ABORTION CARE: FRONTLINE TO FUTURE

What MSI has learned from providing abortion and how we can work together to end unsafe abortion by 2030

MSI would like to warmly thank our partners collaborating with us to scale up abortion access and protect the right to abortion.

These include our donors, the World Health Organisation, UNFPA, FIGO, the Global Safe Abortion Dialogue, SheDecides, IPPF, Ipas, PSI, the Asia Safe Abortion Partnership, ODAS, the Preventing Unsafe Abortion Group, Mama Network, Women on Web, Women First Digital, the Centre for Reproductive Rights, Guttmacher Institute, PAI, Women Deliver, Amnesty International, the International Campaign for the Right to Safe Abortion, and Catholics for Choice. Our national partners include the Coalition for the Prevention of Unsafe Abortion in Malawi, the Pratigya Campaign in India, the Rapid Response Task Force in Kenya, Tanzania and Uganda, and the Coalition for Comprehensive Abortion Care in Ethiopia. A special acknowledgement for the hundreds of local and grassroots partners and youth champions we work with who are creating extraordinary progress in their communities.

CONTENTS

As abortion providers for almost 50 years, our teams and partners on the ground have unrivalled insights. By providing abortion within the fullest extent of the law across six continents, and supporting the public and private sectors to do the same, we have seen and contributed to remarkable change across the global abortion landscape.

Since 2000, our teams have supported over 52 million people to access abortion care. In some countries, MSI provides more than 50% of all estimated safe abortions. We've reached the most marginalised and remote communities where others cannot—or will not—go, allowing us to change lives and gain learnings at scale. Beyond learning directly from our abortion providers and extensive partnership network, we interview an average of 13,000 clients each year on their experiences of accessing reproductive healthcare, too.

This report captures the culmination of these experiences and insights, to contribute our global perspective to enrich the evidence base and further accelerate progress.

EXECUTIVE SUMMARY

Abortion is common and life-saving healthcare. Access to abortion not only supports agency, bodily autonomy and human rights but is also fundamental to meeting the Sustainable Development Goals and building a gender-equal world. Abortion should be available to everyone, no matter who they are or where they live. Instead, it remains stigmatised, inaccessible, and legally restricted all around the world.

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pregnancies end in abortion.

We have in front of us an undeniable global public health and human rights crisis of preventable deaths, lifelong injuries, and the denial of people's bodily autonomy. On top of that are the significant operating challenges for healthcare providers. This is unsustainable.

The landscape continues to evolve rapidly. With many moving parts and deeply contextual and local variances, it can be difficult to assess progress and coordinate resources. But with the dedication of the sexual and reproductive health and rights (SRHR) community, the leadership of the World Health Organisation, and the courage and commitment of the changemakers and providers who are fighting for progress every day, abortion care is expanding and changing the lives of those who access it.

A world free of unsafe abortion is not just a vision, it's an achievable goal. If we change nothing, in the year 2030 we estimate there will be 48 million unsafe abortions: an additional 8 million to the 35 million that will occur this year. But if we course correct, the year 2030 could be the first where no one needs to resort to an unsafe abortion—a year in which there could be 94,000 fewer maternal deaths and 12 million fewer potentially life-long injuries from medical complications[1].

Based on the current deep inequalities and restrictions, we will not achieve this unless urgent, coordinated action is taken. Recommendations are detailed throughout this report, and if they are acted on and adequately resourced, we can finish the revolution of abortion access. This is a future within our grasp—where everyone has access to comprehensive, client-centred, stigma-free, and high-quality abortion care. Our hope is that abortion is so normalised and easy to access that it's unremarkable and unworthy of future reports like this.

We have in front of us an undeniable global public health and human rights crisis of preventable deaths, lifelong injuries, and the denial of people's bodily autonomy.

1. Estimates modelled on the most recent estimates of regional annual abortion rates, projected population growth, change in abortion rates, and the most recent estimate of the proportion of abortions that are unsafe.

In the following six sections, we share on-the-ground experiences, reflect on best practices and promising models, and shed light on how we can move forward together in partnership to save lives and protect the right to reproductive choice. We delve further into:

1. Reducing inequality

Stark inequality in abortion access is growing, with low- and middle-income countries bearing the burden of 97% of unsafe abortions. Young women and people in rural and poorer areas are disproportionately affected, forced to resort to desperate, unsafe measures, which is why 96,000 people will have an unsafe abortion today, and why around 22,800 will die from unsafe abortions this year. Adapting the way we deliver and support services—with approaches such as subsidy schemes, community-based nurses and health workers, strengthening the public sector's capacity, and word-of-mouth whisper networks about services—is making a difference. We must be laser-focused on making abortion more affordable and accessible, and tailoring services to reach people where they need them. Read more on page 6.

2. Ensuring a choice of medical or surgical abortion

Everyone should have a choice of how they have an abortion—whether that's a surgical or medical abortion. Where both options are available in our centres, we find there's a consistent 50/50 split in which method our clients choose. While medical abortion is expanding quickly with increasing investment, surgical abortion is still critical for post-abortion care interventions and second-trimester care, and because many women prefer it. By training public and private providers and ensuring abortion care is built into all aspects of the health system, we can reduce stigma and safeguard a choice of method. Read more on page 10.

3. Innovating to expand abortion access

Working with partners, our country teams have developed, implemented, and advocated for new models and approaches including self-management, telemedicine, task-shifting to lower-level healthcare providers, revised gestational limits and assessments, digital access, and removing unnecessary clinical requirements. We must continue investing in innovation to expand access to abortion—at the same time ensuring women never feel alone in their abortion journey and continue to have agency and the support they need. Read more on page 14.

4. Making abortion care client-centred

Quality must underpin abortion care. It encompasses effectiveness, efficiency, accessibility, acceptability, equity, and safety—and increasingly the health sector is acknowledging that quality is about valuing the clients' perspectives, too. Person-centred care includes counselling and decision-making support, as well as collecting meaningful feedback from those receiving the care, setting up processes for accountability, and addressing client and community perspectives to improve how we're delivering abortion care. Year on year, our programmes are learning and striving to achieve 'gold standard' care. Read more on page 18.

5. Advocating for abortion

Law reform is expanding abortion access, creating significant global progress—more than 60 countries have liberalised their abortion laws in the past 30 years. But many unnecessary legal, clinical, policy and cultural barriers remain. We've seen major breakthroughs by advocating directly to governments, working alongside civil society organisations to push for change, partnering with religious and community leaders, and shifting community narratives around abortion. None of this is possible without partnership, and the thoughtful coordination and resourcing of the pro-choice movement. Read more on page 20.

6. Protecting frontline providers

Frontline abortion providers face increasing discrimination, stigma, threats, and attacks just for doing their work—and it's having a silencing and stigmatising effect. 'Providers Share' and 'Values Clarification' workshops are helping abortion providers cope and build resilience. And a recently established 'Defend the Defenders of SRHR' consortium is calling for action to ensure that there are adequate and resourced measures in place to protect providers, as well as appropriate remedial and legal responses when providers are subjected to harm. Read more on page 24.

We must eliminate unsafe abortion and its devastating impact on communities. Cross-sector partnership should have a strong focus on closing gaps in abortion access, strengthening public sector provision, and investments in both funding and innovation.

REDUCING INEQUALITY

STATE OF PLAY

> **"Safe abortion has often become the privilege of the rich, while poor women have little choice but to resort to the services of unskilled providers in unsafe settings, or induce abortion themselves often using unsafe methods, leading to deaths and denial of women's human rights."**
> – WHO Abortion Care Guideline, 2022

Abortion access isn't a level playing field. We continue to see widening inequities in who can access abortion, and who is dying and injured from unsafe abortion.

The numbers show a stark picture. 97% of unsafe abortions happen in low-and-middle income countries, resulting in higher maternal and child mortality and morbidity. A myriad of barriers and inequities combined with political choices to not invest in services mean the highest rates of unsafe abortion are experienced by people in rural and poor areas, younger women, and those with no formal education. Our providers have stepped in to save the lives of clients who have ingested bleach, broken glass or other harmful materials trying to end their pregnancies.

Meanwhile in humanitarian and fragile settings, a lack of access to contraception and increased sexual violence heighten the need for abortion care. When it's not available, the consequences can be grievous. For example, people in conflict settings in Africa experienced complications from unsafe abortions at rates five to seven times higher than in stable settings. Complications can result in life-long injuries and disability. And this confirms what our frontline teams are seeing in these challenging settings.

Further fuelling inequality is the financial cost of abortion. Even in places where abortion is legal, abortion care is often the privilege of the rich, with many struggling to afford care if they're not subsidised by health insurance or provided by non-profit programmes. Many are forced to turn to clandestine and unregulated providers because they are perceived to be more discreet, and are exploited with high costs for doing so, both in financial payment and in the risk to their health. Resorting to unsafe methods comes with its own financial costs—households lose a combined $922 million of income a year due to long-term disabilities from unsafe abortion.

And troubling inequalities continue to exist by way of countries' individual laws and policies governing abortion. 40% of women live in countries where abortion is banned or restricted, so abortion access is a lottery of where you live.

Increasingly, abortion care is being adapted to reach marginalised groups (who face challenges related to income, location, literacy, age, marital status, sexuality, gender identity, and disability, for example). With adaptations, we can help break cycles of inequality and poverty, while upholding reproductive rights.

Today, someone wanting an abortion might come up against:

- not knowing it's an option due to a lack of awareness, or confusion about their rights
- abortion being illegal or heavily restricted
- not being able to afford it or not having health insurance
- abortion not being available because of a lack of equipment, drugs, or trained providers within the public or private health system
- disinformation online or directly from an anti-choice group
- fear of being stigmatised by their partner, family or community
- care being delayed by medically unnecessary tests
- being disempowered in their own decision-making due to harmful social and gender norms
- being refused care due to the conscientious objection of healthcare providers

RESEARCH SAYS

The cost of unsafe abortion

Unsafe abortion costs healthcare systems more than if governments simply provided safe services. If we continue on the current trajectory of unsafe abortion, in 2030 unsafe abortions will cost health systems an estimated $3.1 billion USD per year—compared with providing safe abortions at a cost of just $938 million[2].

Asia & Africa bear the burden

Over half (53.8%) of the world's unsafe abortions occur in Asia. But Africa bears the greatest burden of the "least safe" methods and therefore deaths from unsafe abortion, with **141 people dying per 100,000 abortions**, exceeding rates in western Europe and North America by over 280 times.

Rural communities lack access

In India, women in rural settings were found to be **26% more likely** than urban dwellers to have an unsafe abortion and more likely to die from abortion.

Adolescents at risk

15% of all unsafe abortions are experienced by girls under 20 years old. And young people account for 23% of hospitalisations from unsafe abortion in Africa.

Rising maternal deaths

In many countries, **maternal mortality is rising**. In 2020, one woman died every two minutes from preventable causes related to pregnancy. To rectify the damage inflicted by COVID-19 on women's healthcare, we must redouble efforts to reduce maternal deaths.

2. Estimates derived from **current modelled cost of providing post-abortion care** and actual cost of service delivery at MSI, assuming a 50/50 split in surgical and medical abortion procedures.

REDUCING INEQUALITY

LEARNINGS FROM FRONTLINE PROGRAMMES

Recognising these disparities, MSI's country teams and our partners have adapted local approaches across service delivery and advocacy. Here are some developing approaches:

Embedding services in public sector
— how governments can protect future access

People rely heavily on the public sector to receive sexual and reproductive health services. By using our expertise as abortion providers, we're partnering with governments in over 20 countries to strengthen and scale up public sector abortion provision. For example, our team in Ethiopia helped integrate abortion training within national healthcare curriculums, while in Zambia we played a pivotal role in advocating for the inclusion of telemedicine within national abortion care guidelines. These interventions are ensuring abortion can be more broadly available in the long-term and that governments are protecting future access.

Disability-inclusive services
— nothing about them, without them

People with disabilities face unique barriers to accessing healthcare, so designing services for and with them is essential. Numerous MSI country programmes have strengthened ties with organisations of people with disabilities (OPDs) and collaborated to deliver practical and values-based training on inclusive services. In Sierra Leone, our outreach teams are committed to making a certain number of healthcare visits each month to communities where there are more people with disabilities.

Hiking for healthcare
— scaling mountains with backpacks of sexual health supplies

In Nepal, community-based nurses and midwives (known as MSI Ladies) are trained by MSI to create awareness of sexual and reproductive health services and provide contraception and medical abortion to women in their homes or local facilities. MSI Ladies in Nepal have big backpacks of supplies and sometimes hike for two or three days to provide services in extremely remote and marginalised communities, where people are often living in poverty and have limited or no other options.

Subsidy scheme
— never turning anyone away

We're committed to never turning someone away if they cannot afford to pay for a service. A subsidy scheme across our international network means we waive fees in our clinics and maternity hospitals, which help around 45,000 clients to access care annually and addresses the barrier of affordability. This is funded by donors or from the revenue generated from clients who are able to pay. On average, waiver clients are young—16% are adolescents compared to 8% of non-waiver clients. Over half of waiver clients are unemployed, and they are also more likely to be students.

MSI Ladies in Nepal have big backpacks of supplies and sometimes hike for two or three days to provide services in extremely remote and marginalised communities, where people are often living in poverty and have limited or no other options.

Sleepovers for services — the dedication of providers to stay the night

Free mobile outreach programmes—where our teams travel into remote and underserved communities to provide reproductive choice—have provided abortion services to over 100,000 women in the past five years, in areas where services have previously been limited or non-existent. We've been adapting, testing, and scaling different outreach models, and one successful approach has been implementing 'sleepovers'. A team of healthcare providers remains at the service delivery site overnight so women who are unable to come for a service during regular daytime hours (for example, because they cannot leave work, have daytime childcare obligations, or they don't want to be seen) can access the care they need.

Whisper networks — the incredible power of word of mouth and trusted networks

Many people lack knowledge of their abortion rights and options and if/where they can access abortion care—less than 50% of women reportedly know what their national abortion laws allow. So raising awareness is a critical step. 'Whisper campaigns' are one successful approach we have used to ensure accurate and empowering information reaches women. Word of mouth has proved to be the most effective way of referring people to safe services, with over half of MSI's abortion clients finding us because of someone who had previously accessed our support. So when clients access our services, we provide guidance on how they can refer other people. Community-based mobilisers are also key to discreetly building awareness of abortion services. They are trusted individuals in their own communities—employed by MSI and supported with regular training—who create awareness of the benefits of reproductive healthcare and where to access it. Equally crucial is partnering with grassroots support networks such as the Mama Network to scale up community-based abortion access and awareness of safe options.

WHAT'S NEXT?

With an estimated 35 million people resorting to unsafe abortion every year, more needs to be done to close gaps in access, which will require a holistic approach that addresses legal, social, cultural, and healthcare system barriers. Opportunities to secure a future of equitable abortion care include:

1. The basics: normalise abortion and make it accessible and affordable

- **Expand abortion access** through improved public and private sector availability, supported self-management, mobile clinics, telemedicine, outreach programmes, working with grassroots organisations, and building the capacity of community health workers. Simultaneously invest in behaviour-change approaches for frontline workers to mitigate stigma and promote non-judgemental and inclusive care.
- **Remove financial barriers** by providing subsidies, insurance coverage, or financial assistance.

2. Health system strengthening

- **Increase public sector collaboration and accountability**, including capacity-building, training healthcare providers, providing equipment, and quality products. Choice and quality can't be dependent on donor support.
- **Integrate abortion care into primary healthcare** including community-based health programmes, contraceptive counselling, sexually transmitted infection screening, and cervical cancer screening.

3. Bold and well-resourced advocacy for legal and policy reform

- **Advocate** for the decriminalisation of abortion and the repeal/amendments of restrictive laws and policies.
- **Work with officials**, professional associations and leaders on operational policies and clinical guidance (and training) that guarantee access to safe and equitable abortion services, and hold decision-makers to account.

ENSURING A CHOICE OF MEDICAL OR SURGICAL ABORTION

STATE OF PLAY

Comprehensive abortion care requires access to tailored information and support, including a choice of method. Surgical abortion involves a low-risk procedure under anaesthetic, while a medical abortion uses tablets to end the pregnancy. For most abortions there is no 'right method', they each have pros and cons depending on the client's preferences and medical needs. Hearing from our clients around the world, we know that the method chosen will depend on the woman, her circumstances, the availability and cost of both methods, and what counselling she is offered.

Medical abortion accounts for 80% of the abortion services that MSI currently provides. It has been transformative for expanding abortion access, especially for women who cannot or prefer not to visit a health facility, because it can be accessed at pharmacies or sometimes via telemedicine (depending on the regulatory environment). But there is a growing concern that people are losing access to surgical abortion, specifically manual vacuum aspiration, as investments and attention are directed towards medical abortion and providers are not trained in surgical methods. Some studies show that medical abortion has largely replaced surgical abortion (in mostly high-income settings).

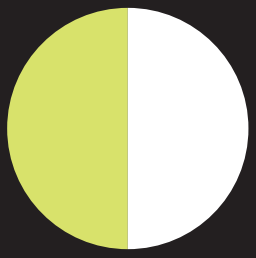
Yet, surgical abortion remains a critical service and must be sustained, not just to provide a choice of methods, but for post-abortion care and managing complications and incomplete abortions. There are an estimated 9 million complications from abortions each year, and this is likely an underestimate due to underreporting in restrictive contexts. Moreover, surgical abortion is needed for abortions beyond the first trimester.

Maintaining client choice is not only important for respecting bodily autonomy, it also helps build better acceptance of abortion, breaking down stigma. Because each method offers a very different experience, clients tend to have strong preferences, and abortion acceptability is greatest when people can choose their preferred method.

RESEARCH SAYS

50/50 choice

Where both options are available (e.g. in MSI clinics), there is approximately a 50/50 split in clients choosing surgical or medical abortion, highlighting the continued demand for both options.



50/50

Young people

Data suggests that more adolescents are accessing surgical abortion compared to medical abortion: 11% of surgical abortion clients were aged 15-19 compared to 5% of medical abortion clients in 2023. This is consistent across MSI's African country programmes, where 14% of surgical abortion clients were aged 15-19 compared to 7% of medical abortion clients.

ENSURING A CHOICE OF MEDICAL OR SURGICAL ABORTION

LEARNINGS FROM FRONTLINE PROGRAMMES

MSI's country teams and our partners are working hard to maintain choice of both surgical and medical abortion wherever possible. Below are some of our learnings:

Valuing options

— what our clients are saying

Many of our clients opt for medical abortion, valuing that it can be self-managed at home, it is effective and convenient, and can be more accessible for those who find in-clinic visits logistically challenging. But even as access to medical abortion accelerates, many people will always prefer a surgical abortion. Reasons our clients have reported choosing a surgical method included that it was faster, less painful and more discrete, preferring it to be dealt with directly by a healthcare professional. If a client is medically eligible for both types of abortion method, which most will be, they should be fully informed about both methods and given a choice.

Maternity hospitals

— maternity care and abortion care under the same roof

Private maternity hospitals can fill a major gap in access to surgical abortions, including second trimester procedures. Because maternity hospitals have surgical capacity, abortion and any complications can be safely managed with 24/7 support. And integrating abortion services with other healthcare like maternity care can help normalise abortion and reduce stigma. The demand is there: MSI's maternity hospitals deliver almost twice the number of abortion and post-abortion care services than MSI's outpatient clinics do. This requires thoughtful consideration of how services are designed to ensure a good client experience, with separate areas for maternity care and abortion care.

Private sector

— we can't work in silos, we must build a network of care

Half of Africa's health expenditure is estimated to come from out-of-pocket payments. The private sector will continue to play a major role in abortion care—and we must work with private healthcare networks to make services affordable and high-quality, so we can accelerate the shift away from unsafe or less safe providers. This includes ensuring that the choice of medical and surgical abortion is widely available, and that providers are supporting people with unbiased, non-judgemental care. In addition to MSI's own clinic and maternity networks, we've engaged over 5,000 franchised healthcare providers across Africa to provide abortion care, and used 'Values Clarification and Attitudes Transformation' and 'Providers Share' workshops to address stigma or discriminatory barriers to providing abortion. Legal literacy, peer-to-peer support, and guides helped build confidence among abortion providers.

> **"These workshops are influential; there were significant improvements. I remember one provider who denied [abortion] services but after the workshops, he became competent and continues to provide these services. It helps our providers to be clear on their values."** – Abatye, MSI Ethiopia

Public sector skills-building — mentoring government-employed health workers

Most women rely on the public sector and hospitals, particularly for post-abortion care services. As a sector, we must continue to build skills in the public sector alongside supporting expansion through the private sector, to ensure a comprehensive, total-market approach to expanding and normalising abortion. MSI partners with governments in more than 20 countries and has trained over 12,000 public health providers across 6000 facilities.

Our country teams report that a major challenge is maintaining government providers' surgical abortion skills and the infrastructure to support safe, quality care. It's essential that public providers are adequately trained and supported with supplies, infrastructure, and supervision to offer comprehensive abortion care including both surgical and medical abortion. Providing regular psychosocial support and mentoring to abortion providers is key, especially for those providing second trimester abortion.

WHAT'S NEXT?

Maintaining and expanding access to abortion care and choice of method will take a multi-faceted approach. Learning from our teams around the world, we offer these valuable ways to sustain abortion method choice in future:

1. Centre choice

- **Respect every individual's autonomy** and their right to make informed decisions about their reproductive health by providing accurate, unbiased information about both medical and surgical abortion where possible. This includes combatting misinformation to ensure clients have accurate information in front of them.

2. Train healthcare providers across sectors

- **Provide comprehensive training** and continuing education for healthcare providers on abortion care, including surgical techniques for both first and second-trimester procedures; part of this is implementing evidence-based clinical guidelines and standards of care.
- **Mentor and train public and private providers** to ensure the entire health system is strengthened in its ability to support client choice.
- **Use stigma-breaking tools** such as abortion-focused Values Clarification and Transformation (VCAT) workshops to foster a non-judgemental environment that respects clients.

INNOVATING TO EXPAND ABORTION ACCESS

STATE OF PLAY

Innovations in abortion care have undoubtedly increased access. Our country teams and partners have the benefit of seeing these innovations play out in real time, both in the evidence we gather through data and results, and through the experiences of the people who are seeking and providing abortion every day. The clear theme has been expanding a person's choice in how, when and where they access abortion. By 2030, our aim is for every woman and girl to be only one contact away from a safe provider or service.

Evolving approaches include:

- the self-management of abortion at home with medical abortion pills and telemedicine
- task-shifting to empower lower-level healthcare providers to deliver abortion
- revised gestational limits, assessing gestation without the need for ultrasounds
- using digital apps and contact centres for accurate information
- engaging with big tech companies like Meta and Google to protect safe and genuine information online, and suppress harmful misinformation and disinformation

Over the past two decades, the massive scale-up of medical abortion access, alongside surgical abortion—in Africa and Asia in particular—has undoubtedly been a gamechanger. But this is mainly concentrated in urban areas, with rural communities being left behind.

Self-managed abortion and the 'demedicalisation' of abortion has revolutionised perceptions, access, and the future of abortion care. The World Health Organisation's self-care and abortion care guidelines mark a shift in how self-managed abortion is perceived—it's no longer associated with being unsafe. This growth has brought with it opportunities to expand abortion, but also more counterfeit and unsafe products in the market, meaning trustworthy brands and products have become even more important. Alongside dodgy products, people still struggle to receive the right information online. A joint report from MSI and CCDH recently exposed examples of tech companies blocking reproductive healthcare information on their platforms across Africa, Asia, and Latin America, while continuing to promote anti-choice misinformation and ads for fake clinics.

Women need to be supported throughout their abortion journey. Providing accessible, tailored, and accurate information is a crucial step, and involves reaching women where they are. We have seen that abortion clients increasingly use digital platforms, peer referral networks, youth centres, community health workers, and grassroots organisations. These trends reaffirm the diversity of clients' circumstances. Some continue to have limited access to clinics, and some face stigma and legal barriers.

And importantly, self-care interventions cannot replace healthcare systems, but are an integral part. For some, self-managed abortion is an empowering experience following an informed choice that they've made, but for others it is not. Because of legal restrictions, it might simply be the safest and most pragmatic option from a range of criminalised and sub-optimal choices. Expanding access to safe, self-managed abortion needs to complement other efforts towards liberating abortion.

Advances in technology have revolutionised abortion access, and these trends towards self-managed care and digital support will continue, with an increased demand for private sector services and the use of telemedicine.

RESEARCH SAYS

Contact centres

People increasingly value quick and accurate information and advice over the phone and social media. Interactions with MSI's contact centres have almost doubled in the last 5 years, with nearly 3.8 million interactions in 2023 with people over the phone, WhatsApp, or online messaging platforms.

Medical abortion

One study reports that **68% of abortion-related deaths** in Africa could be prevented if the medical abortion pill misoprostol was accessible to the majority of women. This is likely an underestimate—with expanding access to Misoprostol and Mifepristone, along with new options entering the market such as Letrozole, the impact of access to quality abortion products is likely much greater.

INNOVATING TO EXPAND ABORTION ACCESS

LEARNINGS FROM FRONTLINE PROGRAMMES

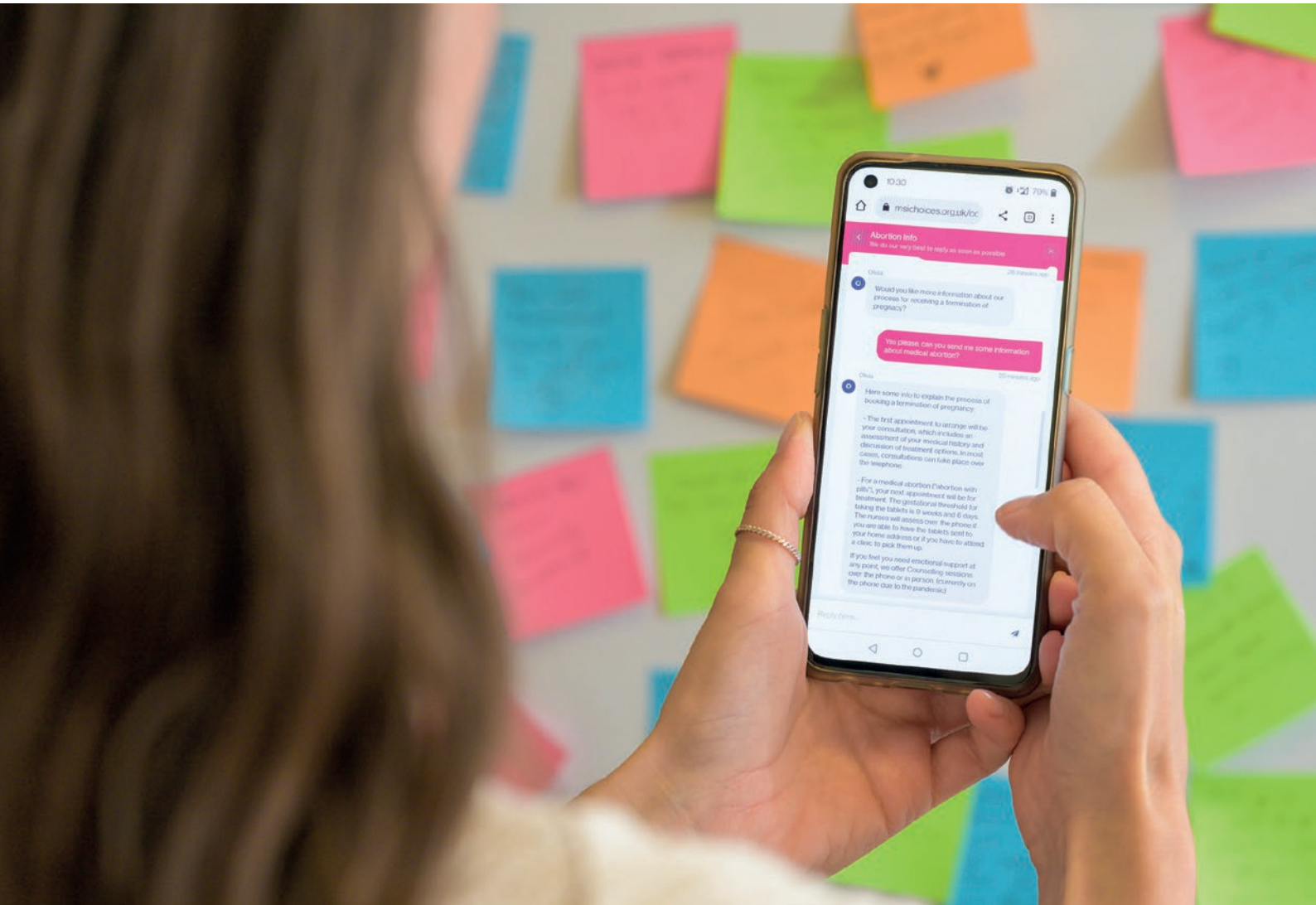
MSI's teams have contributed to the global growth of medical abortion access over the past decade, including with strategies for empowering women with self-management of abortion. To reach women where they are with both information and services, here are some adaptations we've made:

Social messaging for abortion — send us a WhatsApp!

Mobile phones may seem like old news, but the growth in phone ownership, social messaging, and increasing online audiences has had a significant knock-on effect for abortion. MSI currently runs a network of contact centres across 34 countries, providing free sexual health advice and service referrals over the phone, SMS, WhatsApp, and social media. The opportunity for leveraging technology such as hotlines to expand access to information and services is evident. We've also seen a rapidly growing appetite for information via video, and YouTube in particular. In Ghana, MSI partnered with the Ghana Health Service and a Youth Advisory Board to develop a national youth-focused video campaign raising awareness of the risks of unsafe abortion. The videos played on national TV, social media, YouTube, and are used in school education sessions, reaching tens of thousands of young minds.

Telemedicine from the UK to Ghana — abortion access over the phone

Our teams in Australia, the United Kingdom, South Africa, and most recently Ghana, have leveraged their contact centres to deliver telemedicine. Contact centre agents conduct an initial eligibility screening, schedule a remote consultation with a healthcare provider who can prescribe medical abortion pills to be sent to the client's home, and then provide follow-up care for any side-effect management or support. These models have proved themselves feasible and highly valued by clients. MSI research published in the British Medical Journal revealed that at-home abortion care—via telemedicine—is the preferred choice for 8 out of 10 UK clients, and two thirds would choose it again should they ever need an abortion in future.



Community pharmacies
— safe supplies, signposting, and support

In many low- and middle-income settings, a pharmacy is the first port-of-call for those seeking an abortion. They can be an affordable, convenient, and confidential option. Our teams have seen increasing numbers of clients accessing an abortion via their local pharmacy, with the availability of the mifepristone and misoprostol combi-pack improving both access and safety. It's essential that pharmacies are providing sufficient and non-judgemental support and information to ensure women are using the medication safely, but evidence indicates this isn't always the case. A multi-country review found product inserts often lack adequate information. And among people with low literacy, their comprehension of written instructions can be limited. MSI teams create user-friendly product packaging, inserts and leaflets, and signpost to contact centres and other digital information and hotlines.

Quality-assuring products
— making sure abortion pills are safe

Providing information is not enough—women need quality-assured products. In recent years, there's been an increase in sub-standard and unregulated medical abortion products sold in markets worldwide, and our teams continue to respond with life-saving post-abortion care when these go wrong. In Nepal, almost 80% of medical abortion pills are low quality. Our team are crowding out these dangerous products by expanding access to WHO-approved medical abortion products, with nationwide distribution, by leveraging digital communications to raise awareness of quality products, and by advocating for better regulations. Governments increasingly need to take accountability as a watchdog for unregulated abortion products to keep people safe.

WHAT'S NEXT?

Innovations in expanding abortion care continue to have huge potential. But there's more work to be done to support safe, client-centred abortion journeys, and create an ecosystem of support for self-managed abortion care, from grassroots networks to digital platforms. Next steps include:

1. Leveraging digital health solutions

- **Optimise how we're using digital technology** to support abortion journeys. As digital access and mobile phone usage expands, more women will turn to discreet online sources of information. We can harness mobile technology, data and AI to enable women to access faster and better information on their terms.
- **Use digital health platforms** and telemedicine models to expand access to medication abortion, particularly in areas with limited in-facility healthcare infrastructure.

2. A continuum of care

- **Provide clients with information and resources** for self-management and follow-up. This includes ensuring product packaging is accessible for a range of literacy levels.
- **Establish community-based models** of care that engage trusted community members, and task-share abortion care with midwives, community health workers, and peer counsellors so they can provide information, support, and referrals for abortion. Community partnerships are key.

3. Invest in research and technology

- **Support innovation** to develop new technologies, methods, and service delivery models that improve the safety, efficacy, and accessibility of abortion care.
- **Collaborate to identify gaps** in knowledge, address emerging challenges, learn from each other, and explore opportunities for advancing reproductive health and rights globally.

MAKING ABORTION CARE CLIENT-CENTRED

STATE OF PLAY

Quality of care is essential to healthcare delivery. While expanding access, we can't compromise on quality. A wealth of evidence has established that when you provide quality services, it drives people to seek healthcare more often, improves health outcomes, reduces inequality, and helps to break down stigma.

But what do we really mean by quality? When it comes to abortion, the focus on quality tends to be on abortion providers' technical competence, healthcare facility infrastructure, and the quality of products and equipment. But little has been done to measure client perspectives on respect, confidentiality, non-judgement, and whether counselling and information has supported them to have true choice. This is partially due to social and legal constraints, but it's also driven by the stigma associated with abortion, and a failure to consider individual needs and preferences.

At times, the client experience has been included in the evaluation of quality, but this has typically been examined through the lens of 'satisfaction ratings' including the likelihood of recommending the service to others. This is feedback that's often solicited through client exit interviews, conducted by the service provider themselves.

So, the sector has been shifting in recent years to better consider clients' perspectives, needs, and individual circumstances. This means ensuring clients have access to accurate information to make an informed choice on the care they receive and method they opt for. It values confidentiality, safety, comfort, and dignity and holds us—providers of abortion—accountable to the client.

Moving away from viewing overall quality as synonymous with clinical quality, it's important that as a sector we're interrogating all aspects of the client experience, and reframing abortion care within a wider human rights framework.

> **"I was about one month into the pregnancy and it was a surgical abortion. It wasn't painful—it was very simple. I've never regretted it. A friend recommended the clinic to me and I have recommended the clinic to two friends."**
> – Dina, MSI client in Ghana

RESEARCH SAYS

WHO prioritises person-centred care

The World Health Organisation's 2022 Abortion Care Guidelines' quality framework specifically calls out person-centred care as one of its six components (efficient, accessible, acceptable, person-centred, equitable, and safe).

Measuring abortion quality

The first global 'Abortion Care Quality Tool' standardises how the sector measures the quality of abortion care in low- and middle-income countries, with client experience at the centre. A research-developed and field-tested set of 29 indicators helps improve services and health outcomes.

LEARNINGS FROM FRONTLINE PROGRAMMES

MSI teams and partners have been working to integrate client experience in how we appraise and improve our services. All clinical quality assurance systems should be designed to lead to a positive and respectful experience. Here are some successful approaches:

Client-centred care framework
— striving for 'gold-standard' care

Client-centred care frameworks help us move beyond measures of the client-provider interaction to a culture of prioritising client trust, staff well-being, and supporting choice and autonomy. At MSI, our framework underpins our contraception, safe abortion, post-abortion care, and maternity provision. Each MSI country programme receives a client-centred care score annually, disaggregated by which channel the service was delivered (for example via MSI clinic or public sector support). Year on year, our programmes have improved their scores, with a view to delivering 'gold standard' care. By setting out a clear framework and metrics, providers can better understand how they can improve and work towards progress.

Abortion quality index
— quality means doing it right when no one is looking

MSI's abortion quality index (AQI) monitors the quality of abortion programmes. It allows us to share evidence-based recommendations for quality improvements to our teams, and brings abortion quality to the fore. By embedding our AQI scores into routine planning and improvement processes, we can clearly see where resources need to be allocated.

Feedback direct from clients
— telling us how to improve

Abortion providers must be accountable to clients. By integrating routine client feedback forms into our processes, we hear directly from our clients on their experiences, including the support they received from providers, stigma and pain management. Capturing our clients' voices helps us improve and adapt our approach. For example, based on direct client feedback via a new digital feedback tool, MSI Ghana increased communication on wait times—and saw clients' satisfaction scores increase. And following client feedback in Sierra Leone, the team rearranged waiting areas to provide more space for loved ones accompanying clients.

Securing more person-centred guidelines
— guidelines are more than a document

We've joined local partners in advocating for the adoption of WHO Abortion Care Guidelines at the national level. In Malawi, this led to new post-abortion care guidelines in 2019, and in Zimbabwe, the national post-abortion care programme has now become the national comprehensive abortion care programme, marking a step towards normalising abortion. These changes have brought an increased focus on client experience.

WHAT'S NEXT?

Client-centred care must prioritise the needs, preferences, and rights of people seeking abortion, and requires healthcare providers to put in place monitoring and accountability systems. To be truly responsive to the diverse needs and experiences of people seeking abortion care, we recommend:

1. Prioritising client experience

- **Offer comprehensive support** throughout the abortion process, including pre-procedure counselling, decision-making support, and post-abortion follow-up.
- **Ensure trained, competent healthcare providers**, and empower them to adhere to evidence-based clinical guidelines, standards of care, and best practices to ensure client safety and pain management.

2. Continuous feedback

- **Establish feedback mechanisms** for quality assurance and evaluating care, such as satisfaction surveys, focus groups, and community advisory boards—and incorporate client feedback into efforts to improve services.
- **Gain 'real time' feedback** by utilising technology and smart processes at scale, for continuous adjustments.

ADVOCATING FOR ABORTION

STATE OF PLAY

More than 60 countries have liberalised their abortion laws in the past 30 years. We've seen huge regional movements gain traction, for example in Latin America where 'the Green Wave' is ushering in a new era of liberalisation in Argentina, Columbia, and Mexico. There has undoubtedly been progress towards improved abortion laws, regulations, policies, and ultimately access.

But this progress is slow, patchy and reversable. Anti-choice groups are promoting disinformation, confusion and stigma to agitate against the right to abortion and inflict abuse on those who defend and provide abortion. Our teams have seen this activity increase globally since the 2022 US Supreme Court decision to overturn the right to abortion that was established by Roe v Wade in 1973.

Each country has different cultural and legal landscapes, so there isn't a one-size-fits-all approach in advocacy, but one thing is consistent: locals are the experts. Global organisations like MSI have a role in providing financial and technical support for local partners to help drive change.

At the country level, we've seen a subtle erosion of rights-based language. In Zambia and Ghana, a shift from 'sexual and reproductive health and rights' to 'family planning and reproductive health', or 'maternal, neonatal and child health', is erasing sex and rights from the conversation. These shifts in language are concerning—they're creating more space to challenge the legal frameworks that expand abortion access.

Another notable shift in framing is recognising the right to bodily autonomy. UN agencies are making this case more frequently in addition to messages around improving public health. It was encouraging to see the 2022 WHO Abortion Care Guidelines are rights-based. Human rights treaty bodies now acknowledge that denying abortion does violate established human rights—we recently saw this with the International Convention on Civil and Political Rights establishing the right of a woman to not be forced to choose between pregnancy and her life. These international declarations are important as they flow down to national legislation. Courts in Kenya, Nepal, and Bolivia, for example, have incorporated WHO abortion guidance into their own national standards. But there's a long way to go to secure universal buy-in.

Key challenges are a lack of local data to support arguments for abortion access, and the increasing politicisation of abortion and women's bodies. To expand abortion, we first have to hold the line on reproductive rights and try not to lose the progress already made. But looking at trends over recent decades, we can be confident that progress is winning.

> **"I always knew that I didn't want to have a child or not until I had done everything I wanted... it made me think of the women who are in different parts of our country without access and are forced to have children or die trying... I think it is important for abortion to be legal for everyone and not just in certain areas of the country."** - MSI Mexico client (25)

RESEARCH SAYS

40% under harmful laws

40% of women of reproductive age—753 million women[3]—live under laws where abortion is banned or restricted.

Rolling back rights

Out of the four countries that have rolled back legislation on abortion in the last thirty years, three have done so in the last 17 years in a relatively recent anti-rights trend.

3. This analysis draws from recent data from the UN Population Division.

MSI has

500+

partnerships from grassroots to global

ADVOCATING FOR ABORTION

LEARNINGS FROM FRONTLINE PROGRAMMES

MSI has a diverse network of over 500 local, national and global partnerships across the larger pro-choice ecosystem. If our on-the-ground experience tells us anything, it's that widescale change only happens with coordinated, respectful, and resourced partnerships. Here are some examples of where and how we've moved the needle:

Shifting narratives
— how do we ensure the message lands

Securing buy-in for abortion access and rights across different countries requires the ability to move nimbly between the ways that we frame arguments. In some contexts, decision-makers respond better to human rights messaging; in others, advocates know to speak more about public health and reducing maternal deaths. Our teams have found that tailoring messaging around creating supportive health systems can work well, especially when working with ministries of health, local government, and health systems leaders, and has helped improve abortion guidance in restricted settings.

Linking abortion with the wider social determinants of health is important, too. A lack of access to abortion is rooted in power and gender inequality, and MSI's teams and partners continue to highlight that it's forcing girls out of school, stopping women from pursuing the futures they want and reaching their potential, and hindering their ability to participate in political and social life or in finding solutions to the climate crisis—which perpetuates cycles of intergenerational poverty. By building compelling messages that speak to different audiences, we can shift narratives and create change from the ground up.

Financing abortion
— like with any healthcare, someone has to pay

Advocating for governments and insurance companies to pay for comprehensive abortion care is critical. In 2022 in Kenya, MSI leveraged our established health system strengthening partnerships with county governments to build confidence in the legality and importance of post-abortion care. They kept these discussions rooted firmly in healthcare to avoid being swept up in political debate, and the result was three county governments allocating extra money (£470,000 more than the previous year) towards post-abortion care, creating a specific budget for it—paving the way for more county governments to follow suit.

Abortion guidelines
— translating political decisions into access

Guidelines are a driving force for implementing abortion care, and can have a massive effect on combatting stigma and confusion. When WHO launched the new Abortion Care Guidelines in 2022, the Ethiopian Ministry of Health decided to update their guidelines, too. MSI Ethiopia and others in the Coalition for Comprehensive Abortion Care were at the forefront of these discussions, bringing their expertise and local partnerships to the table and advocating for the inclusion of humanitarian and outreach provision. With anti-choice groups trying to delay the process, MSI Ethiopia held 'Values Clarification and Transformation' sessions with key stakeholders and partners to progress it. After concerted advocacy and partnership, Ethiopia's most comprehensive abortion guidelines to date were approved in 2024, helping to operationalise abortion care best practice and notably making the option of self-managed abortion a reality for women in Ethiopia.

Nurses & midwives' curriculums
— training university students in abortion care

DRC has a high rate of maternal mortality, and unsafe abortion is the second leading cause. **Two thirds of an estimated 593,000 annual abortions** end in health complications because of dangerous methods and the lack of training of healthcare providers. By engaging with the Ministry of Health, the MSI DRC team successfully integrated two new training modules into the curriculum for university students of nursing and midwifery. Already in the pilot phase, this fundamental change to the DRC healthcare curriculum has seen more than 2200 midwives and nurses trained on providing safe abortion.

> **"This work takes time... it takes at least 18 months to two years from the first time we contact a religious leader to the point where they are a self-starting champion who actively speaks out for reproductive rights. We partner, support, give them opportunities to learn and build their confidence, time and time again—this work can't be done with a single workshop."**
> - Simeon, MSI Malawi

The power of religious leaders — faith leaders are becoming champions of choice

Faith, to many people, is foundational to who they are, their values, and what decisions they make—so religious leaders are often trusted sources of information and politically influential. From Afghanistan to Zambia, our teams engage with religious leaders on sexual and reproductive health and rights, with many becoming champions of choice as a result. In Malawi for example, home to one of the most restrictive abortion laws, MSI partners with the Religious Leaders Network for Choice, supporting with training and capacity building, and giving leaders a platform for exposure. Some of the religious leaders we've worked with now deliver 'Value Clarification and Transformation' workshops to stakeholders including other religious and community leaders, MPs, and journalists, to sensitively challenge negative beliefs on abortion and contraception. They also create resources on the intersection of religion and reproductive choice to help combat misinformation.

WHAT'S NEXT?

Enabling the environment for abortion care—particularly in the face of rising opposition—requires a strategic approach. We must work together to form a unified front, challenge restrictive policies, counter misinformation, and safeguard reproductive rights.

1. Coalition building & campaigns

- **Build coalitions and partnerships** with grassroots groups, like-minded organisations, healthcare providers, and community leaders to amplify efforts and leverage collective resources and expertise. This includes fostering alliances with diverse stakeholders, including women's rights organisations, HIV/AIDS organisations, LGBTQI+ organisations, healthcare associations, religious groups, and civil society organisations, and new potential allies (e.g. the private sector), to build broad-based support for abortion rights and access.
- **Develop tailored political strategies** to remove abortion restrictions and promote abortion liberalisation (and full decriminalisation) in law and policy.

2. Communicating with communities

- **Develop strong communications** that promote accurate information about abortion, dispel myths and misconceptions, and challenge stigma and disinformation; engaging communications in dialogue to build support.
- **Work with journalists and social media influencers** to ensure accurate and balanced coverage of abortion-related issues and to highlight the importance of reproductive rights. Amplify the voices of experts and individuals who have experiences of abortion.

3. Building our evidence base

- **Collect more national and regional data** estimates within countries of the prevalence of abortion and post-abortion care, as well as the safety and quality of services, the experiences of clients, and the impacts for people and the healthcare system.
- **Invest in improved public sector reporting** of abortion and post-abortion care services. And support local research agencies to conduct more systematic data collection.

PROTECTING FRONTLINE PROVIDERS

STATE OF PLAY

There is growing recognition of the burden on frontline abortion providers, and the need to strengthen our response to the discrimination, stigma, threats, and attacks they're targeted with. These issues are systemic across the world but particularly in contexts where laws and social norms are hostile to sexual and reproductive health and rights.

A report by Amnesty based on almost 50 interviews with abortion rights defenders from all over the world, including MSI team members, features stories of harassment and outlines major concerns for the safety and protection of abortion providers. Healthcare workers explained how they're feeling isolated and unsupported, their work is increasingly difficult and dangerous to carry out, and they fear the threat of criminalisation, harassment, violence, ostracisation, and burnout—whatever the legal context. Some health workers have seen their personal details leaked online, while others are unsure whether they'll make it home safely.

This is having a silencing and stigmatising effect on those providing abortion, as some live in constant fear. It's one of the human impacts of the failure to make abortion accessible and normalised around the world. Such an environment also creates barriers for everyone who needs abortion care—particularly those who are most marginalised.

To address this culture of hostility, MSI joined other healthcare bodies and advocates in 2022 to call for better protection for frontline providers, in a coalition called Defend the Defenders of SRHR. It calls on our own organisations, other reproductive healthcare employers, governments, and donors to ensure that there are measures in place to protect those working on the frontline to defend our rights, as well as appropriate remedial and legal responses when providers are subjected to harm. Because no-one should have to face abuse, intimidation, or harm for providing essential healthcare.

RESEARCH SAYS

Attacks on USA providers

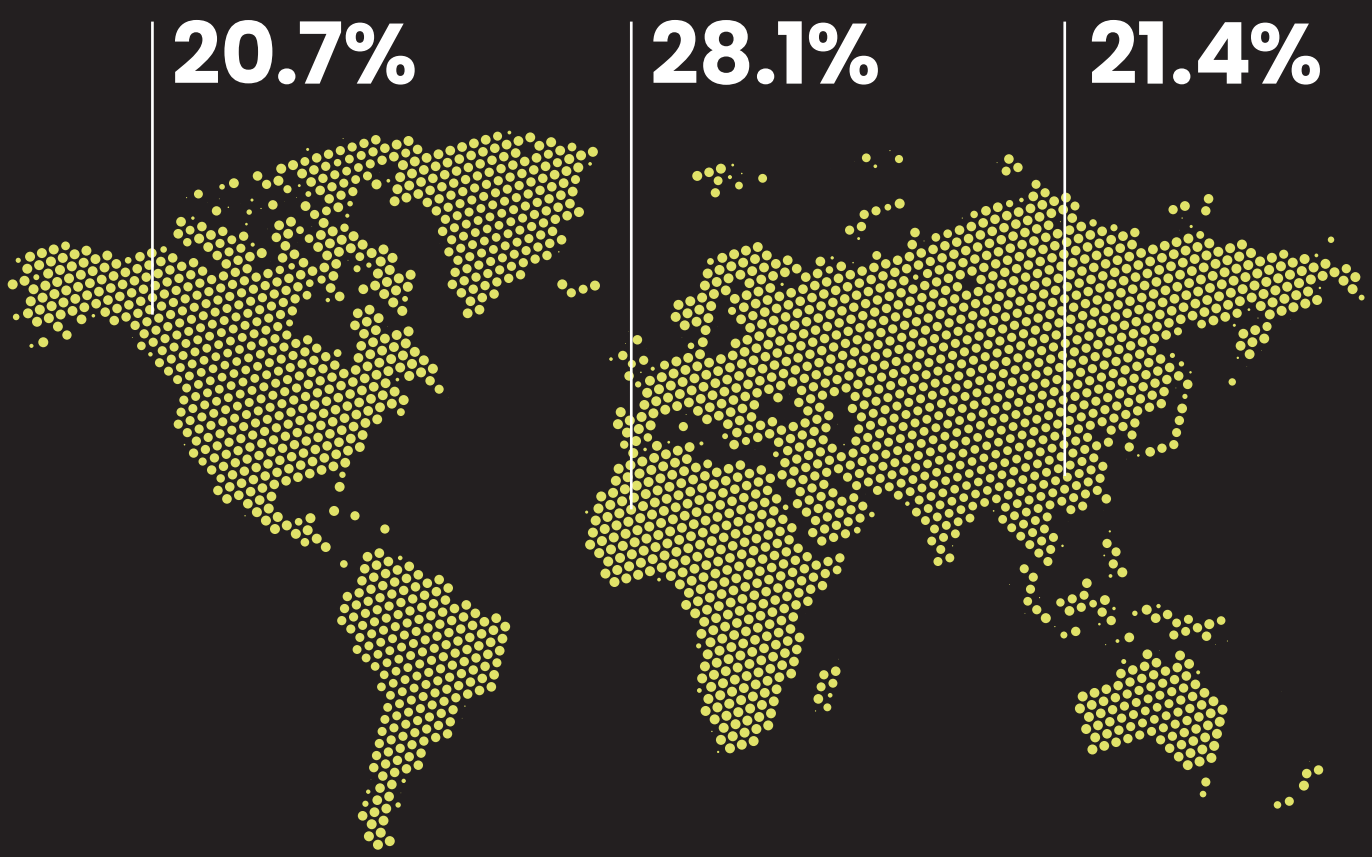
In the **USA alone**, at least 11 sexual and reproductive health providers have been murdered since 1990, with 41 bombings and 173 arson attacks against clinics since 1977.

Providers lean on peers

'Providers Share' workshops build abortion providers' resilience. **Evidence shows** participation has a lasting positive impact on morale and leads to reduced isolation and burnout.

Facing violence globally

13.4% of abortion providers have faced violence or aggression against them or their families due to their jobs. The rate in Africa reaches 28.1%, in Asia 21.4% and in North America 20.7%.



PROTECTING FRONTLINE PROVIDERS

LEARNINGS FROM FRONTLINE PROGRAMMES

It's clear that abortion providers experience hostility on a global scale. Here are some of the approaches we're taking to build their resilience and better protect them:

Hearing from abortion providers' experiences
— the harm and fear they're facing

Due to stigma, we hear from some of our providers that they're afraid to tell their own families that they work at MSI for fear of judgement, or even ostracisation. In one example, the husband of an MSI team member threatened to end their marriage after finding out where she worked. In another, one of our providers in DRC was arrested when police discovered that she had provided an abortion to a young woman in their community. Despite this abortion being legal, the police detained the provider for 48 hours. Her case was eventually dropped but her name had been made public and she experienced verbal abuse as a result. Despite this traumatising experience, she continues to provide essential abortion care.

It's important that we're documenting experiences and stories like these, building data and evidence around this issue, and making the larger picture clear. MSI has partnered in a scoping review and published findings in the British Medical Journal, hosted a global webinar to bring these experiences to light, and are finding other ways to share these stories and engage the global sector and states to protect our providers.

'Providers Share' workshops
— how peer-to-peer support is helping providers

We have found that one of the best ways to support frontline team members is through 'Providers Share' workshops. These are peer-to-peer support sessions where providers can ask questions about how to deal with stress, share their experiences, and understand how they can be prepared for challenging situations. Many report they find it easier to share their emotions, difficulties and concerns with others who can relate to their experiences. The MSI Zimbabwe team introduced these sessions at the end of 2018 and post-abortion care providers have reported that they've helped to lift the emotional burden of not disclosing their work to those around them, and helped them to discuss challenging post-abortion care cases—in the process building peer-to-peer support and teambuilding.

> **"Providers Share workshops ease a lot of pain. Providers need this platform there so they can openly share without limitation."** - MSI Zimbabwe post-abortion care provider

Ongoing clarifying of values
— getting in tune with their abortion beliefs and values

Before a provider starts providing abortion services, it's crucial they have the correct training—both in medical skill and also in how they mentally show up. 'Values Clarification and Attitudes Transformation' (VCAT) workshops can have a major impact in combatting stigma and supporting pro-choice attitudes. We incorporate roleplay activities into these sessions for a practical application of values and attitudes and their impact on clients. Getting in tune with their values helps providers stay true to course and build resilience against external stigma and attacks. VCATs are evidence-based—a study found improvements in knowledge, attitudes, and practices, as well as a 13% increase in abortion clients in the clinics that received these workshops.[4]

These trainings are not a one-time intervention; they're an ongoing process to normalise abortion work, and MSI is working to integrate this throughout all our training processes and increasingly use these approaches to support public sector providers, too.

> **"A woman losing her life because she couldn't find a proper provider is the part that I don't forget [about the VCAT workshop]. Helping these women remains in my heart. I think it would have been nicer if I took the training earlier."**
> - Oromiya, a VCAT participant

4. Source: Wollum, 2024. 'Does a values clarification and attitudes transformation (VCAT) workshop influence provider attitudes, knowledge, and service provision related to abortion care?: Evidence from a mixed-methods longitudinal randomized controlled trial in Ethiopia'. Manuscript under review.

WHAT'S NEXT?

Healthcare providers need to be recognised, protected, and supported. The 'Defending the Defenders' consortium and MSI's own team members' experiences offer some ways forward in supporting our abortion providers:

1. Supporting providers with workshops

- **Foster a supportive pro-choice environment** within healthcare institutions that respects and protects providers.
- **'Providers Share' and 'Values Clarification and Attitude Transformation' workshops** should be integrated across training processes, and made available to abortion providers to share their experiences and support each other.

2. Community education

- **Engage religious and community leaders** as advocates for reproductive rights and access to safe abortion.
- **Promote comprehensive sex education and awareness** campaigns with accurate information about reproductive health, and challenge myths and misconceptions—building acceptance of abortion as legitimate healthcare, and sharing stories to normalise it.

3. Call on organisations and states

- **Work with states and healthcare employers** to understand they have an obligation to provide healthcare workers with a safe and enabling environment. We must do more to anticipate risks, help colleagues prepare and mitigate risks, provide psycho-social support, and ensure people's safety.
- **Document and analyse** the anti-abortion and anti-gender attacks and the full picture of abuse towards healthcare workers for a more robust understanding.

FINISHING THE ABORTION REVOLUTION

“Our global society’s most privileged have been easiest to reach with advancements. In a world of tremendous wealth and proven solutions in sexual and reproductive healthcare, such disparity suggests a lack of will, not a shortfall of ideas or resources.”
– UNFPA State of World Population, 2024

Across time, women everywhere have needed and wanted abortion, and they will continue to do so. In the last century, safer abortion has become available and has transformed lives and generations; yet it remains out of reach for millions. This is an unfinished revolution, and there’s no excuse for it.

The world has all the knowledge and tools we need to end unsafe abortion by 2030. We have global guidelines, protocols, technology, and evidence of best practices to ensure that all people can receive confidential, respectful, and high-quality abortion care services. What we are lacking is political will and resources. We need to decide that women’s autonomy and lives are worth protecting; we need resources to implement effective approaches at scale; we need to integrate abortion as part of a comprehensive approach to health; and we need to focus efforts on reaching the most vulnerable and marginalised groups.

Governments must adopt and advance a comprehensive sexual and reproductive health and rights agenda. Civil society groups must work across sectors, advocate to secure political will, share their quality insights and data, and hold governments accountable to their commitments. And donors must invest—now more than ever—in expanding abortion services. We must work in unison and in partnership to eradicate unsafe abortion.

People need abortions today. So while we turn increasingly towards expanding medical and self-managed abortion, boldly advocating for abortion access, and training public sector workers to strengthen healthcare systems, we must keep investing in abortion providers who are on the ground right now filling gaps and changing lives.

Until no one dies from an unsafe abortion.
And until no one is left behind.

FURTHER RESOURCES

- **Abortion Care Guidelines** & Clinical Practice Handbook (2022), World Health Organisation
- **Abortion Care Quality (ACQ) Tool** for measuring the quality of abortion services, Metrics for Management, Ibis Reproductive Health & Ipas
- **Defending Frontline Defenders of SRHR**, a cross-sector project strengthening protection for those defending sexual and reproductive health and rights
- **Hostilities faced by people on the frontlines of sexual and reproductive health and rights: a scoping review**, BMJ Global Health
- **The World's Abortion Laws**, Centre for Reproductive Rights
- **How to talk about abortion: A guide to stigma free messaging**, IPPF
- **Abortion language guide**, MSI
- **Global abortion policies data base**, World Health Organisation
- **An Unstoppable Movement: A global call to recognise and protect those who defend the right to abortion**, Amnesty International
- **Adding it Up: Investing in Sexual and Reproductive Health 2019**, The Guttmacher Institute
- **Values Clarification (VCAT) Facilitators Training**, MSI
- **My Body, My Voice: Women's views on abortion care (Report One, 2019)** & **My Body, My Voice: Women's views on abortion care (Report Two, 2020)**, MSI

REFERENCES

Bearak JM, Popinchalk A, Beavin C, et alCountry-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015–2019BMJ Global Health 2022;7:e007151.

Sully EA et al., Adding It Up: Investing in Sexual and Reproductive Health 2019, New York: Guttmacher Institute, 2020, www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019.
United Nations, Department of Economic and Social Affairs, Population Division (2022). World Population Prospects 2022, Online Edition.

Ganatra B, Gerdts C, Rossier C, et al. Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model. Lancet. 2017 25;390(10110):2372–2381. https://doi.org/10.1016/S0140-6736(17)31794-4. Epub 2017 Sep 27. Erratum in: Lancet. 2017 Nov 25;390(10110):2346. PMID: 28964589; PMCID: PMC5711001.

Boydell V, Gilmore K, Kaur J, et al. Hostilities faced by people on the frontlines of sexual and reproductive health and rights: a scoping review. BMJ Global Health 2023;8:e012652.

Defending frontline defenders of sexual and reproductive health rights: a call to action-oriented, human rights-based responses | BMJ Global Health

Rahaman, M., Das, P., Chouhan, P. et al. Examining the rural-urban divide in predisposing, enabling, and need factors of unsafe abortion in India using Andersen's behavioral model. BMC Public Health 22, 1497 (2022). https://doi.org/10.1186/s12889-022-13912-4

Pasquier, E., Owolabi, O.O., Fetters, T. et al. High severity of abortion complications in fragile and conflict-affected settings: a cross-sectional study in two referral hospitals in sub-Saharan Africa (AMoCo study). BMC Pregnancy Childbirth 23, 143 (2023). https://doi.org/10.1186/s12884-023-05427-6

Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. Obstet Gynecol. 2012 Feb;119(2 Pt 1):215-9. doi: 10.1097/AOG.0b013e31823fe923. PMID: 22270271.

Bearak J et al., Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019, Lancet Global Health, 2020, 8(9):e1152–e1161, https://doi.org/10.1016/S2214-109X(20)30315-6

Five takeaways from MSF's study on unsafe abortions, https://www.doctorswithoutborders.org/latest/five-takeaways-msfs-study-unsafe-abortions, Sept 6th, 2023

Vlassoff et al. Economic impact of unsafe abortion-related morbidity and mortality: evidence and estimation challenges. Brighton, Institute of Development Studies, 2008 (IDS Research Reports 59). https://www.who.int/news-room/fact-sheets/detail/abortion Notes; Conversion from US Inflation Calculator-www.usinflationcalculator.com

PMA Nigeria Abortion Study: Unsafe Abortion Results, October 2020

Yokoe R, Rowe R, Choudhury SS, et al, Unsafe abortion and abortion-related death among 1.8 million women in India. BMJ Global Health 2019;4:e001491 – extracted from: https://www.ndph.ox.ac.uk/news/two-thirds-of-abortions-unsafe-in-over-half-of-indian-states-studied

Espinoza C, Samandari G, Andersen K. Abortion knowledge, attitudes and experiences among adolescent girls: a review of the literature. Sex Reprod Health Matters. 2020 Dec;28(1):1744225. doi: 10.1080/26410397.2020.1744225. PMID: 32284012; PMCID: PMC7888105.

Cecilia Espinoza, Ghazaleh Samandari, and Kathryn Andersen. Abortion knowledge, attitudes and experiences among adolescent girls: a review of the literature. Sex Reprod Health Matters. 2020; 28(1): 1744225. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7888105/

Popinchalk A, Sedgh G. Trends in the method and gestational age of abortion in high-income countries. BMJ Sexual & Reproductive Health 2019;45:95-103.

Footman, Katy. Structural barriers or patient preference? A mixed methods appraisal of medical abortion use in England and Wales. Health Policy. Volume 32. 2023. 104799. ISN 0168-8510. https://doi.org/10.1016/j.healthpol.2023.104799

Kanstrup C, Mäkelä M, Hauskov Graungaard A. Women's reasons for choosing abortion method: A systematic literature review. Scandinavian Journal of Public Health. 2018;46(8):835-845. doi:10.1177/1403494817717555

Bankole A et al., From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa

Harper CC, Blanchard K, Grossman D, Henderson JT, Darney PD. Reducing maternal mortality due to elective abortion: Potential impact of misoprostol in low-resource settings. Int J Gynaecol Obstet. 2007 Jul;98(1):66-9. doi: 10.1016/j.ijgo.2007.03.009. Epub 2007 Apr 27. PMID: 17466303.

World Health Organisation. WHO guideline on self-care interventions for health and well-being, 2022 revision. https://www.who.int/publications/i/item/9789240052192

World Health Organisation. Abortion care guideline. 2022.

Porter Erlank C, Lord J, Church K. Acceptability of no-test medical abortion provided via telemedicine during Covid-19: analysis of patient-reported outcomes. BMJ Sexual & Reproductive Health 2021;47:261-268.

Adu J, Roemer M, Page G, Dekonor E, Akanlu G, Fofie C, Teye MD, Afriyie PO, Affram AA, Ohemeng F, Tabong PT, Dwomoh D. Expanding access to early medical abortion services in Ghana with telemedicine: findings from a pilot evaluation. Sex Reprod Health Matters. 2023 Dec;31(4):2250621. doi: 10.1080/26410397.2023.2250621. Epub 2023 Sep 20. PMID: 37728548; PMCID: PMC10512762.

MSI Reproductive Choices. Supporting self-management of medication abortion from pharmacies: Evidence update and recommendations for practice. 2018. www.msichoices.org/wp-content/uploads/2023/10/ma-information-evidence-brief.pdf

Footman K, Keenan K, Reiss K, Reichwein B, Biswas P, Church K. Medical Abortion Provision by Pharmacies and Drug Sellers in Low- and Middle-Income Countries: A Systematic Review. Stud Fam Plann. 2018 Mar;49(1):57-70. doi: 10.1111/sifp.12049. PMID: 29508948; PMCID: PMC5947709.

Grossman A, Prata N, Williams N, Ganatra B, Lavelanet A, Läser L, Asmani C, Elamin H, Ouedraogo L, Rahman MM, Conneh-Duworko MJ, Tehoungue BZ, Chanza H, Phiri H, Bhattarai B, Dhakal NP, Ojo OA, Afolabi K, Kabuteni TJ, Hailu BG, Moses F, Dlamini-Nqeketo S, Zulu T, Rehnström Loi U. Availability of medical abortion medicines in eight countries: a descriptive analysis of key findings and opportunities. Reprod Health. 2023 Apr 11;20(Suppl 1):58. doi: 10.1186/s12978-023-01574-3. Erratum in: Reprod Health. 2023 Oct 26;20(1):160. PMID: 37041543; PMCID: PMC10091522.

Say L, Chou D, Gemmill A, et al. Global causes of maternal death: a who systematic analysis. Lancet Glob Health2014;2:e323–33.doi:10.1016/S2214-109X(14)70227-X.

NAF. National Abortion Federation Releases 2021 Violence & Disruption Report. 2022. https://prochoice.org/national-abortion-federation-releases-2021-violence-disruption-report/

Mosley, Elizabeth A., et al. "Addressing Abortion Provider Stigma: A Pilot Implementation of the Providers Share Workshop in Sub-Saharan Africa and Latin America." International Perspectives on Sexual and Reproductive Health, vol. 46, 2020, pp. 35–50. JSTOR, https://doi.org/10.1363/46e8720. Accessed 3 May 2024

Guttmacher Institute, Democratic Republic of the Congo country profile, 2022, https://www.guttmacher.org/regions/africa/democratic-republic-congo.

MSI and CCDH, Digital Disparities: The global battle for reproductive rights on social media, 2024, https://www.msichoices.org/latest/digital-disparities-the-global-battle-for-reproductive-rights-on-social-media/

Asma Khalil, Athina Samara, et al. A call to action: the global failure to effectively tackle maternal mortality rates. The Lancet, 2023. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(23)00247-4/fulltext#seccestitle10

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CHOICES

MSI Reproductive Choices
1 Conway Street, Fitzroy Square,
London W1T 6LP, United Kingdom
Telephone: +44 (0)20 7636 6200
Email: partnerships@msichoices.org
Registered charity number: 265543
Company number: 1102208