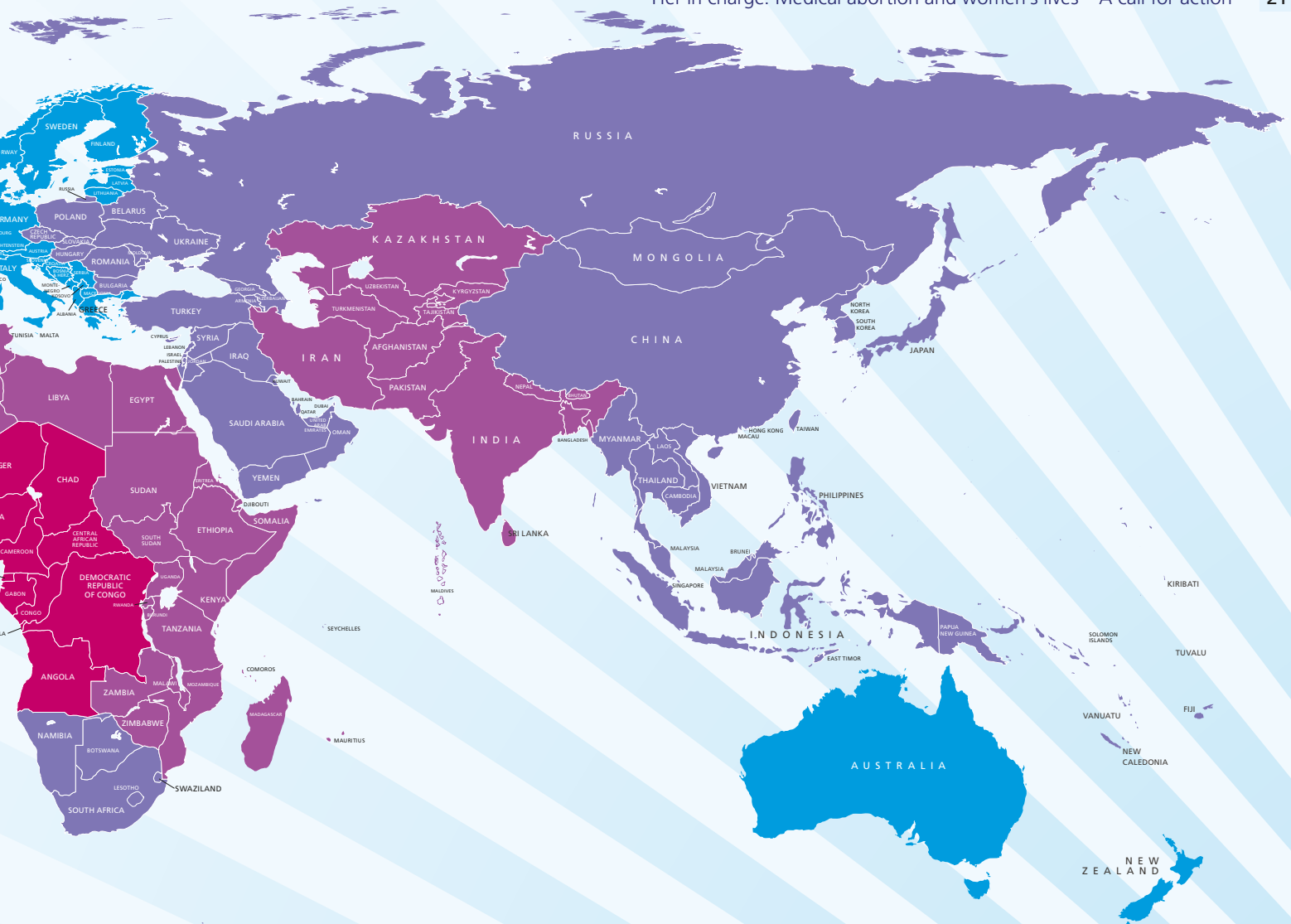
Mira, Burkina Faso



"I am Mira. I am 21 years old, a second year student of legal and political science. I fell in love with a boy, we had sex, and I became pregnant. I did not think it could happen to me: I'm smart and responsible. It was at this moment that many questions came to my mind. Should I [continue] the pregnancy? Should I tell my boyfriend? Should I talk to my friends? Should I talk to my mom? Should I have an abortion? What is the impact of this pregnancy on my future?"

I quickly realized that my boyfriend and I are still students so how could we care for a child? You should know that my parents are poor and very traditional, and would not have supported me... I would not want to be at the origin of the disgrace of my family and to attract the wrath of my dad.

I am a student in the second year – I have my whole future in front of me. I would like to be a magistrate in my professional life. Frankly, I knew deep inside me that this pregnancy would hinder my plans."



Salma, Palestine



Salma was 20 years old and unmarried when she found out she was pregnant. She was worried about what would happen if her family found out. Punishment for 'dishonouring' the family is common in Palestine, and pregnancy outside marriage can result in a woman being beaten by her family. Afraid of her pregnancy being discovered, Salma managed to get hold of the abortion medicine misoprostol on her own, but because she didn't have complete information on how and when to take it, she experienced complications. Afterwards, she went to the Palestinian Family Planning and Protection Association (PFPPA) clinic for support. Salma later said she had been unaware that PFPPA provided such care and would have preferred to have come to the clinic in the first instance, where she could have received counselling and compassion, rather than taking misoprostol by herself without information or support.

Emmy, France*



Emmy said she "fell in love with the wrong person at the wrong time." She chose a medical abortion because it felt like the easiest option for her. "This was the cheapest way to proceed (legally with professional help) and I thought it would be easily done. But in France you need to wait a week before the doctor can start the abortion, in case you change your mind."

Sangeeta, Nepal



Due to her lack of money and problems at home, Sangeeta didn't want to continue with her second pregnancy, feeling strongly that the timing wasn't right for her. "I've been married for 10 years and have one son who is eight years old. I haven't studied and am currently a housewife. In another 5 to 6 years I might be ready, but not now."

Key

Percentage of abortions that are unsafe:

- 80% or more
- 50—79%
- 10—49%
- Less than 10%

* These stories are individual voluntary submissions to Women on Web, used with Women on Web's permission and edited for length and clarity. To protect the privacy of certain individuals, the names and identifying details have been changed. The opinions expressed are those of the individuals and do not necessarily represent IPPF or its work.

This map was adapted from data and graphics by the Guttmacher Institute and Ganatra, B, et al (2017)

The Global Gag Rule

The US has long been the world's largest donor of overseas health assistance. The Helms Amendment, passed by the US Congress in 1973, ensures healthcare providers that are grantees of USAID cannot use funds to promote or provide safe and legal abortion.

In 1984, President Reagan introduced the Mexico City Policy, later named the Global Gag Rule (GGR) by advocates in opposition to the policy. The GGR denies USAID family planning funds to healthcare providers that 'perform or actively promote abortion as a method of family planning', even though the Helms Amendment already requires them to separate US funding from other non-US funds that support safe abortion provision. In 2016, the USAID family planning budget was US\$567 million.

Under the Trump-Pence Administration, the GGR was expanded to cover global health funds totalling US\$9 billion, including US\$6 billion of funds to prevent and treat HIV under the US President's Emergency Plan for AIDS Relief

(PEPFAR). This means that healthcare providers are forced to choose whether to offer integrated healthcare and rights-based family planning or to receive USAID funding and thereby restrict their healthcare provision.

During this expanded GGR, IPPF stands to lose US\$100 million for integrated health projects worldwide, including maternal health, family planning, HIV and Zika prevention, and much more. Across 30 member associations in Africa, South Asia and Central America, funding losses are as large as 70% of annual operating budgets, affecting clinical operations, staffing and mobile outreach. The reduced provision for safe and legal abortion as part of integrated healthcare, as well as family planning cuts, may force women to turn to unsafe abortion, risking life-changing injuries and death.

IPPF continues to seek alternative funds for integrated healthcare and rights-based family planning around the world.



Photo: IPPF WHR / Tochtli Garcia / USA

The challenge: Accelerating progress to reach all women with safe abortion

Despite some progress, major gaps in safe abortion provision remain, driving millions of women to seek abortion outside formal health systems.

Global efforts to vastly expand women's access to modern contraception are still insufficient. As a result, women are not able to plan their pregnancies. About half of the 1.6 billion women of reproductive age living in low- or medium-income countries want to avoid a pregnancy, but nearly a quarter of them are not using modern contraceptive methods.⁵⁷ The result is that about 44% of all pregnancies worldwide are unintended, with women denied their right to decide if, when and how many children to have.⁵⁸ Global efforts to reduce the unmet need for modern contraceptives must be accelerated.

Despite these issues, governments and policymakers in many parts of the world still refuse to take women's right to safe abortion seriously, and few recognize the clear conclusion that safe abortion is part of SRHR, without caveats.

While action is needed on many fronts, the inadequate progress in government and health systems can often be traced to laws and policies

that limit women's access to safe abortion, as well as to gaps in health service delivery systems.

Legal and health system challenges to safe abortion access

To this day, many countries based mainly in low- and middle-income regions have restrictive laws and policies that limit when women can use contraception, have abortions, and even seek healthcare without parental or spousal consent. Five countries have an absolute ban on abortion.ⁱ Abortion laws throughout the world define health professionals as the only legal abortion providers, which puts women who self-induce at legal risk. Restrictive laws often impose criminal penalties, including arrest and incarceration, on women who seek abortions and health professionals who provide them. These laws are harmful: restricting access to abortion does not reduce the number of abortions, but instead forces women to seek

ⁱ Dominican Republic, El Salvador, Malta, Honduras and Nicaragua.

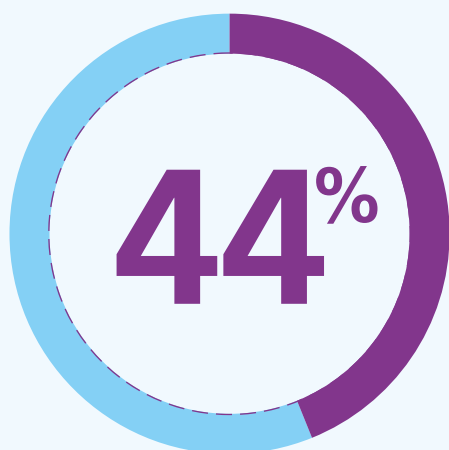
unsafe alternatives.⁵⁹ Countries with more liberal laws, broad legal grounds for abortion, and accessible services have lower rates of unsafe abortion and related death and illness.⁶⁰

Policies and health system guidelines

sometimes impose procedural barriers that are not medically necessary and make access more difficult, including mandatory waiting times, scripted and biased counselling, and multiple provider approvals, such as by doctors. Such barriers discourage women from seeking care, cause delays in access and increase the cost of services.⁶¹ These procedural barriers must be removed.

Scientifically accurate information about abortion is patchy in many places. Anti-rights groups have perpetuated myths about abortion that are misleading and incorrect, adding to stigma and misunderstanding about the safety of abortion. Evidence-based information proves them wrong,⁶² but changing the misperceptions is a challenge. Comprehensive sexuality education and non-stigmatizing and accurate information are powerful tools to tackle this.⁶³

The **refusal of providers to offer abortion care**, even where abortion is legally permitted, breaks the fundamental commitment of health workers to 'do no harm' and prioritizes the personal, private beliefs of providers over the rights and healthcare needs of patients.^{64,65} This denial of



44%

abortions a year are unsafe

Integrated definition of sexual and reproductive health and rights (SRHR):

- Accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education
- Information, counselling and care related to sexual function and satisfaction
- Prevention, detection, and management of sexual and gender-based violence and coercion
- A choice of safe and effective contraceptive methods
- Safe and effective antenatal, childbirth, and post-natal care
- **Safe and effective abortion services and care**
- Prevention, management and treatment of infertility
- Prevention, detection and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections
- Prevention, detection and treatment of reproductive cancers

Starrs, AM, et al (2018) Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The Lancet Commissions*. 391 (10140), pp.2642–2692.

care forces women through pregnancies against their will. In cases where women are referred to another provider, healthcare delivery becomes very inefficient and increases the workload of those who meet their professional obligations as providers. Conscientious objections must not be allowed to prevent health providers from denying care.

Limited access to safe abortion provided by a health professional within SRHR programmes is likely to get worse in the coming years, as governments struggle to staff health facilities adequately. The WHO estimates the **global deficit of skilled healthcare professionals** is continuing to grow and will reach 12.9 million by 2035. People in rural areas or those relying on the public sector may have the least access to a health



Photo: IPPF EN / Jon Spaul / Macedonia

professional, especially one skilled in abortion-related care.⁶⁶ Governments should strengthen health systems by investing in staff training and health infrastructure. However, given the projected lack of skilled staff, even if governments and private health systems suddenly scale up efforts to offer abortion services, millions of women will still be left with limited options for facility-based care. Many other women may simply prefer to manage their own abortions without the involvement of a medical provider.

If all women who seek unsafe abortions use misoprostol rather than more invasive and dangerous methods, abortion-related deaths could decline by two-thirds in low- and middle-income countries.⁶⁷

Impact of decriminalization, Ethiopia

The sixth floor of the Tikur Anbessa Hospital in Addis Ababa is a happy place. It is the maternity ward, and every day women are guided through labour and safe delivery. They can rest and recover, healthy and ready to rejoin their families.

But this was not always the case. Before Ethiopia's restrictive law on abortion was lifted at the turn of the 21st century, over half the ward was filled with women suffering sepsis and haemorrhages and awaiting hysterectomies as a result of unsafe abortion.

With over a third of maternal mortality cases resulting from unsafe abortion, the Ethiopian government had a public health crisis on its hands. The 1957 penal code had criminalized abortion in almost all cases. In the absence of access to safe abortion, women would turn to traditional healers for plant roots or chemicals, often ending in serious injury or even death.

Genet Mengistu, Executive Director of the Family Guidance Association of Ethiopia (FGAE), remembers this time vividly: "when I was a child, when I was growing up, you heard that someone [had] died and you hear[d] different stories about it, but finally you [would] find out that [that] young girl died because of [an] unsafe abortion."

Genet recalled how the late Prime Minister Meles Zenawi championed women's rights after seeing the human cost of this law. With the support of the health minister, the late 1990s saw the growth of a strong network of compassionate leaders – from across health organizations, NGOs and women's associations – passionate about improving women's health and life chances, and liberating them from their reproductive burden. It was clear that the law needed to be changed.

The day the law changed in 2005, women and girls in Ethiopia gained a new freedom. They were now able to decide if and when to have

children. They were given their futures. As clinician Tafesech Zewede reflects, by providing services to young women, "we can change their lives". Just one comprehensive abortion care service can change the life of a young person, she says.

The change hasn't been easy. People's knowledge about their right to access abortion and family planning is still low, especially in rural areas, and stigma is high. Some women will travel to clinics further away from home to receive care because they are scared of their community finding out. When the law changed, some service providers chose not to provide women with these services, and others that do still face stigma. Many of Tafesech's patients still struggle: "the majority of clients who come for abortion services have no freedom to talk about their case. They're afraid, shy to explain what they came for."

But despite these challenges, liberalizing abortion law in Ethiopia has changed the lives of countless women. Comprehensive abortion care is available in public, private and non-governmental sites like FGAE throughout Ethiopia. And now, half of the beds on the sixth floor of Tikur Anbessa Hospital have been reallocated for cancer care. Maternal mortality due to unsafe abortion has declined dramatically. Although there is still a long way to go, women have far more freedom to control their lives, their bodies and their futures.



Photo: IPPF / Panos / Ethiopia

A call for the expansion of medical abortion

Medical abortion is far from being a new strategy. Women have used medical abortion for years, and many organizations have helped them do so.

However, medical abortion has not yet reached the scale necessary to dramatically avert maternal mortality rates stemming from unsafe abortion and to be truly in women's hands. Its expansion needs to be exponential.

All women seeking abortion should be able to choose a safe abortion method – medical or surgical abortion – that works best for them. When women cannot or choose not to seek care from a health facility, expanding legal access to medical abortion is an important interim step.

Making mifepristone more widely available would allow millions more women choose whether or not to move through a full pregnancy safely and effectively. Bringing self-use of these medications out of the shadows and taking concrete and coordinated steps to ensure broader political, health system and community support can transform women's lives and health.

There needs to be a paradigm shift among policymakers and other stakeholders committed to SRHR that reframes the importance of women being able to manage their own medical abortions

legally and safely, with or without the involvement of a healthcare provider. Ensuring that women have access to the necessary information and support allows them to make informed choices about how to manage an unintended pregnancy, rather than being passive recipients of services. Action from governments to ensure that this practice is safe, affordable and legally available is long overdue.

This approach will not necessarily meet the needs of every woman. Many women will continue to prefer an abortion provided or supported by a health professional in a public or private facility. Some women are not eligible for medical abortion while others will need support to accurately determine the gestational age of the pregnancy and so determine the dosage of medications. A small percentage of women will need follow-up care by a health professional for complications. Facility-based care can offer other benefits as well, including resources for women who have experienced female genital cutting or domestic violence, and trained professionals who can answer questions, address concerns, provide counselling and offer post-abortion contraception.

Building on successes to date

Good work has been done in the past decade to empower women to use medical abortion safely on their own. This experience provides important insights into promising models for care and how to strengthen them.

NGOs and civil society networks have long offered support to women seeking medical abortion through telemedicine and text messages, in-person accompaniment models, and hotlines for advice about dosage and complications.ⁱ Some groups are working to increase information provided by pharmacists and drug sellers. A systematic review shows that women can obtain dependable and clear information from reputable sources outside the health system.⁶⁸ Groups such as Samsara, Women on Web, Safe2Choose, Women Help Women, and others are bridging the gap between advocacy and service provision in helping women manage unintended pregnancy with medical abortion.

Social marketing by organizations including Marie Stopes International (MSI), Population Services International and DKT International has made abortion medications available at affordable prices in many countries. This may be particularly important in rural areas where it is not feasible to buy medical abortion pills over the internet. Despite this work, mifepristone remains expensive in much of the world and it is not available yet in most countries, likely because of legal restrictions on abortion remaining in place.

National and international organizations, such as IPPF member associations and the Reproductive Health Supplies Coalition, have successfully advocated for the country registration of medical abortion drugs and for their inclusion into national essential medicine lists.

Being aware of which drugs are registered and available in a specific country can support broader access to the medications. IPPF's new medical

ⁱ A new quantitative study of a hotline in Indonesia, the first to document self-use of abortion after 12 weeks, suggests that the model may be as effective as providing medical abortion in a clinic. Gerdtz, C, et al (2018) Second-trimester medication abortion outside the clinic setting: an analysis of electronic client records from a safe abortion hotline in Indonesia. *BMJ Sexual & Reproductive Health* Published Online First: 18 July 2018.

Examples of hotlines and accompaniment models

Aunty Jane is a live counselling hotline launched by Kenyan activists in 2012 to provide non-judgemental, clear information about life-saving sexual health issues, including using misoprostol for safe abortion.

Las Libres is a Mexican organization that trains a network of volunteers to counsel women on how to safely use medical abortion and accompany them through the process.

Safe2Choose is an online resource comprising multilingual counsellors, medical doctors and public health experts that provides counselling for safe abortion and information about how to obtain abortion pills.

abortion commodities database (www.MedAb.org) offers concrete information about the availability of quality brands of mifepristone, misoprostol, and the combi-pack in countries. It is designed for service providers, procurement agents and others working on safe abortion programmes, rather than for women directly.

Medical abortion has enabled the growth of task-sharing in countries where non-physician health workers such as nurses, midwives and clinical officers are authorized to provide medical abortion in primary care facilities. Creative partnerships between community health workers or lay volunteers and health systems are helping women find out whether they are pregnant and refer them to facility-based care.⁶⁹

Researchers from different organizations are testing models to ensure woman can self-manage abortion safely, including how to link them with effective contraceptive methods after a medical abortion, how to ensure that women can accurately self-assess eligibility for the procedure, and how best to strengthen referrals to health facilities when needed.^{70, 71, 72, 73}

Governments should play a leading role in these efforts

Governments have a responsibility to ensure that all women have access to SRHR care, regardless of their ability to pay. Allowing additional options for the self-management of medical abortion in no way removes or reduces this responsibility. Governments should welcome creative approaches taken by CSOs and NGOs to help women find and use medical abortion and should partner with these groups to increase their effectiveness and reach.

Debates on medical abortion without direct medical supervision

Medical abortion has dramatically increased access to abortion for millions of women and is a game changer in terms of power and gender dynamics.

It is important to discuss the potential risks identified by some that need to be managed – not avoided – by health systems. Some health professionals are against allowing women to legally obtain and use medical abortion pills without the supervision of a medical professional. Their reasons may include concerns about safety in those situations where women do not have accurate information about their use, or they might want to keep control of medical procedures within the health system. Studies in countries in Asia where women have used medical abortion with the incorrect dose or outside recommended time frames have already led to calls to restrict access to abortion medication rather than expand it.⁷⁴

There needs to be more evidence documenting women's ability to accurately self-assess and determine eligibility and gestational age for accurate dosage before taking medication. While some studies have examined home use of misoprostol following clinic administration of mifepristone, these may not be generalizable to broader populations or to settings where mifepristone is unavailable. A systematic review of effectiveness, safety and acceptability notes that one study found the home users of misoprostol

were more educated and had a lower gestational age and higher number of previous pregnancies on average than those who had both drugs administered at a clinic.⁷⁵

Where mifepristone is unavailable and misoprostol is used alone, higher failure rates will be more likely, making it important to ensure women understand signs of an incomplete abortion and where to go for additional care if needed.

Women who are unable to assess eligibility for medical abortion may be unaware of contraindications, such as ectopic pregnancy, or may use the wrong dose of medications. Some women have physiological conditions that do not allow for an accurate assessment of gestational age, such as erratic menstrual cycles or altered bleeding patterns from a contraceptive method. These women may need support from a trained health or lay provider to verify that they are no longer pregnant. This means that work needs to be done to develop appropriate assessment tools for women to use prior to and following the use of medical abortion to support self-management.

An increase in medical abortion may also mean that providers have few opportunities to perform vacuum aspiration or dilation and evacuation, and so find it difficult to maintain the essential surgical skills needed for these procedures. Continual training can help to guarantee the availability of quality surgical methods of abortion, alongside medical abortion.



Interview with Dr Leonel Briozzo

Dr Leonel Briozzo is Chief of the Maternity Unit at the Hospital Pereira Rossell, a public hospital in Uruguay's capital Montevideo. He is a member of the Ethics and Professionalism Committee of the [International Federation of Gynecology and Obstetrics](#) (FIGO) and adviser to the Medical Council in Uruguay. He is also founder and international advisor to the *Iniciativas Sanitarias* in Uruguay and an external adviser to IPPF's Governing Council. Dr Briozzo was Under-Secretary of Health during the Presidency of José Mujica between 2011 and 2015. He played a pivotal role at the First Conference of Population and Development in the Americas (CEPAL-ECLAC) which approved the historic Montevideo Consensus.

What was your role in the acceleration of access to safe abortion in Uruguay and what motivated you to lead this significant change?

My vocation, initially for medicine and for gynaecology and obstetrics later, is based on my conviction to work for equity, social justice and freedom.

In 2001, when I started teaching gynaecology and obstetrics at university, Uruguay was going through a deep economic and social crisis which led many people into poverty. As unsafe abortions and maternal deaths increased exponentially, finding a solution became urgent. We were convinced that prevention of unsafe abortion was fundamental – including education for a pleasurable and responsible sexuality and contraception – together with the liberalization of abortion, so if this is the final option taken by women, it is done without risk to them or their environment.

In this context, we conceptualised the Harm Reduction Model in 2001, led by the organization "Iniciativas Sanitarias" (Health Initiatives), together with a broad coalition of health actors. The implementation of the model all over the country placed safe abortion as a health issue and contributed to develop a shared agenda with the women's movement and social and progressive political groups of the left (Frente Amplio) which led to the achievement in 2012 of the decriminalization of abortion, in

what I call a continuous process of liberalization of abortion as a practice.

At that time, I was Uruguay's Under-Secretary of Health, and President José Mujica gave me all his support to make sure that the Abortion Law was implemented. In the long term, this political decision demonstrated enormous health and social benefits.

What is the Harm Reduction Model?

In 2001, safe abortion in Uruguay could not be legally provided by the health system and was highly stigmatized. However, it was possible to work before and after abortion occurred and so we did.

Before, we provided comprehensive and high-quality advice for women to assess the decision of taking misoprostol. After, we offered post-abortion consultation.

We did all this based on bio-ethical principles of confidentiality between the medical professional and the patient and of putting the interests of our patients at the core of medical practice and before our own opinions.

Thus, instead of judging women from the pedestal of hypocrisy, we ethically involved ourselves in the process from the principles of beneficence – not maleficence – autonomy and justice, providing health care with technical quality and humanity.

Why was abortion with medication prioritized as part of this model?

Because it was the only way in which women could interrupt – or at least start the interruption of – unintended pregnancy by themselves, self-administering a medicine in a safe way and based on scientific evidence.

This dramatically changed the role of health professionals from providing clandestine abortion to modifying the culture of the healthcare system with their commitment,

collaborating as agents of social change for women to access their rights.

Years later, what is your evaluation of the results of the harm reduction model?

The quantitative impact of the harm reduction model was immediate, first reducing the figures of maternal mortality at the Public Hospital where we worked and later in the whole country. The qualitative transformation of perceptions of health professionals, users and the community was more complex, but it also had great impact right from the start. The media was a key ally to disseminate the model and ensure messages were solid and consistent.

What would you recommend to decision makers who are thinking about accelerating access to safe abortion in the world?

The struggle for the decriminalization of abortion is part of the struggle for equity and justice. In Latin American, where we have a strong influence of the churches, it was important to debate the matter from the public health perspective and the right to health care first and the right to decide after. The basis of all our actions is to be in favour of life, women, children and society, seeking to reduce the number of abortions. The decision of the women should be what matters the most for health professionals.

Some final words?

We are pro-life because with the policies we developed and our health practice, we have decreased maternal mortality, child mortality and the number of abortions. People who are against this are anti-rights.

Activism for women's rights, Chile

Until 2018, Chile was part of a radical club of six countries around the world. Alongside Honduras, El Salvador, Nicaragua, Malta, and the Dominican Republic, it operated a policy of total reproductive coercion. The ban on all forms of abortion was introduced in 1989 by then-President Augusto Pinochet, and for the last 19 years a generation of women were forced through pregnancies against their will, robbing families of their reproductive freedom. This outdated law killed women, broke up families and destroyed lives, marking Chile out as an extreme and militant country, out of step with all but five other states worldwide.'

But on a bright winter's day, on 21 August 2017, women were finally free. After years of activism by grassroots women's groups, health trade union organizations, political organizations, academics and human rights advocates, and then months of contentious debate in Congress, the Constitutional Court decided to end its policy of reproductive force by passing a bill that allows abortion in three cases: if the life of the woman is at risk; if the pregnancy is the result of rape; or if the fetus will not survive. With an overwhelming amount of public support and the backing of President Michelle Bachelet, the new law was a momentous change.

La Mesa, a national network of abortion rights activists, played a pivotal role in bringing the law in line with citizens' attitudes. La Mesa member Debora Solis, of the Asociación Chilena de Protección de la Familia (APROFA), describes that day as a "milestone in the history of the struggle for the full exercise of human rights for women in Chile".

But the work is not over. As Debora comments: "undoubtedly, we still have a long way to go towards eliminating the social stigma related to abortion and to stop anti-rights groups that seek to create barriers when it comes to implementation of the law." Women, men and their families still experience stigma and shame when accessing abortion – and many radical, chauvinistic movements are still trying to challenge the law, which has an overwhelming amount of public support.

Seeing a law brought in by a dictator overturned through the strength of collective organizing was breathtaking for Claudia Dides, Executive Director of the sexual and reproductive health organization MILES. "That day I felt a joy so deep, like I felt the day that we defeated the dictatorship in the plebiscite in 1988," she says. "I felt that all the humiliation, all the disqualification, the rejections, the distrust and the personal attacks didn't matter. I felt that we have been given a big step towards giving women their dignity back, especially those who had no one or nothing to turn to."

Defining an action agenda

To ensure more women can safely use medical abortion without direct medical supervision

Safe abortion urgently needs to become a priority for governments, health systems, CSOs and development partners, whether provided in a health clinic or a woman's home. The barriers that governments have put in place must be removed.

This report calls for coordinated action and political will to ensure under-served women have abortion options that are safe, legal and acceptable, including the self-use of medical abortion.

A full action agenda for achieving this goal includes the following steps:

Actions at country level

- Governments and relevant partners, including CSOs, should do research on the barriers and challenges around women self-administering medical abortion. This research needs to identify how to increase women's ability to determine their eligibility and to complete abortions, alongside identifying preferred service delivery and support models, including for self-management. It also needs to identify ways to ensure links to additional counselling or facility-based care are available if needed.
- Mifepristone, misoprostol and combi-packs including both medicines should be registered and available in country.^{i, ii}
- Mifepristone and misoprostol should be included in national essential medicines lists to help facilitate procurement and supply. Licences should allow for use in a wide range of settings and medicines made available free of charge at the primary care level. Over-regulation that limits access to medicines must be avoided.
- Governments should develop measures to ensure the quality of abortion medications and establish and monitor quality standards for abortion-related care within health systems.
- Medical abortion for comprehensive abortion care must be available in national sites that provide services for women in humanitarian settings, to address both the high unmet reproductive health needs of these women and the consequences of gender-based violence.
- Governments should remove abortion from the penal code and end criminal penalties for women who use medical abortion on their own. Regulations and health systems guidelines

i A recent study is a first to identify research that would meet the US Food and Drug Administration (USFDA) requirements for regulatory criteria for over-the-counter use. Kapp, N, Grossman, D, Jackson, E, Castleman, L, Brahma, D (2017) A research agenda for moving early medical pregnancy termination over the counter. *BJOG*. 124, pp.1646–1652.

ii Mifepristone at certain doses can be and is being used in some countries as an emergency contraceptive. Registering it as such could facilitate wider access to the medication and help prevent unintended pregnancies if used immediately after sex. See: Shen J, Che Y, Showell E, Chen K, Cheng L 2017. Methods of Emergency Contraception. *Cochrane*. Available at https://www.cochrane.org/CD001324/FERTILREG_methods-emergency-contraception

should make clear that self-management is permitted. Women and providers who are currently in prison for abortion-related charges should be released.

- Public, private and non-profit service providers should ensure the availability and provision of quality medical abortion as part of comprehensive abortion care, alongside surgical methods. Services should be designed to enable task-sharing between a wide range of health professionals including midwives, nurses and auxiliary nurses. Women need to be supported to self-manage aspects of their medical abortion according to their needs and preference.

Actions within government health systems to improve abortion overall

- Training in abortion care for health workers at all levels should be mainstreamed into pre- and in-service education programmes. Job descriptions for all health workers should include abortion care to avoid provider refusals.
- National policies and guidelines should allow for the task-sharing of abortion care to a range of health workers including midwives, nurses and auxiliary nurses.
- Governments should authorize and support community or lay health workers to provide medical abortion at the primary care level by designing mechanisms so they can assess eligibility, provide abortion medications, support women throughout the process, provide referrals and dispense contraceptives through a task-sharing approach.
- Governments should develop and mainstream comprehensive sexuality education programmes that include accurate information about contraception and abortion options. This will help shape more equitable gender relations for future generations.
- Health financing should include all recommended methods of abortion as essential components of SRHR within the primary health care package and universal health care. Universal health coverage should include safe abortion to ensure all women can afford to obtain services, regardless of their ability to pay.
- Government budgets and external development partners should allocate funding for abortion supplies, training and services – particularly at the primary level – as a core element of SRHR services.

Actions at the international level

- Research institutions and service-providing organizations should pursue a coordinated agenda to fill evidence gaps about the safe self-use of medical abortion. Recommendations drawn from a group of 20 global researchers representing nine different international organizations and universities include the following:⁷⁶
 - ◆ Undertaking studies that explore women's preferences for abortion and their experiences with the self-use of medical abortion, including links with contraceptive services and referrals for follow-up care.
 - ◆ The best models for reaching women with high quality drugs, information and support, including appropriate roles for pharmacists and community lay or health workers.
 - ◆ Clinical outcomes following the self-use of medical abortion, particularly beyond 63 days. This includes women's ability to self-assess eligibility for medical abortion and to determine when the abortion is complete, especially when misoprostol is used without mifepristone and as compared to clinic-based care.
- Well-designed research should be conducted to refine the best tools and checklists for assessing women's eligibility for medical abortion. These need to be tested in community settings. Research should also address questions about safety, effectiveness and the feasibility of using lay health workers to administer medications, manage common side-effects and assess the need for clinic-based follow-up. Experience from NGOs and CSOs that provide counselling, advice and accompaniment to women using medical abortion are important sources of information to establish this evidence and test effective models.

- As of June 2018, there are no combi-packs including both medications that meet WHO pre-qualification standards. The limited number of combi-packs that are quality-assured through Stringent Regulatory Authorityⁱⁱⁱ approvals are often expensive and not widely available. The WHO should simplify and streamline the pre-qualification process for medical abortion medicines by providing regular and clear guidance to manufacturers and make the process cheaper. The WHO could pre-qualify an affordable combi-pack including both mifepristone and misoprostol, as well as additional mifepristone and misoprostol products to support efforts that increase access.
- Manufacturers and global institutions (WHO, UNFPA, bilateral donors) should increase the availability of quality-assured medical abortion commodities, including mechanisms for post-manufacture product testing and risk mitigation.
- Both medical abortion drugs should be included in equipment packs, technical guidelines, and in budgets for humanitarian crisis situations, including within the MISP used to supply crisis settings.
- Professional medical associations should emphasize to members the importance of access to safe abortion in women's lives and to strengthening their commitment to the ethical provision of care. This includes placing the woman's best interests above the individual provider's personal feelings about abortion.⁷⁷
- External development partners should expand dedicated funding for abortion supplies, training and services as a core element of SRHR services, and support efforts to expand options for self-management of medical abortion.

IPPF, as a global service provider and leading advocate of sexual and reproductive health and rights, pledges to uphold its commitment to providing gender-sensitive and rights-based comprehensive abortion care to all, and to working in partnership with others to ensure that the conditions and structures are in place to help women access safe abortion in the way that works best for their lives.

iii A Stringent Regulatory Authority refers to a regulatory authority which is:

- a) a member of the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) (prior to 23 October 2015: the US Food and Drug Administration, the European Commission and the Ministry of Health, Labour and Welfare of Japan also represented by the Pharmaceuticals and Medical Devices Agency); or
- b) an ICH observer prior to 23 October 2015 (European Free Trade Association, as represented by Swiss Medic and Health Canada); or
- c) a regulatory authority associated with an ICH member through a legally binding, mutual recognition agreement prior to 23 October 2015 (Australia, Iceland, Liechtenstein and Norway).

Conclusion

This report recognizes that the international community has been slow to address women's access to safe and legal abortion, openly and in a coordinated way. The needs are clear. The time to act, *together*, is now.

Despite significant progress to reduce unsafe abortion since the ICPD Programme of Action was adopted in 1994, oppressive policies and laws remain. The result is that each year an estimated 25 million women who choose not to progress through their full pregnancy are forced to seek care clandestinely, on their own or without the support of a healthcare provider, sometimes in dangerous ways.

Medical abortion offers opportunities to expand access to safe abortion and breaks the constraints of gender inequality by empowering women to decide when and how they choose to move through a full pregnancy. Removing coercive barriers to services enables women to make their own decisions, giving women real options – whether that means a self-administered medical abortion, an abortion provided in a health facility, or services to support moving through the

full pregnancy. Governments, decision makers, religious leaders and the medical profession owe women urgent action to ensure they have choices that respect their bodily integrity and protect their health and lives.

As the 25th anniversary of the ICPD approaches, we must all look critically at what remains to be done to ensure that every abortion is a safe abortion. IPPF invites policy makers and the global SRHR community to join us in taking action to make this goal a reality.

IPPF is committed to safe and legal abortion for every woman in the world. We will continue to stand beside women at every step of their reproductive lives and ensure that they are offered all options and supported to decide what is best for them, free of discrimination and stigma.



Endnotes

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