Access to Medical Abortion and Self-Managed Abortion:

Key insights from health care workers and advocates on guaranteeing human rights

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Presenters:

- **Sabin Shrestha**, Executive Director, Forum for Women, Law and Development (FWLD), Nepal
- **Dr. Bela Ganatra**, Unit Head, Preventing Unsafe Abortion, Department of Sexual and Reproductive Health, World Health Organization
- **Dr. Nafissa Osman**, Eduardo Mondlane University, Faculty of Medicine, Department of Obstetrics/Gynecology, Mozambique, and FIGO safe abortion committee members
- **Jedidah Maina**, Executive Director, Trust for Indigenous Culture and Health (TICAH), Kenya

Moderation by:

- **Patty Skuster**, Ipas & **Christina Zampas**, Center for Reproductive Rights

What is medical abortion?

A non-invasive and highly acceptable option to pregnant persons. Medical abortion can be provided using tablets of mifepristone and misoprostol in combination or misoprostol alone.

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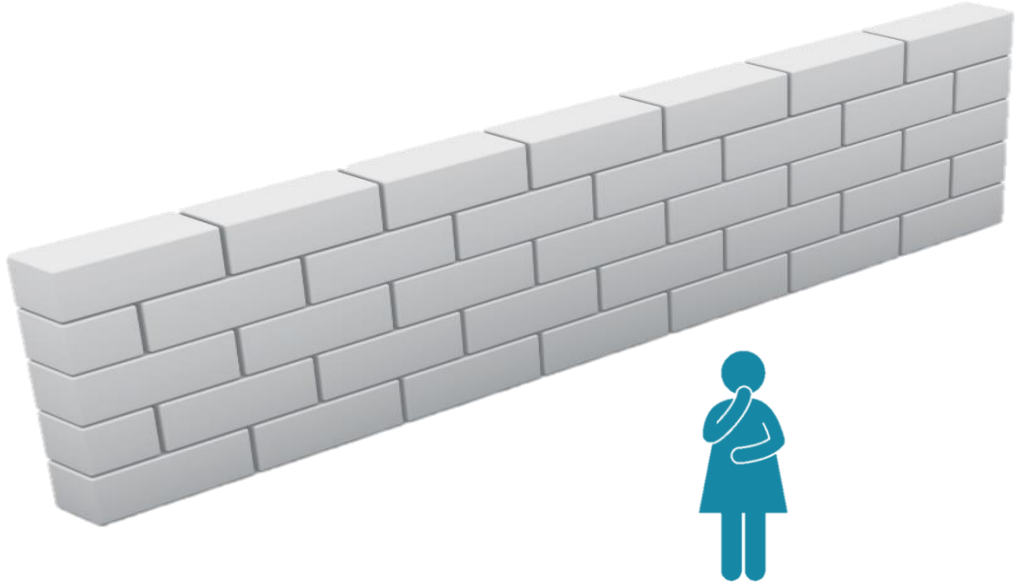
A non-invasive and highly acceptable option to pregnant persons. Medical abortion can be provided using tablets of mifepristone and misoprostol in combination or misoprostol alone.

What is self-management of medical abortion?

When the pregnant person finds the medication and the information on how to use it and on how to assess eligibility, progress, and outcome by themself without the intervention of a health care provider.

Legal barriers to medical abortion and self-managed abortion



- Regulation of abortion within the penal code
- Abortion medicines not registered
- Health facility requirements
- Only health care professionals are permitted to provide abortion

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NEPAL

ACCESS TO MEDICAL ABORTION AND SELF-MANAGED ABORTION

FORUM FOR WOMEN, LAW AND DEVELOPMENT
1995
FWLD
Working for non-discrimination and equality

Sabin Shrestha

Sita (name changed) was a minor (15 years old) and a survival of rape. She became pregnant as an aftermath of the rape incident. After her family discovered she was pregnant, they consulted and decided to terminate the pregnancy. As decided, her father brought the medicine from the pharmacist . Later Sita along with her father and pharmacist were prosecuted for consuming medicone to terminate her pregnancy. However, the Court convicted Sita for performing illegal abortion and sentenced her on the basis of her admission to the consumption of the medical pills. Sita’s father and the pharmacists were acquitted from the conviction as the father did not support the abortion despite of him bringing the medicine and the pharmacist’s involvement in the illegal abortion was not proved.

REPRODUCTIVE HEALTH RIGHT IN NEPAL

The Constitution has guaranteed reproductive health rights as fundamental right

Supreme Court has interpretation abortion right is an important component of Reproductive Health Right

Safe Motherhood and Reproductive Health Rights Act, 2018 has recognized right to obtain abortion

ABORTION LAW IN NEPAL

Up to **12** weeks of pregnancy

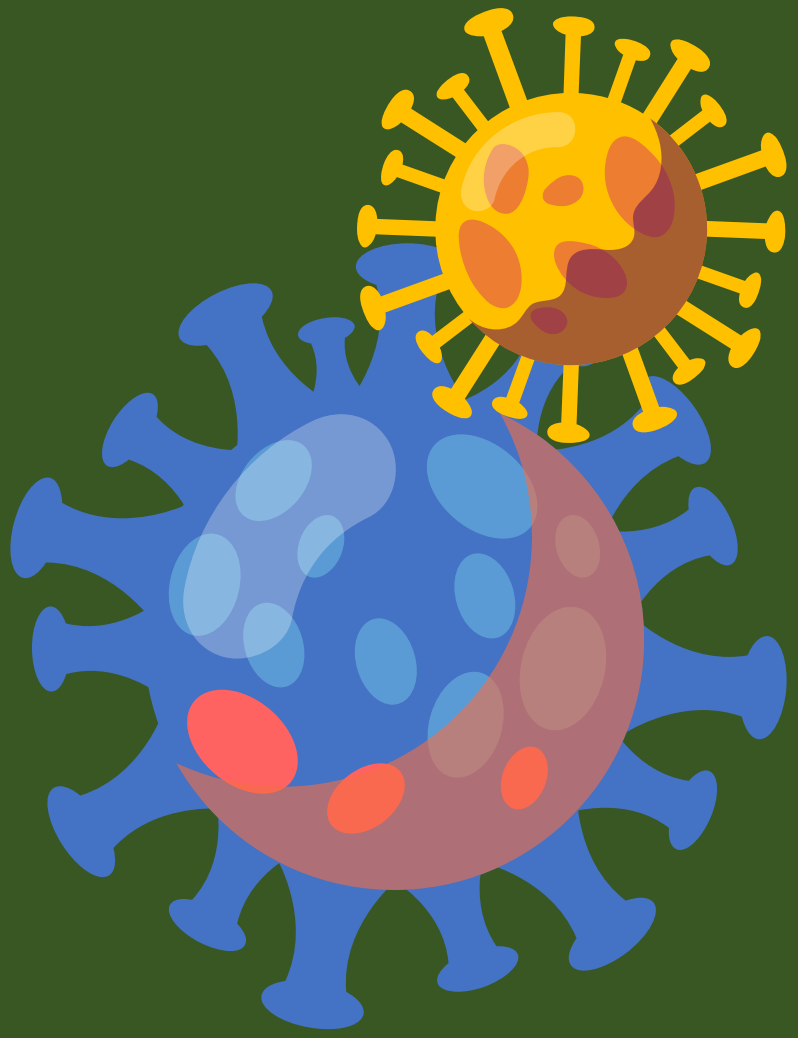
Up to **28** weeks of pregnancy if there is danger to the life of a pregnant woman or her physical or mental health may deteriorate

---

Up to **28** weeks of pregnancy if woman in case the conception is a result of **rape** or **incest**

Listed health services provider in a listed health institution fulfilling prescribed standards

SAFE ABORTION SERVICE DURING COVID-19



36% of the women seeking for safe abortion have been declined to get such services

Interim reproductive health service guideline that stated a use of medical abortion for those seeking abortion

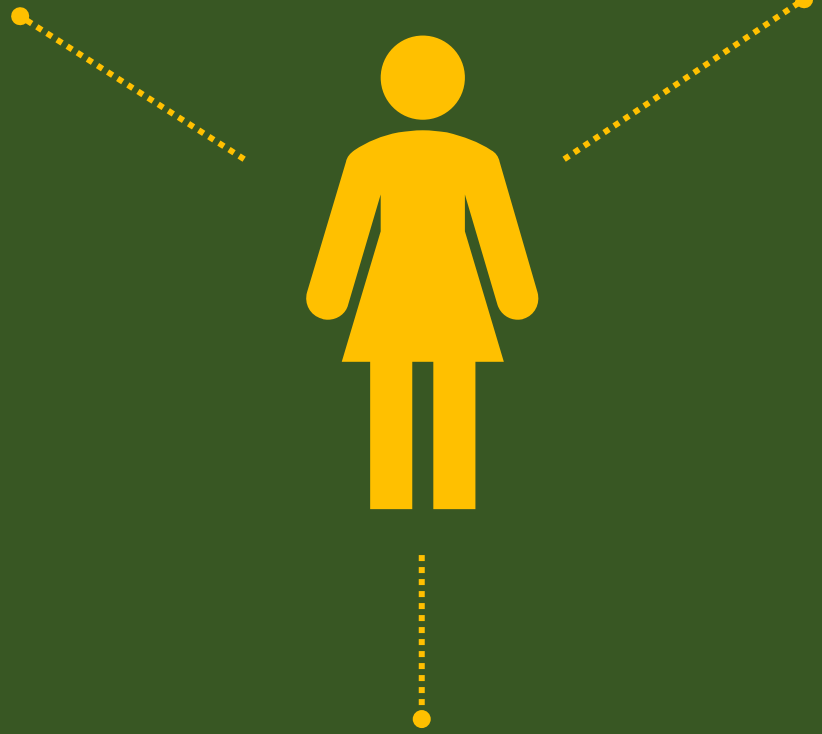
Supreme Court of Nepal issued order to include reproductive health kits in the essential packages

11 new cases of illegal abortion have been prosecuted in the 8 months lockdown period

58% of abortion in Nepal are unsafe and illegal

De(criminalization) of Abortion

Women are not able to access and self-managed abortion which limits their right to fully enjoy reproductive health as their choice



Otherwise, there will be continued risks to life, health and autonomy

Committees should recommend to states to allow abortion on request and to ensure its affordability

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Medical Abortion –Current Guidelines and Evidence

Dr. Bela Ganatra; Unit Head PUA /Dept. of Sexual and Reproductive Health

Closed door briefing to the UN Treaty monitoring bodies

18/3/21

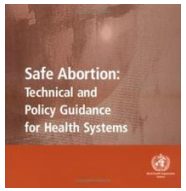
human reproduction programme hrp
research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

World Health Organization

Medical Abortion

- Use of two medicines : Mifepristone and then 1-3 days later, Misoprostol.
- If both medicines not available, misoprostol alone can be used
- Abortion occurs over several hours or days, similar to a miscarriage
- Research on the medicines and regimens to be used from the 1980s -1990s including large trails coordinated by HRP/ WHO
- Large body of evidence on safety and efficacy from all over the world
- Science has evolved on
  - **When** can it be done
  - **What** is needed for a safe medical abortion
  - **Who** can provide it
  - **Where** it can be provided

Evolving Evidence & Recommendations on Medical Abortion



MA recommended as an option

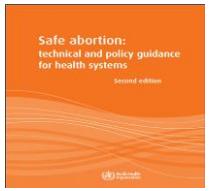
1st Abortion Guideline

2003

2005

Essential Medicine List

Mifepristone & Misoprostol enters EML. But only on complementary (supplemental) list; under close supervision.



MA recommended across pregnancy duration

2nd Abortion Guideline

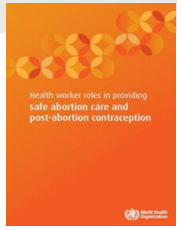
2012

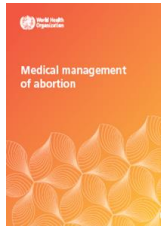
2015

Task sharing guideline

MA at primary care; wide range of providers; out of facility use

"Self" as an active actor in process.





Further simplifications in service provision

Medical Abortion Guideline

2018

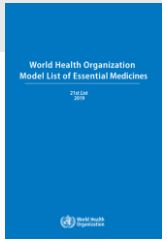
2019

Essential Medicine List

Mifepristone and misoprostol moved to "core" list

Requirement for close medical supervision removed

2020



Updated recommendations on telemedicine, role of self in managing the abortion

3rd Abortion Guideline

2021 (forthcoming)

Safety : Population level

Safe:

- WHO recommended medicines or surgical procedures with trained person /information

Least Safe :

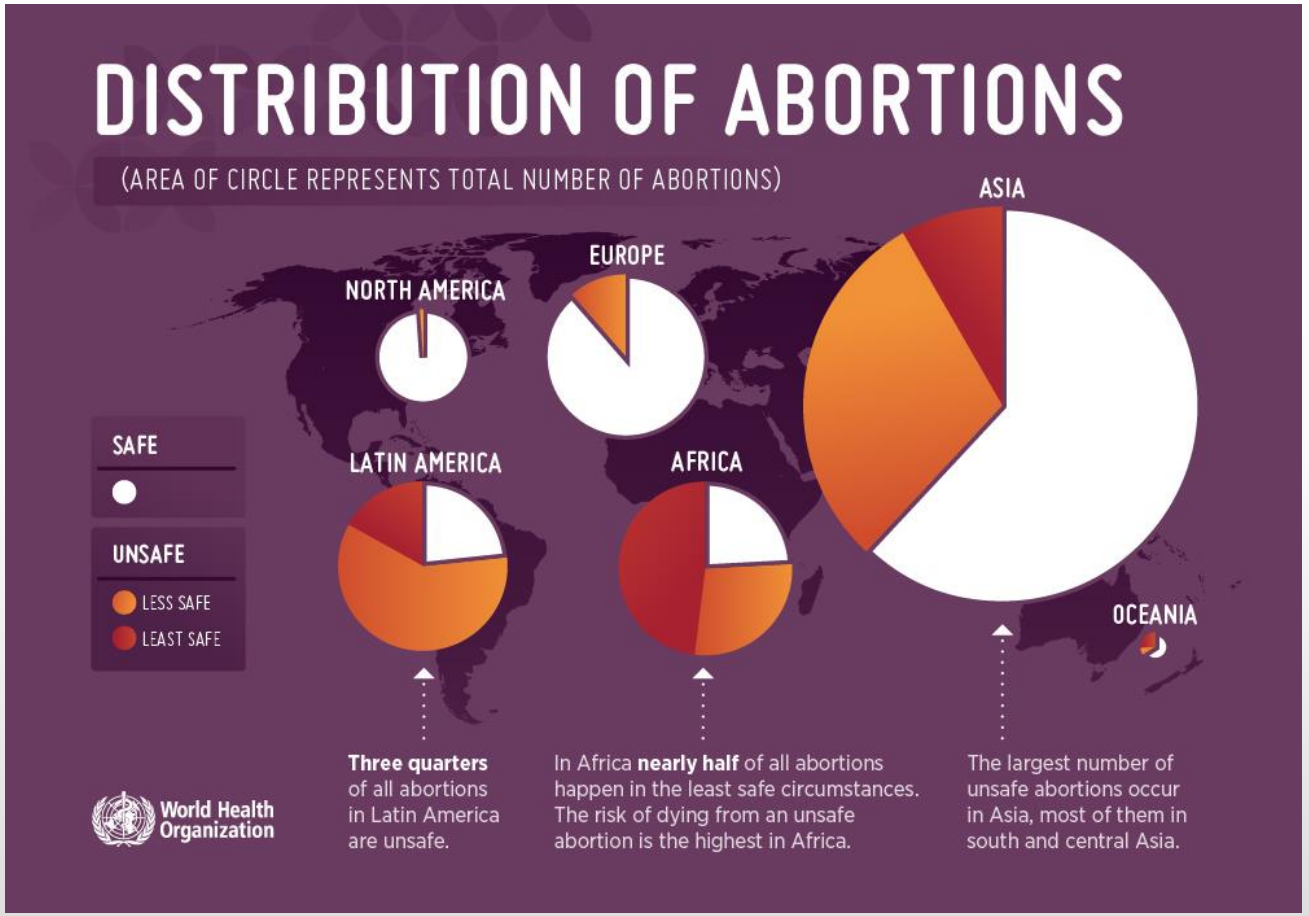
- Untrained person + traditional methods/ inserting dangerous substances

“Less safe”:

- Safe medicine (misoprostol)

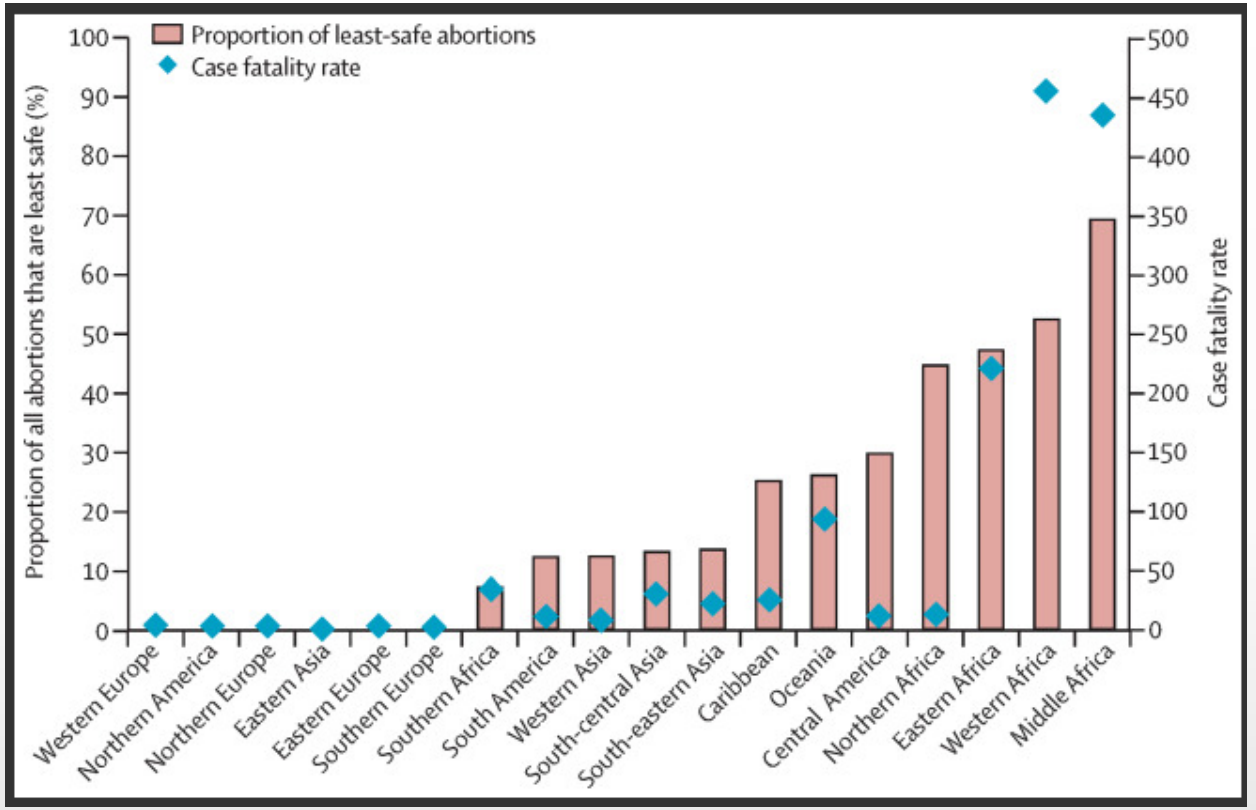
BUT

- Other barriers : lack of accurate information, falsified or sub standard products, no trained person to support, legal risks



Source : Ganatra, Gerdts et al; Lancet v 380; Nov 2017; https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext

Deaths from abortion



Deaths from abortion are high where the prevalence of the “least safe” is high.

human reproduction programme hrp research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

World Health Organization

Source : Ganatra, Gerdts et al; Lancet v 380; Nov 2017; https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext

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Access to Medical Abortion & Self Managed Abortion

Sharing insights with UN Treaty Monitoring and Special Procedures Members

March 2021

Dr. Nafissa Bique Osman

Associate Professor of Obstetrics/Gynecology Universidade Eduardo Mondlane Hospital Central de Maputo, Mozambique

&

FIGO Safe Abortion Committee Member

Overview

FIGO
International Federation of Gynecology and Obstetrics
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- **FIGO** is a professional organisation that brings together obstetrical and gynaecological (ob-gyn) associations from all over the world (130+ countries)
- **FIGO's vision** is that women and girls of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. We lead on global programme activities, with a particular focus on sub-Saharan Africa and South East Asia.
- **FIGO' Safe Abortion Committee** – provides guidance and capacity building support to Ob-Gyn member societies globally, based on medical/clinical evidence and human rights standards.
- **FIGO's Safe Abortion – 2007** – Prevention of Unsafe Abortion Project (40+ countries) & Advocating for Safe Abortion Project

FIGO’s Advocating for Safe Abortion Project

East/Southern Africa

Kenya

Mozambique

Uganda

Zambia

West Africa

Benin

Côte d'Ivoire

Mali

Central Africa

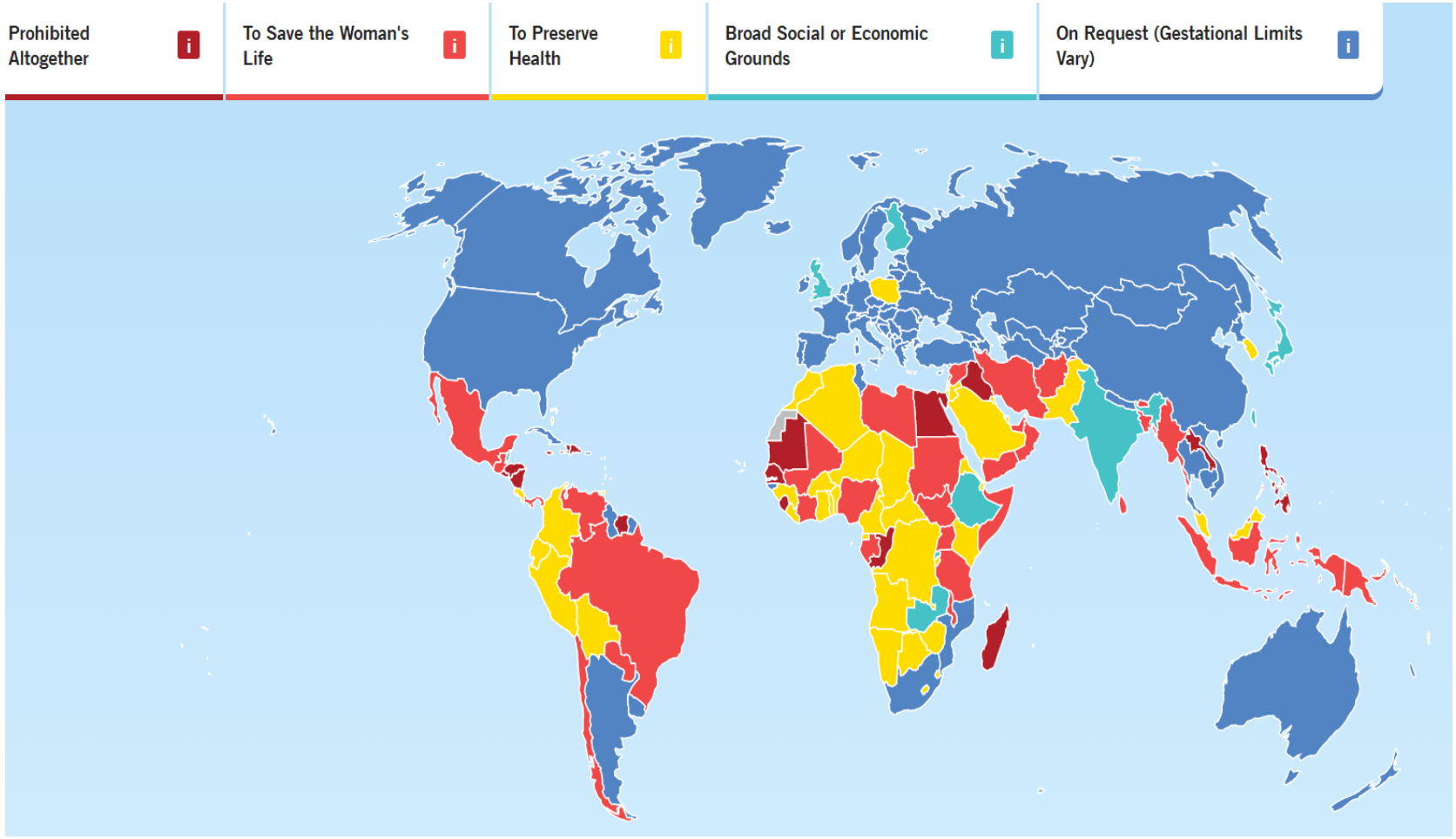
Cameroon

Latin America

Panama

Peru

WORLD'S ABORTION LAWS



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- **25 million unsafe abortions** took place each year (2010-2014). (Guttmacher)
- **45% of all abortions** are **unsafe**. (Guttmacher)
- **97%** of unsafe abortions take place in Africa, Asia and Latin America (Guttmacher)
- The **risk of dying** from an unsafe abortion - **highest in Africa** (WHO)
- **USD 553 million** - annual cost of treating major complications from unsafe abortion (WHO)
- **Africa** – only 3/55 countries allow abortion upon request (varying pregnancy duration grounds) Mozambique, South Africa & Tunisia
- **Maputo Protocol** - 40/55 countries have ratified – Article 14 (2) sets access to abortion as a woman/girl's right
- African Commission of People and Human rights **– Decriminalise abortion campaign** (2016)

Mozambique – Country Profile

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- Pop 2020- 30 million
- 47.8% male & 52.2% female

- Maternal mortality 489/$_{100.000}$ live births
- Unsafe abortion - 9%
- Total Fertility rate - 5.3
- Contraceptive prevalence- 25%
- Unmet need for family planning (married women) 23%

Source: INE 2017, DHS 2011, MM Report 2017, IMASIDA 2015

Abortion- Legal and Policy in Mozambique

- Penal Code (**law 35/2014** of 31 December)
- Ministerial Diploma **60/2017**, which approves the **clinical norms**.
- **Abortion is legal** on request within the first **12 weeks** of pregnancy.
- Rape and Incest, within **16 weeks**.
- Serious malformation of the foetus within **24 weeks**
- Unviable foetuses, or mother's live in danger, abortion is allowed at any time, **But:**
- Abortion **must be carried out** in the **Health Units** of the National Health Service, **by health professionals**.
- Requires **sign-off/approval** from health workers
- Current abortion law **does not allow** for telemedicine and self-managed abortion.

Barriers/Challenges to access safe abortion

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Individual/community level

- Social norms of stigmatization of abortion; gender-based violence.
- Lack of awareness about the law and where to find safe services

Health facility level

- Slow Implementation of the law, policies and guidelines
- Service providers **personal values, believes**, and **attitude**,
- Lack of **functional safe abortion services** (including trained staff, supply of drugs) and availability of free, accessible and acceptable safe abortion service.

Unequal access

- rural/urban, women/girls- especially those from poor and marginalized sectors – who are at greater risk to high levels of violence and **unsafe abortion**.

Safety & Success of abortion pills in Mozambique

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- **Medical abortion is a very safe treatment** with an extremely few contraindications and precautions.
- Comparison of Misoprostol and Manual Vacuum Aspiration in 270 women with incomplete abortion in Maputo. Success was 91% / 100% but women in Misoprostol group were more satisfied.
- Health units - very uncommon to have complications of safe abortion even if the women self manage the pills.
- In clinical trials, **success rates are between 92.5% and 100%** depending on gestational age, the time interval between Mifepristone and Misoprostol, the misoprostol administration route and doses.

Source: C.Bique, M. usta, B. Debora, E. Chong, E. Westheimer, B. Wiinikoff. Comparison of misoprostol and manual vacuum aspiration for treatment of incomplete abortion. International Journal of Obstetrics (2007) 98, 222-226

Early Medical Abortion: A practical guide for health care professionals. Christian FIALA, Aubert AGOSTINI, Teresa-Alexandra CARMO-BOMBAS, Kristina GEMZELL-DANIELSSON, Roberto LERTXUNDI, Marek LUBUSKY, Mirella PARACHINI. ISBN 978-2-9553002-1-3 2018 2nd Edition.

World Health Organization (WHO). Safe abortion: technical and policy guidance for health systems. WHO Geneva, Switzerland 2012

Mechanism of medication abortion 1/2

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Mifepristone is an **anti-progestin synthetic hormone**, which competitively blocks the progesterone receptors, inhibiting the action of progesterone.

- At tissue level, **increases the contractility of the uterus** by its sensibilization of the myometrium to prostaglandin.
- Mifepristone also **causes the cervix to soften and ripen** and results in a release of endogenous prostaglandins from decidua.
- The **effects** begin 12-24 hours after administration and is **maximal at 36-48 hours**. The clinical effects last for 3 days following single intake.

Source: Early Medical Abortion: A practical guide for health care professionals. Christian FIALA, Aubert AGOSTINI, Teresa-Alexandra CARMO-BOMBAS, Kristina GEMZELL-DANIELSSON, Roberto LERTXUNDI, Marek LUBUSKY, Mirella PARACHINI. ISBN 978-2-9553002-1-3 2018 2nd Edition.

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Mechanism of medication abortion (2/2)

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Misoprostol is a **prostaglandin E1 analogue** that can be used either in combination with Mifepristone or on its own.

- Is effective on multiple administration routes. The pharmacokinetics and bioavailability differ according to administration route.
- Misoprostol **induces cervical softening and dilation** and **enhance uterine contractions**, which aids in expelling the products of conception.

Source: Early Medical Abortion: A practical guide for health care professionals. Christian FIALA, Aubert AGOSTINI, Teresa-Alexandra CARMO-BOMBAS, Kristina GEMZELL-DANIELSSON, Roberto LERTXUNDI, Marek LUBUSKY, Mirella PARACHINI. ISBN 978-2-9553002-1-3 2018 2nd Edition.

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Addressing Side effects & Complications

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- **Pelvic cramping pain.** due to uterine contractions and gestational sac expulsion. Managed by NSAID drug like Ibuprofen or Paracetamol.
- **Vaginal bleeding**. Heavier than normal menstruations for 2-4 hours and than decreases.
- Nausea, vomiting, diarrhea, are **transient** and dose dependent, usually no need for medication.
- **Prolonged or heavier than menstrual bleeding.** Need of blood transfusion or back-up curettage (aspiration) is extremely rare (**0%-0.2%** and **0.3%-2.6%** of cases, respectively).
- **Infection** is a rare complication but depends on individual risk factors, reported <5% of women after medical abortion.
- **Risk related to medical abortion is lower than in a surgical method**, the risk is similar to spontaneous abortion and it can be easily managed.

Source: Early Medical Abortion: A practical guide for health care professionals. Christian FIALA, Aubert AGOSTINI, Teresa-Alexandra CARMO-BOMBAS, Kristina GEMZELL-DANIELSSON, Roberto LERTXUNDI, Marek LUBUSKY, Mirella PARACHINI. ISBN 978-2-9553002-1-3 2018 2nd Edition.

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Dawood MY, Khan-Dawood FS. Clinical efficacy and differential inhibition of menstrual fluid prostaglandin F2alpha in a randomized, double-blind, crossover treatment with placebo, acetaminophen, and ibuprofen in primary dysmenorrhea. Am J Obstet Gynecol 2007;196(1):35.e1-5

Conclusion

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"*When I knew that I was pregnant, I was scared to talk to my mother, my friend took me to a traditional healer who put smoked herbs mixed bleeding and fainted, my family took me to this hospital*." 16 yr old girl, Zambezia province

FIGO considers reproductive autonomy, including **access to safe abortion services, to be a basic and non-negotiable human right**. Abortion is a time sensitive, essential medical service – one that should be provided in accordance with women and girls' preferences, and with **safety, privacy and dignity** at the forefront.

FIGO calls for **decriminalization of abortion** and demands that **all governments remove the barriers** that impede access to safe abortion services and ensure **universal access to safe abortion for all girls and women** – both during COVID-19 and afterwards.

Thank you very much

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Questions?

Recommendations

***Ask State parties the following*:**

1. Is medical abortion legal and available in your country? If it is legal, is it regulated in an appropriate way for the intended use and to enable self-managed abortion, or is it regulated under frameworks intended for surgical or vacuum aspiration?
2. Are the drugs misoprostol and mifepristone registered and included on the national list of essential medicines? If yes, is misoprostol used for abortions?
3. Do the regulations allow for telemedicine/health in your country? Are they read to include medical abortion services?
4. Does the law contain requirements that result in criminalization of abortions that are obtained outside the formal health care setting?
5. Do abortion providers or individuals who seek abortion experience arrest, harassment, bribery, or criminal penalties related to abortion?

Recommendations

***Recommend that States Parties*:**

1. Decriminalize all abortions, completely removing abortion and any regulation of abortion from criminal or penal codes;
2. Ensure access to all methods of safe abortion, including medication abortion;
3. Establish a human rights obligation of States to ensure the provision of abortion on request. Recommendations should fully reflect the fact that laws containing barriers and limited **grounds** to access abortion are harmful to a person's health and life, and are discriminatory, and violate a the right to bodily autonomy;

Recommendations

***Recommend that States Parties*:**

4. Prevent and remove all barriers to accessing quality, affordable, and acceptable abortion care and services (such as distance to health-care facilities, high cost for goods and services, mandatory waiting periods, biased counselling requirements, required involvement of a health professional unless the support is requested by the women/girl, third-party authorization requirements, telemedicine abortion services) and take steps to reduce abortion stigma;
5. Ensure that all healthcare workers are trained on women/girls' and pregnant peoples' human right to access to abortion services, and mechanisms are in place to ensure accountability for health-workers' clinical and ethical duty to provide abortion services.

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