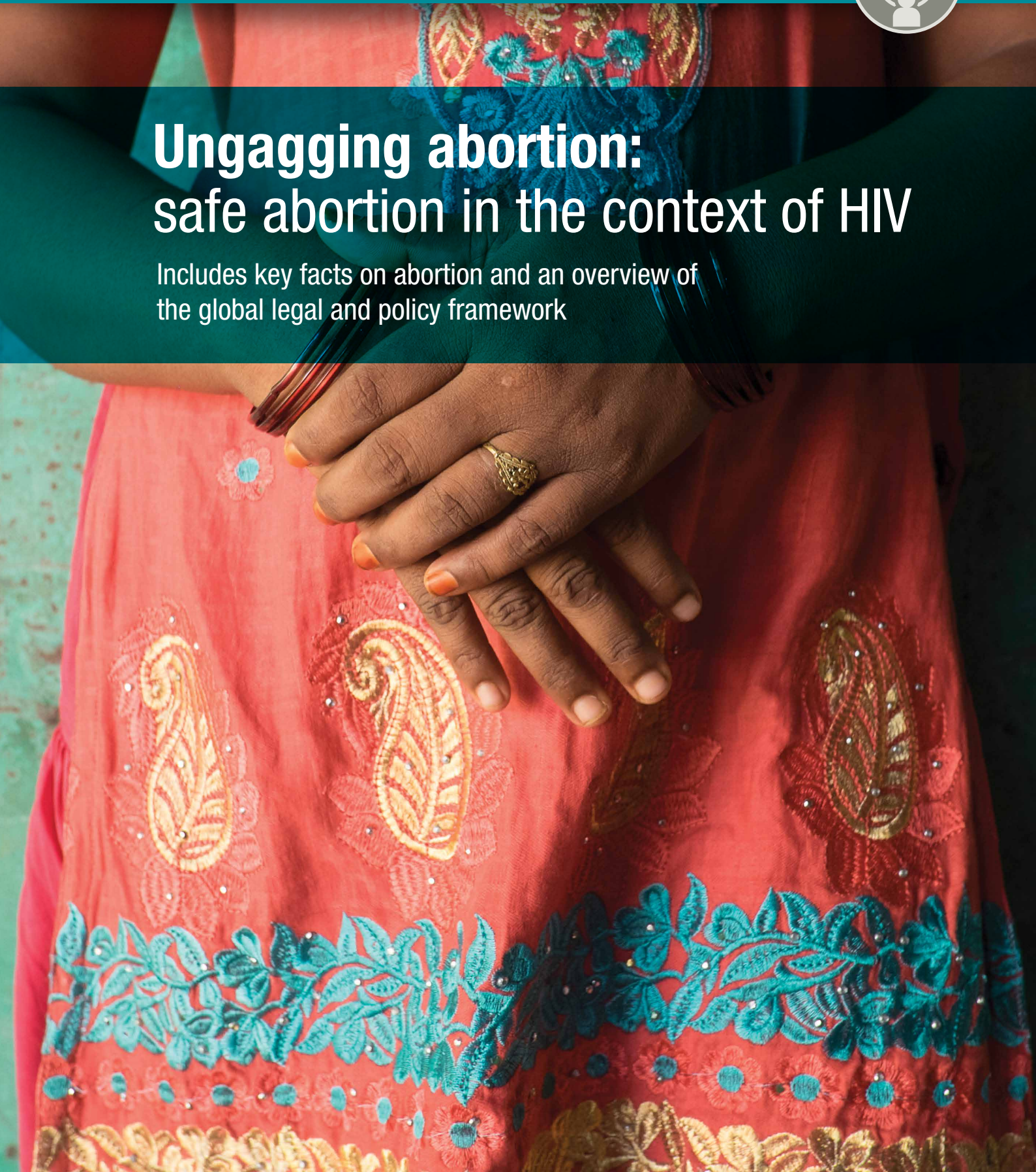




Ungagging abortion: safe abortion in the context of HIV

Includes key facts on abortion and an overview of
the global legal and policy framework



About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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Cover photo: Dolly, a sex-worker in Doulatdia Brothel is a service beneficiary of the Link Up project.

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Design and illustration: Jane Shepherd

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Acronyms and abbreviations

ART	antiretroviral therapy
CSO	civil society organisation
GBV	gender-based violence
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IPV	intimate partner violence
PAC	post-abortion care
PPH	prevention of post-partum haemorrhage
SDGs	Sustainable Development Goals
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
VCAT	values clarification and attitude transformation
WHO	World Health Organization

Ungagging abortion: safe abortion in the context of HIV

Introduction

The International HIV/AIDS Alliance (the Alliance) uses a person-centred approach to increase access to quality HIV and health services and to realise the human rights of people living with HIV and others affected by HIV.¹ This means we look at health from an individual perspective. We consider health as much more than the absence of illness and think holistically about an individual's full range of needs, desires, capacities and human rights. The values of equality, equity, power and integration underpin our interventions at all levels: individual, peers, family and community, services, Alliance practitioners, and the legal and policy environment.

Most people think about their sexual and reproductive lives in a holistic way with HIV as only one aspect. Working for broader sexual and reproductive well being opens up many more opportunities to prevent HIV and provide care for people with HIV, as well as improving sexual and reproductive health in its own right.

The Alliance's approach to sexual and reproductive health and rights (SRHR) includes increasing access to comprehensive, high quality SRHR services and integrated HIV-SRHR programming for key populations, adolescents affected by and at risk of HIV, women and girls in all their diversity, and people whose HIV vulnerability and health is impacted by gender-based violence.

Key sexual and reproductive health and HIV interventions²

- Safer sex promotion to prevent STIs, HIV and unintended pregnancy
- Activities to support a satisfying sexual life
- Increasing access to HIV testing and counselling
- Joining up family planning and HIV services
- Safe abortion and post-abortion care (PAC)
- Protecting and enhancing fertility
- HIV treatment (ART)
- Preventing HIV transmission to babies during pregnancy, delivery and after birth
- Improving maternal and newborn health
- Optimising integration between STI and HIV services
- Prevention, diagnosis and treatment of SRH-related cancers
- Addressing gender-based violence

Safe abortion and PAC (via direct service provision or referrals), comprehensive sexuality education and counselling and information on a full range of family planning methods (including safe abortion), all need to be in place to ensure that all people can fully realise their SRHR. Service delivery also needs to be supported by advocacy for the safeguarding or extension of laws and policies which allow women to choose to access a safe, legal abortion if they need it. Safe abortion is arguably the most contested part of this package and needs special attention.

A challenging political environment: the global gag rule and HIV

Over the last few years, there has been an unprecedented resurgence of attacks on women's sexual and reproductive rights. Significantly in 2017, US President Donald Trump reinstated and extended the Mexico City Policy – also known as the global gag rule – to all global health programmes. This has multiplied the challenges of working to promote access to safe abortion within the context of a comprehensive SRHR agenda and also threatens organisations contributing to the global HIV response. Many of these are already working in restrictive legal environments around abortion, which constrains their ability to provide, refer, counsel or advocate for safe abortion. The global gag rule further 'gags' these efforts.³

The global gag rule covers any non-US based international or local organisation receiving US funding. Under the 'standard provisions' of the policy, all contracts will stipulate that organisations receiving US funding must not provide, counsel or refer to abortion services, or advocate to maintain or liberalise existing abortion laws in their country.

As the US is the largest funder of health services in the Global South, the global gag rule threatens all health programmes, but particularly those on SRHR and HIV. Evidenced-based integrated programmes will be threatened as any facility delivering an integrated programme that even refers a client for an abortion service will no longer be eligible to receive US funding. Even in countries where abortion is legal, providers taking US funding would be unable to provide this service.

The global gag rule does allow for some exceptions. These include referral in the case of rape, incest or to save the life of the mother; as well as when a pregnant woman has stated that she wants to terminate the pregnancy and explicitly requested information about where she can obtain a safe, legal abortion. PAC is also not included in the global gag rule. Therefore, women who experience complications from unsafe abortion can access care without penalty and health care providers can still provide this lifesaving service.

Evidence shows that rather than reducing the numbers of abortions, the global gag rule has led to an increase in abortions and unintended pregnancies.⁴

The Alliance secretariat has made the decision not to seek or renew existing US government health assistance funds to support the implementation of our programmes, while the current restrictions and conditions of the global gag rule are in place (see box on page 6). We feel that in the current volatile environment threatening women's rights we need to articulate our understanding and position on safe abortion, in the context of a comprehensive SRHR agenda, which we see as integral to an effective HIV response. This paper aims to do this. It provides civil society organisations working on HIV prevention, treatment, care and support with information on safe abortion, freedom from coerced abortion, and PAC, and related discussion and recommendations to inform the development of programmes and policy work in relation to women and HIV. As such, we hope it will be useful resource for Alliance partners and other civil society organisations that want to:

- do (more) work on abortion as part of a comprehensive SRHR package
- engage at different levels of advocacy
- understand more about how or why the global gag rule affects them
- develop an advocacy position on abortion
- understand linkages between abortion and HIV, and how access to safe abortion contributes to an effective HIV response
- discuss the issue with their staff and board
- discuss the issue among the communities they work with; among others.

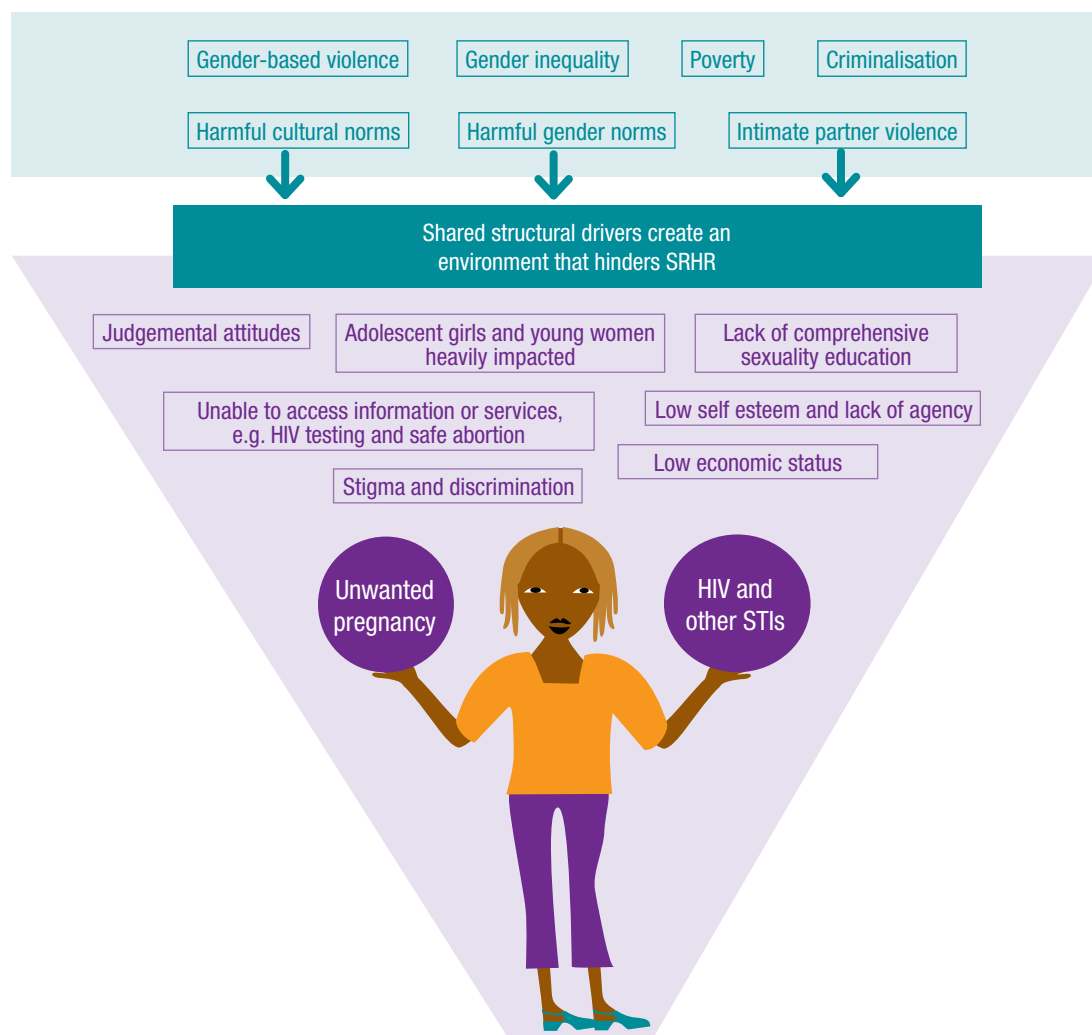
The importance of women's SRHR for an effective HIV response

For women living with and most affected by HIV, sexual and reproductive health and rights are crucial. This includes the right of women and girls in all their diversity to make decisions concerning their sexual activity and reproduction, free from discrimination, coercion, and violence. HIV among women is commonly associated with sex, pregnancy, childbirth and breastfeeding. Some sexually transmitted infections (STIs) can also increase HIV risk. HIV and sexual and reproductive ill-health share root causes, including structural drivers such as poverty, harmful cultural norms and gender inequality, social marginalisation and criminalisation of key populations, and lack of access to information and services.²

Safe abortion⁵, freedom from coerced abortion, and PAC are key aspects of SRHR for all women, especially for women living with and affected by HIV.

Like HIV, abortion is highly politicised and stigmatised. People feel strongly about it and reliable sources of information may be difficult to find. Community-based organisations addressing HIV may work with women who have a broad range of challenges including the need for accessible HIV or pregnancy prevention services, among others. However, while in many places communities are experienced in supporting people living with HIV, in general communities are less experienced in supporting women with their SRHR needs, and abortion in particular.

Examples of shared barriers to achieving SRHR in respect to abortion and HIV



Why are safe abortion, freedom from coerced abortion and PAC important for women living with and affected by HIV?

Safe abortion, freedom from coerced abortion, and PAC are priority issues for women living with HIV.⁶ Like all sexually active women of reproductive age, women and adolescent girls living with or affected by HIV can find themselves pregnant when they do not want to be. Unintended pregnancy can result when women do not have access to contraception, have had a contraceptive failure, or been unable to access emergency contraception. It may be a result of coerced sex or rape, including within marriage, and it may occur when women have been unable to negotiate sex with a condom.



As these experiences show, women living with HIV and women from key and vulnerable populations (including sex workers, women who use drugs, adolescent girls and young women) face additional barriers to accessing and utilising comprehensive SRHR services. Women experiencing unwanted pregnancy may choose to terminate the pregnancy for a similarly wide range of reasons including but not limited to: wanting to finish school; their own physical and/or mental health; not feeling able to feed and care for an (additional) child; fear or experience of intimate partner or domestic violence triggered by the pregnancy; or due to a change in circumstances such as relationship breakdown or unemployment.

The relationship between HIV and gender inequality, gendered social norms, harmful cultural practices such as early and forced marriage, and violence against women is increasingly clear. We know, for example, that women living with HIV experience high rates of gender violence, including intimate partner violence (IPV), before and after HIV diagnosis.^{6,7} IPV interferes with women's ability to negotiate safe sex practices^{6,8} and thwarts women from practising their preferred contraception over time. In some regions, women who experience intimate partner violence are 50% more likely to acquire HIV than women who do not experience violence.⁹ Similarly, women who have experienced gender violence are twice as likely to have an abortion as women who have not experienced violence.¹⁰

The same gender inequality, gendered social norms, violence against women and, in the case of adolescents and young women, age-related and other power differences that make women vulnerable to HIV, can also lead to lack of knowledge of and access to family planning, lack of autonomy regarding the use of contraception, and vulnerability to unintended pregnancy. Women from key populations, including sex workers, women who use drugs, and migrant women, often face legal barriers to accessing services, in addition to social stigma and marginalisation.

Attitudes towards women living with HIV, fertility and pregnancy

Many women living with and most affected by HIV want to have children; they should be supported to do so. Historically, however, women living with HIV have been pressured not to have children and many continue to face barriers to realising their fertility desires. Many have been coerced into terminating their pregnancies – even in countries and contexts where abortion is illegal.¹¹ In other cases, women living with HIV have been forcibly sterilised, sometimes as a condition to being 'allowed' a termination.^{6,11} It is now widely recognised that health care providers who perform abortions or sterilisations without the woman's fully informed consent are not only violating her human rights, they are violating global guidelines and their professional duty.¹² However, incidences of women living with HIV experiencing rights violations at the hands of health care providers continue to be reported.¹³

Women living with HIV may also face negative community attitudes toward both childbearing and abortion. A study in Nigeria and Zambia¹⁴ found that pregnant women living with HIV were stigmatised for obtaining an abortion, due to prevailing moral attitudes regarding pregnancy termination; *and* for *not* obtaining an abortion, due to widely held beliefs that women living with HIV should not have children.

It is clearly of key importance to support women living with HIV to realise their SRHR including through access to family planning, safe abortion, PAC and freedom from coerced abortion, so that they are able to control their own fertility. Yet there is still much to be done to ensure the integration of HIV and SRHR services.¹⁵

What do we know about abortion and women living with and affected by HIV?

Given the stigma surrounding abortion, and the fact that legal frameworks which restrict or criminalise safe access to abortion lead many women to seek illegal, unsafe and/or 'backstreet' abortions (see Annex), it is hard to present a clear statistical picture of abortion, particularly as it relates to women living with and affected by HIV. The statistics we do have suggest that globally, one quarter of all pregnancies end in abortion (27% in high-income countries and 24% in low- and middle-income ones), with married women more likely to obtain abortions than unmarried women.¹⁶ The majority of abortions take place in the first trimester (88% in 2006).¹⁷ It is estimated that about 25 million unsafe abortions take place each year and the majority of these (97%) take place in low- and middle-income countries.¹⁸

Global guidance on abortion and women living with HIV

The 2017 *WHO Consolidated Guidelines on SRHR of women living with HIV*¹² include two new recommendations related to safe abortion services:

Recommendation B.30: WHO recommends that safe abortion services should be the same for women living with HIV who want a voluntary abortion as for all women.

Recommendation B.31: WHO suggests that women living with HIV who want a voluntary abortion can be offered a choice of medical or surgical abortion, as for all women.

The Guidelines also include the following remarks:

- Abortion services should be free of coercion and offered in a respectful and non-judgemental manner.
- Health workers offering abortion, as with all health workers, must respect the rights of the women living with HIV by (a) providing access if desired and (b) ensuring women make the choice for themselves.
- If only one type of abortion (medical or surgical) is offered in a specific setting, women living with HIV should have access to that option. Limited options for all women should not result in women living with HIV having less access than other women.

WHO maintains that both medical and surgical abortion is safe for women living with HIV, although there is a need for further research on this, and a Cochrane Review is currently underway to assess the effectiveness and safety of both types of abortion, and to examine abortion outcomes for women living with HIV.¹⁹

Important to note is that **women have similar numbers of abortions (abortion rates) in countries where abortion is liberally available or in countries where it is severely restricted.** In countries where abortion is highly restricted, the abortion rate is 37 per 1,000 women; in countries where abortion is available on demand, the rate is 34 per 1,000 women.²⁰ This means that restrictive legal environments fail to stop women from seeking abortions. Here is the key difference: in liberal environments, women are more likely to be able to obtain a *safe* abortion; women in a restrictive environment are more likely to obtain an *unsafe* procedure.

Most of the deaths from unsafe abortions take place in the global South and 44% of these deaths take place in Africa.²¹ Recent estimates of the proportion of maternal deaths due to abortion range from between 8% and 18%.²² In 2014, it is estimated that there were 22,500 to 44,000 abortion-related deaths worldwide.

Unmet need for modern contraception is a key factor when women find themselves pregnant when they don't want to be. It is estimated that 84% of unintended pregnancies are due to unmet need for contraception.²³ While we do not have accurate data about the number of women living with HIV who choose to terminate a pregnancy, numerous small studies around the world show there is a high level of unmet need for contraception among women living with HIV. For example, in Sub-Saharan Africa between 66 and 92% of women living with HIV reported not wanting another child, now or ever, but only 20-43% were using contraception.²⁴ A study in two HIV clinics in Ghana also found high levels of unmet need for family planning among women living with HIV, with lower income and younger women particularly affected by lack of onsite family planning provision.²⁵ A key strategy in avoiding unwanted pregnancies is access to family planning services (ideally integrated with HIV prevention and treatment services).⁴

How can civil society organisations support women living with and affected by HIV who face unintended or unwanted pregnancy?

It is important for civil society organisations (CSOs) working with women living with and affected by HIV to know the legal context with regard to abortion, to ensure they can provide appropriate support to women who are facing unintended or unwanted pregnancy. More information on the legal context is provided in the Annex.

Even in countries where abortion is restricted or illegal, there are many ways in which civil society organisations can support women living with and affected by HIV who face an unintended or unwanted pregnancy to access services and realise their SRHR.

1. Post abortion care

At a minimum, CSOs working with women living with and affected by HIV can support women in accessing PAC, which is always legal and is often lifesaving.



Civil society organisations can:

- Find out where PAC is provided, and how women can be referred for it. Make this information available to women involved in the organisation's activities or using its services.
- Engage with PAC providers to ensure women living with and most affected by HIV are able to access PAC free from judgement, stigmatising attitudes and breaches of human rights, confidentiality and respect.

2. Community mobilisation

The stigma that surrounds abortion is a persistent barrier to safe abortion.⁴ As with reducing HIV stigma, it is at community level where real change takes place. Women with unwanted pregnancies are common and everyone knows someone who has had an abortion.



Civil society organisations can:

- Increase legal literacy on abortion in the community as a key component of comprehensive SRHR awareness-raising; and ensure that women know under what circumstances safe abortion is legal, and how/where to obtain it in these circumstances.
- Use non-judgemental language to talk about abortion and/or PAC in the community.
- Use local opportunities to raise awareness of the importance of abortion and/or PAC as a key element of SRHR, including for women living with and affected by HIV, women from key and vulnerable populations (including sex workers, women who use drugs, adolescent girls and young women, and others in specific circumstances of vulnerability).
- Use local opportunities to raise awareness of and support for the right of women living with HIV to become pregnant and have children, and not be subjected to coerced abortion or sterilisation.
- Use non-judgemental language to talk about and show support for pregnant women living with HIV in the community.
- Show support for the current pro-safe-abortion campaigns and movements for women's choice, such as She Decides (www.shedecides.com) and the Ipas 'Abortion is not a crime' (www.ipas.org/en/What-We-Do/Advocacy/Abortion-Is-Not-a-Crime.aspx) campaign.

3. International online networks

Self-administration of misoprostol (used in medical abortion – see Annex) has become widespread across the world and one of the ways that this is happening is via international abortion online networks. Women find websites online and order misoprostol to be posted to their homes. The women then follow medical instructions on the website. While most of these abortions are technically illegal, they are safe, or at least *safer* (see also page 19).



Civil society organisations can:

- Be aware of the legal framework surrounding abortion in each country. The Global Abortion Policies Database is a useful resource.²⁶
- Being mindful of the legalities in each country, share the list of reliable sources of information on safe abortion and availability of medical abortion pills with women through your organisation (see Annex).
- Support a harm reduction approach to abortion by ensuring or advocating that information on how to obtain a safe medical abortion, including with self-administered misoprostol, is given to women without judgement (ideally by medical personnel).

What is a harm reduction approach to abortion?

Many CSOs working with people living with and affected by HIV have experience of using harm reduction models. A harm reduction approach to abortion follows three core principles:²⁶

1. The neutrality principle refers to the focus on the health-related risks and harms of [unsafe] abortion, rather than its legal or moral status. This shift brings about a change in public policy responses to unsafe abortion, namely public health interventions rather than prohibition and punishment.
2. The humanistic principle refers to the entitlement of all women, regardless of their decision-making about pregnancy, to be treated with respect, dignity and worth. All women deserve to be treated as members of the community, whose health and lives matter.
3. The pragmatic principle accepts the inevitable reality that women have unsafe abortions for many reasons, and thus emphasises the importance of meeting the needs of women where they are, which may include self-inducing abortion outside the health system.

4. Social and peer support

For women in situations of unintended or unwanted pregnancy, abortion and PAC, and for women living with HIV who are pregnant and want to continue their pregnancy, social support is a crucial element of SRHR and abortion support, in addition to medical care.



Civil society organisations can:

- Ensure the organisation can provide or facilitate social support systems for women in situations of unintended or unwanted pregnancy, abortion or PAC. This might include one-to-one counselling, safe spaces, and/or peer support.
- Ensure the organisation can provide or facilitate social support systems for women living with HIV who are pregnant and want to continue their pregnancy, through approaches such as mentor mothers and working to promote supportive health care environments in which pregnant women living with HIV are treated with respect and not subjected to coerced abortion.

5. Integrated approaches to SRHR

An ideal service delivery picture would see comprehensive SRHR delivered in ways that best suit women and their partners. There is a growing body of evidence for the importance of integrated health care programmes with referral systems and linkages that work well. Integrating SRHR information and services and HIV prevention, treatment, care and support, means that opportunities are not missed to provide women with pregnancy testing, family planning, voluntary counselling and testing (VCT) for HIV, antiretroviral therapy (ART), and safe abortion or post-abortion care.⁴



Civil society organisations can:

- Share information and raise awareness, including with decision- and policy-makers at local and national level, about the interconnectedness of access to contraception (including emergency contraception), unwanted pregnancy, abortion and PAC.
- Advocate locally and nationally for integration of SRHR and HIV services.
- If the organisation is a service provider, consider how it can expand the offer of integrated services including HIV, family planning, pregnancy, abortion (in circumstances that the legal framework provides for) and PAC.
- Advocate for health care services which are supportive and respectful of the SRHR of women living with and affected by HIV, and their decisions around family planning, pregnancy and abortion.

6. Advocacy

Advocacy work on abortion might include appeals to governments to liberalise laws, appeals to ministries of health to provide guidelines or allow lower level providers to provide abortion services, or to the public to help people realise how devastating a strict law is for women. Ideally, advocacy work on abortion is carried out in partnership with other organisations.²⁸ While it is often local pressure that drives policy change, the process can be slow, with victories and set-backs. Also, understanding the sometimes confusing policy frameworks covering abortion can require specialised policy and legal expertise.



Civil society organisations can:

- Ensure organisational literacy about the national laws and guidelines around access to safe abortion, and the international commitments and protocols the country has signed up to (see Annex), and whether these commitments have been domesticated.
- Increase organisational understanding and capacity to advocate on abortion and related issues, including with regard to women living with and affected by HIV. This may include partnering with other organisations with expertise in this area.
- Develop and share with policy-makers requests and positions on liberalisation of abortion law and implementation of existing policy guidelines in favour of safe abortion, including for women living with and affected by HIV, and respect for SRHR and decisions on family planning, pregnancy and abortion for women living with and affected by HIV.
- Advocate for national health guidelines to reflect the latest scientific evidence around safe abortion and make the case for the health imperative of providing safe abortion services as part of a comprehensive SRHR package.
- Advocate for more providers to be trained on how to carry out safe abortion and post abortion care services where numbers currently do not meet demand.

7. Promoting holistic health care programmes

The importance of programmes integrating SRHR and HIV has already been discussed. Women need non-judgemental services that meet all their needs. In the intimate setting of a family planning and/or HIV counselling and testing consultation, women might bring up gender violence or the fact that they are pregnant and don't want to be. In countries where abortion is restricted, the critical importance of counselling and referral come to the fore. Providers should respond non-judgementally to women's needs and discuss their options with them. Ideally, providers should know where safe abortion services might be delivered in their countries. They might be able to use a harm reduction approach and refer their clients to a website with information on how to self-administer a medical abortion. While this may seem somewhat risky, health care providers know that women with unwanted pregnancies may make desperate choices: visits to 'backstreet' abortion providers can have dangerous consequences. This is a difficult grey area. One approach that has been widely used for supporting health care providers faced with these difficult decisions is called Values Clarification and Attitude Transformation (VCAT),²⁹ which can help providers to develop their thinking around how to best support women.



Civil society organisations can:

- Use the VCAT approach in their own organisation.
- Promote the VCAT approach with local service providers.
- Ensure counselling and appropriate referrals are available for all women. experiencing sexual and gender based violence and/or unintended pregnancy, including for emergency contraception, safe legal abortion, and PAC, as well as HIV and STI testing and treatment, including post exposure prophylaxis.

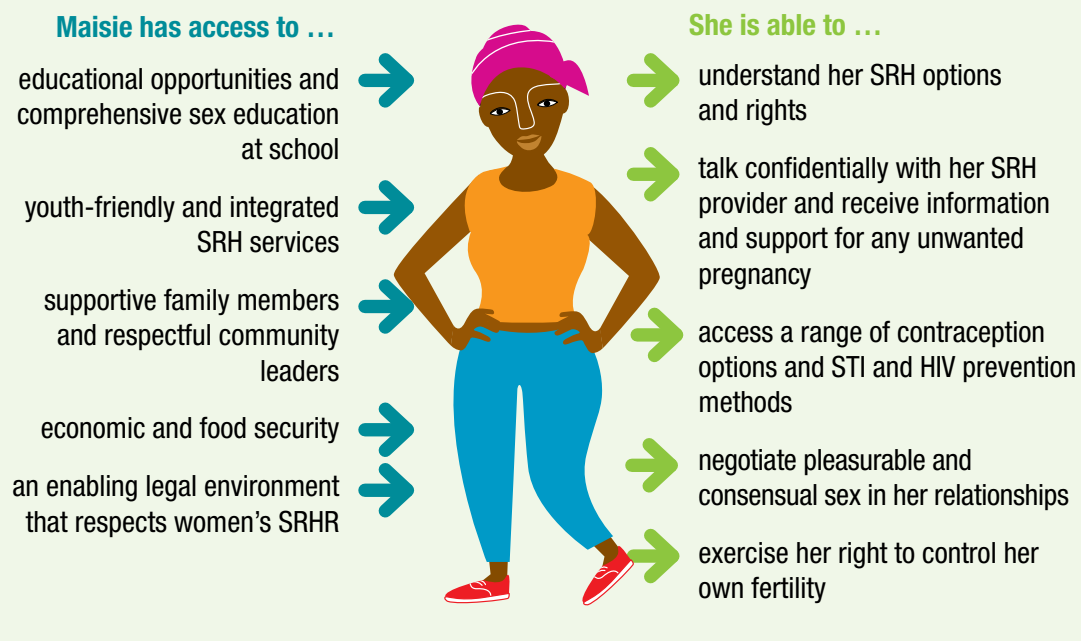
Conclusion

Despite the challenges to women’s SRHR in the current global environment, there are also opportunities. There is wide recognition that SRHR are essential for sustainable development, and a new definition of comprehensive SRHR to accelerate progress for all, which includes safe and effective abortion services and care.⁴ We hope the ideas and information in this paper and Annex, will support Alliance partners and other civil society organisations in ensuring that women living with and affected by HIV are able to access their full SRHR.

Case scenario: Joyce and Maisie

Joyce was 15 when she got pregnant for the first time. A boy at her school told her that she wouldn’t get pregnant on her first time. When the pregnancy started to show, she was expelled from school. Joyce had heard that there were ways to stop the pregnancy but she also remembered overhearing the story of a girl in her school who had died ... and anyway, she didn’t know who she would ask. After giving birth, Joyce felt isolated from her old friends. Her mother and father kept reminding her what a burden she was now that there was an extra mouth to feed. She hated asking her parents for money, so when she or the baby needed something, Joyce would go to the local bar. There she met truckers bringing goods over the border. In return for sex they would buy her dinner or clothes. If she agreed to have sex without a condom they gave her cash. When she got pregnant again, she went to the local clinic and was told she had HIV. She was given treatment to stop her baby from getting the virus and to keep her well. The nurses said she should tell her partner, but she didn’t know who to tell so she said nothing and carried on meeting her truckers. When one of them saw her medication in her bag, he told everyone at the bar and the owner threw her out.

Joyce hopes that her cousin Maisie, who is now 16, has a better life.



Annex: Key facts on abortion and an overview of the global legal and policy framework

What is abortion?

Abortion methods are changing fast. There are two types:

- **Medical abortion:** use of pharmacological drugs (mifepristone and misoprostol) to terminate pregnancy. Sometimes the terms ‘non-surgical abortion’ or ‘medication abortion’ are also used.
- **Surgical abortion:** use of transcervical procedures (placing a medical instrument into the womb) for terminating pregnancy, including vacuum aspiration and dilation and evacuation.

In the past decade, the use of medical abortion has changed abortion services. It is safe enough for women to carry out at home (ideally under medical supervision). Combination drugs (misoprostol and mifepristone) are currently registered for use in nearly 30 countries, the majority in the Global North, and medical abortion is increasingly the preferred abortion method in the US and Europe. Worldwide, misoprostol is widely available (as a treatment for ulcers). There is an increase in the numbers of women obtaining misoprostol in circumstances where it is not legal, but where using it is much safer than some of the abortion alternatives women have resorted to.

Each woman seeking abortion services should be counselled on her abortion options and she should make the abortion method choice herself. Some women choose to have a medical abortion because they prefer not to have an intimate medical procedure when they can take pills privately at home. Other women choose a surgical abortion to have the procedure over quickly and away from home to keep the procedure secret from their family.

How the ulcer drug Misoprostol changed maternal health care

Women in Mexico first discovered that a common ulcer medication also caused miscarriage. Off-label use for abortion became common and the drug was popular on the black market. International clinical trials followed and misoprostol was found to have a myriad of maternal health uses including: prevention of post-partum haemorrhage (PPH), incomplete abortion, and therapeutic abortion.

Misoprostol is now registered in many countries in the Global South, often for the prevention of PPH. Depending on the country, it is widely available in health centres for PPH and often available in pharmacies (and increasingly on the black market).

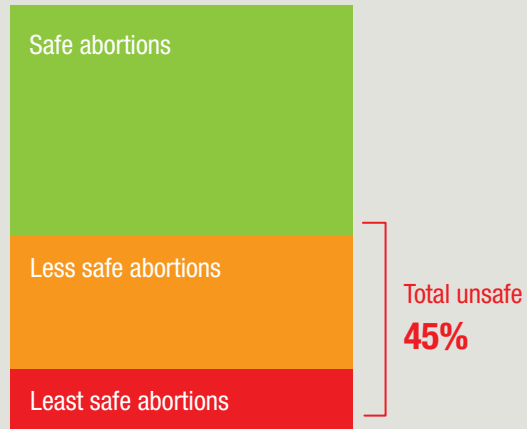
What makes an abortion ‘safe’?

Abortion is one of the safest medical procedures when carried out by a trained health care practitioner in an appropriate setting. In contrast, abortion is unsafe when carried out by untrained practitioners in unsafe conditions or even by the woman herself. These unsafe options might include drinking household cleaning liquid or the insertion of a sharp object. It is estimated that the majority of abortions that take place in Africa (excluding South Africa) are categorised as ‘least safe abortions’.³⁰ See page 19 for more information on the difference between ‘less safe’ and ‘least safe’.

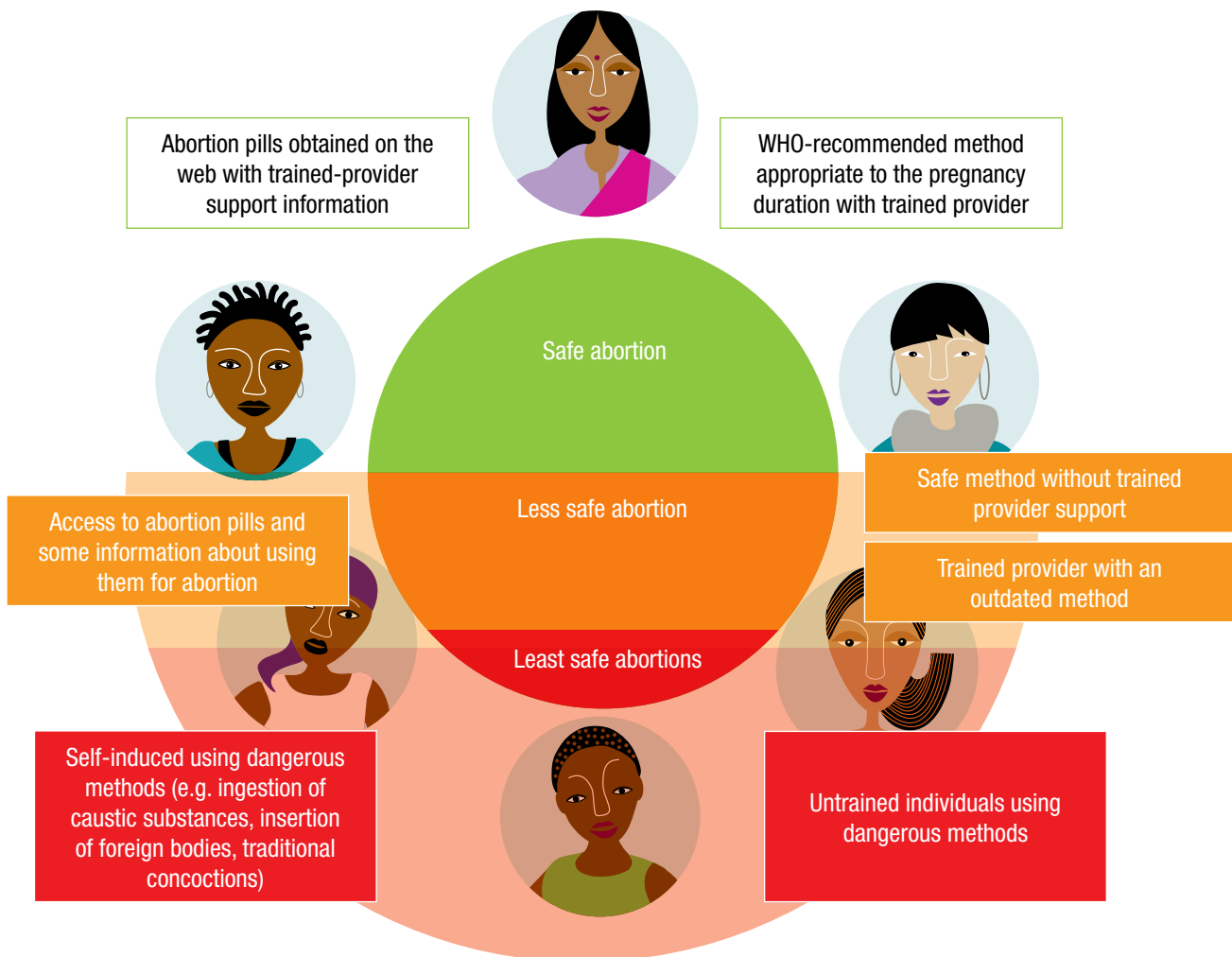
Worldwide abortions by safety. Almost half are still unsafe.

Of the 56 million abortions that take place each year worldwide, an estimated 25 million are unsafe.

Source: WHO and Guttmacher Institute (2017), 'Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model'. *The Lancet*, Vol.390,10110.



Gradation of abortion safety



Note: Abortion can be safe, even if it takes place in a restricted environment. Abortion can also be unsafe in an unrestricted environment.³¹

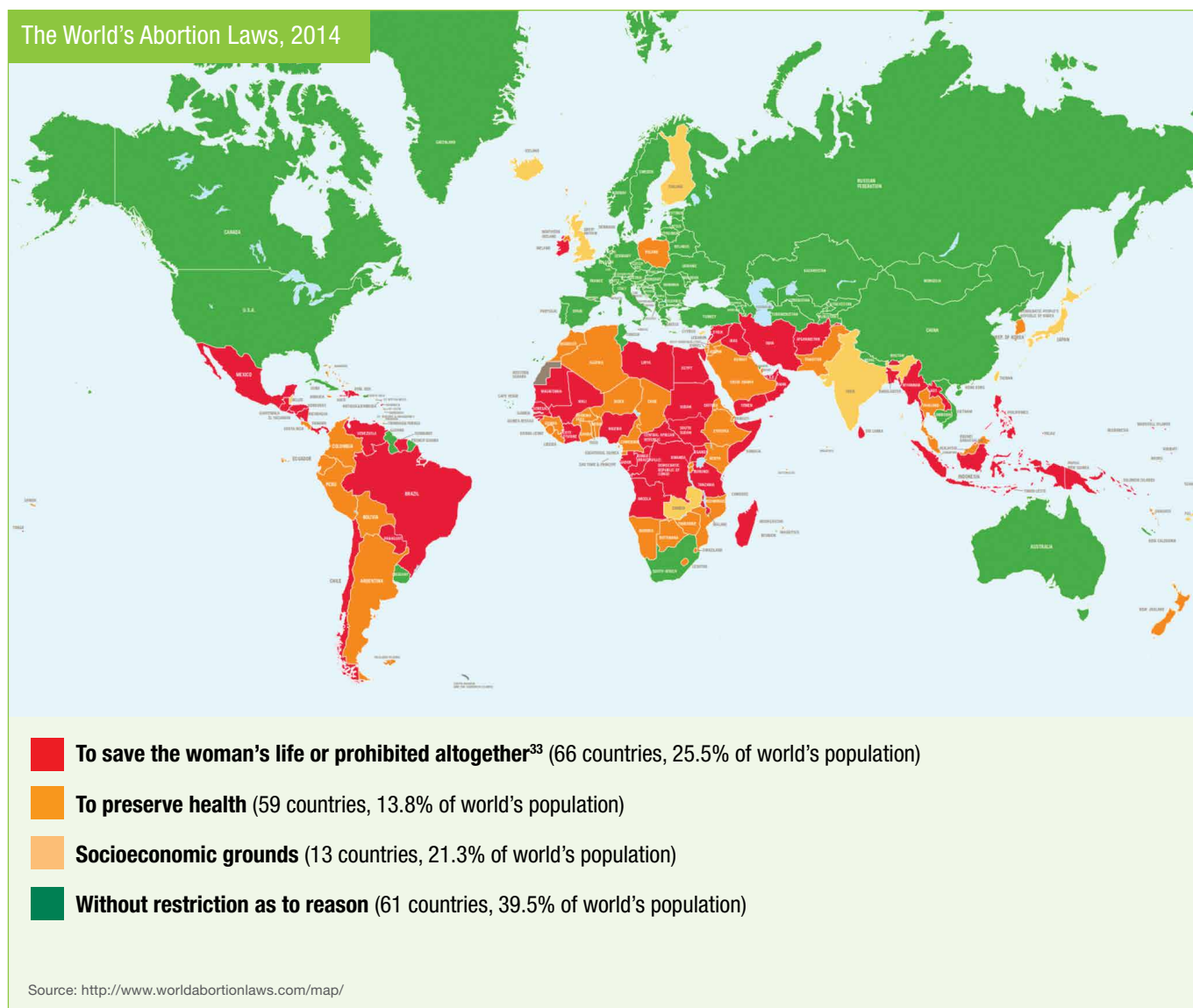
When and where is abortion legal?

Abortion is almost always legal in some circumstances in all countries. Only a few countries do not allow abortion in any circumstance, even to save a woman's life. Other countries allow abortion in the case of rape or incest. In some, the woman's mental or physical health are included as exceptions. The Center for Reproductive Rights have produced a map showing the world's abortion laws which breaks down the circumstances under which abortion is legal.

PAC is always legal, and vitally important for many women. PAC is the same procedure which is given to women who have miscarried

or are suffering from the outcomes of an incomplete abortion. (In most cases, a health care provider cannot distinguish between the two.) Life-saving care is given to stop bleeding and prevent infection. It is usually carried out in the gynaecological wards of hospitals or health centres and PAC is a very common service.

Even in countries where abortion is severely restricted or in USAID-funded projects subject to the global gag rule, **PAC is always allowed.** PAC is actually even more important in countries with restrictive laws, where more women with unintended pregnancies resort to clandestine abortions that are not safe, and should be an essential reproductive health service.³²



What are the main barriers women face in accessing abortion?

Criminalisation: In some countries, a woman who procures an abortion is considered a criminal (see the map of abortion laws on page 20). How strictly this is observed or enforced varies from country to country, with some countries prohibiting abortion under any circumstance. An extreme case is El Salvador where there have been prominent cases brought to public attention by Amnesty International,³⁴ including that of a 19-year-old woman who had been raped and was pregnant but did not know it. She fainted and was taken to a health centre bleeding brought on by miscarriage. Believing that the woman had attempted to self-administer a termination of pregnancy, hospital staff turned her in to the authorities and she was given a 30-year prison sentence for aggravated homicide.

Religion: Both Catholic and Evangelical churches are strongly opposed to abortion, although there are also Christian faith-based organisations who actively lobby and advocate for decriminalisation of abortion such as Catholics for Choice (www.catholicsforchoice.org). While not mentioned in the Quran, how abortion is interpreted varies by each Muslim country. Religious and cultural taboos are strong in many parts of the world. The pressure on women to adhere to religious norms weighs heavily. Health care providers with strong religious beliefs often cite religion as a reason to not carry out abortion procedures in their work.

Stigma: Religious and social pressure mean that abortion stigma is high and that women feel that they need to carry out their procedures in secret, even in more liberal legal environments. Clandestine procedures are much more likely to be unsafe.⁴ For women living with HIV, they may experience the double stigma of living with HIV and having an abortion.

Age: Adolescent girls and young women face particular challenges accessing safe abortion services, as well as a range of SRHR information and services which leave them vulnerable to unintended pregnancy in the first place, and HIV. Barriers include societal expectations and attitudes about what girls and young women should be and do; taboos around sex and sexuality; and national laws and guidelines restricting unaccompanied access to sexual and reproductive health services.¹³ Recognising the evolving capacity of children as they move through adolescence and into adulthood is important for balancing the need for child protection with the growing autonomy of young adults. The UK's Fraser Guidelines are a useful tool that helps service providers decide whether a person who is still considered a child by law is capable of making an informed decision about his or her well being.³⁵

Financial barriers. Many women face economic barriers to accessing safe abortion, even in countries with fewer restrictions. Poor women and girls and those who do not have health insurance may not be able to cover the costs involved.⁴

Married women have amongst the highest number of abortions. These women include young women, older women, recently married and those who have been married for a number of years. Married women often have less access to contraception because they are dependent on their husbands for financial support and may not have a say in how the family income is spent. Additionally, due to an imbalance of gender equity and violence, women may not have control over how many children they want to have.

Which global policy instruments support safe abortion?

There are numerous international treaties that support a woman’s right to legal abortion services. Their right to abortion is supported by the guarantees in these treaties to life, health, and freedom from cruel, inhuman or degrading treatment, among other things. Below we briefly refer to the Sustainable Development Goals, and the Maputo Protocol. For more detailed information on all the abortion human rights instruments, please see the Center for Reproductive Rights paper ‘Safe and Legal Abortion is a Woman’s Human Right’.³⁶

Sustainable Development Goals:³⁷ The SDGs uphold the ICPD Programme of Action³⁸ and the Beijing Platform for Action³⁹. While not specifically mentioning abortion, Target 3.7 commits to: ‘By 2030, ensure universal access to sexual and

reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs’ and Target 5.6 commits to: ‘*Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action*’. In this way, abortion is implicitly included under ‘reproductive health care services’ and ‘reproductive rights’. The table below details the specific targets and indicators with highest relevance for safe abortion care. Existing indicators however do not explicitly include any abortion measurement. (It should be noted that abortion data, while improving recently after better funding, are difficult to obtain, especially in countries where abortion is restricted.)

Sustainable Development Goals relevant to safe abortion and PAC

Target	Indicator
SDG 3: Ensure healthy lives and promote well being for all at all ages	
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group
SDG 5: Achieve gender equality and empower all women and girls	
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
5.C Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels	5.C.1 Proportion of countries with systems to track and make public allocations for gender equality and women’s empowerment

Maputo Protocol:⁴⁰ The Maputo Protocol is an African regional human rights instrument introduced in 2003. The protocol, considered groundbreaking, includes the right to abortion in some cases:

*To protect the reproductive rights of women by authorising 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 foetus.*⁴⁰

The Maputo Protocol has been signed and ratified by 36 countries and signed but not ratified by a further 15 African countries. Three countries have not signed or ratified the Maputo Protocol.

National legal frameworks: Each country's abortion policies are unique and complex. Even

in countries where abortion is severely restricted, there are ways that women and their health care providers push the boundaries and Governments may push them back. For example, abortion is legal in the case of rape in Zimbabwe but obtaining an abortion for an under-aged girl still involves a convoluted trip to court and is not often attempted. In addition, the window of opportunity for a woman to obtain an abortion is often quite short. An adolescent girl may not realise she is even pregnant until the second trimester, making obtaining an abortion more complicated. In Tanzania, the policies and rights documents can actually oppose each other (see the box below). Further, understanding of the precise provisions of the law is often very limited – sometimes even among health providers themselves, and women are often unaware of exceptions to abortion laws.

Tanzania abortion policy presents a complicated picture

A good example of a tangled abortion policy context can be found in Tanzania. Abortion is permitted to save the life or health of the mother and in cases of sexual violence and may be delivered by any health care provider. Tanzania has signed the Maputo Protocol, making the state legally bound to fulfil the rights in the protocol. Yet, while Tanzanian's Constitution does not mention the termination of pregnancy, the Penal Code⁴² is drastic:

Attempts to procure abortion. *Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever is guilty of an offence and is liable to imprisonment for fourteen years.*

Procuring own miscarriage. *A woman being with child who with intent to procure her own*

miscarriage unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, or permits any such thing or means to be administered or applied to her, is guilty of an offence and is liable to imprisonment for seven years.

Supplying drugs or instruments to procure abortion. *Any person who unlawfully supplies to or procures for another anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of an offence, and is liable to imprisonment for three years.*

For more information, see: Center for Reproductive Rights (2012), *Briefing Paper: A Technical Guide to Understanding the Legal and Policy Framework on Termination of Pregnancy in Mainland Tanzania*. Available at: <https://www.reproductiverights.org/document/the-legal-and-policy-framework-on-abortion-in-tanzania>

Where can I find reliable information?

Abortion is controversial and sources of information, particularly on the web, depend on the views of those who produce the information. Reliable sources may be hard to find on the internet as many with a religious or moral point of view pose as ‘evidence based’. The list below is not comprehensive but gives a starting point for reliable, evidence-based information on abortion.

Where can I get expert practical advice and abortion support?

In countries where safe abortion is available (with or without restriction in the law), and also in countries where safe abortion is restricted by law, expert advice on accessing services including PAC should be sought from organisations including Marie Stopes International, IPPF affiliates, and

some Population Services International (PSI) services.

A useful map of abortion laws in each country is available here: www.womenonwaves.org/en/map/country. This also shows information for each country about the availability of misoprostol, possible abortion providers and local women’s organisations.

Women in countries where a safe and legal abortion is possible, should go to a doctor. For women in countries where abortion is restricted, pills for medical abortion can be obtained at: www.womenonweb.org/

Instructions for self-administering a medical abortion can be found here: <https://iwhc.org/resources/abortion-self-administered-misoprostol-guide-women/>

Organisation and website	Key resource
World Health Organization www.who.int/reproductivehealth	<i>Safe Abortion: Technical and policy guidance for health systems</i> www.who.int/reproductivehealth/publications/unsafe-abortion/9789241548434/en/
Guttmacher Institute www.guttmacher.org/international/abortion	<i>The Incidence of Abortion Worldwide</i> www.guttmacher.org/journals/ipsrh/1999/01/incidence-abortion-worldwide
Center for Reproductive Rights www.reproductiverights.org	<i>The World’s Abortion Laws Map</i> https://worldabortionlaws.com/
Ipas www.ipas.org	<i>Enhancing the quality of abortion care: Successful initiatives to improve clinical skills and facility services</i>
Amnesty International	<i>My Body My Rights</i> www.amnesty.org/en/get-involved/my-body-my-rights/
International Planned Parenthood Federation www.ippf.org/	<i>Make abortion safe. Make abortion legal</i> www.ippf.org/resource/make-abortion-safe-make-abortion-legal <i>Changing perceptions about abortion in rural Uganda</i> www.ippf.org/resource/changing-perceptions-about-abortion-rural-uganda
Marie Stopes International https://mariestopes.org/resources/	<i>Growing the global evidence base for access to safe abortion</i> www.mariestopes.org/resources/growing-the-global-evidence-base-for-access-to-safe-abortion/

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