

# IFMSA Policy Document

## Ensuring Access to Safe Abortion

Proposed by Team of Officials

Adopted at the IFMSA General Assembly March Meeting 2023.

### Policy Commission

- Rakiya Mohammed - NiMSA-Nigeria - [Mohammedrakiya6@gmail.com](mailto:Mohammedrakiya6@gmail.com)
- Ewa Szplit - IFMSA-Poland - [e.szplit@gmail.com](mailto:e.szplit@gmail.com)
- Klaudia Szymuś - IFMSA Liaison Officer for Sexual and Reproductive Health and Rights Issues, incl. HIV and AIDS - [lra@ifmsa.org](mailto:lra@ifmsa.org)

### Policy Small Working Group

- Rakiya Mohammed - NiMSA-Nigeria
- Lauren Martin - AMSA-Australia
- Saneeka Vaidya - MSAI-India
- Naisha Lalwani - IFMSA-The Netherlands
- Klara Miljanić - CroMSIC-Croatia
- Pelin Bademkiran - TurkMSIC-Turkey

## Policy Statement

### Introduction:

The UDHR and the WHO describe health as a core right that involves physical, mental, and social well-being, not just the absence of disease, as well as the individual's autonomy to make decisions regarding their health. Sexual and reproductive health and rights are an integral part of an individual's health and well-being. Access to safe abortion and post-abortion care is a crucial element in an individual's reproductive health and well-being; it has been proven to reduce the complications and/or mortalities that may follow an unsafe or incomplete procedure.

### IFMSA position:

The IFMSA recognizes that access to safe abortion is an individual's right that protects their health, well-being, and bodily autonomy and upholds the values of gender equity, social justice and human rights. We support the efforts that aim to legalize abortion and make it a service that is affordable, available and accessible for all people in need, with particular consideration for left-behind populations. Safe termination of pregnancy should be accessible to all, and efforts should be made to minimize barriers such as cost, language, cultural background, stigma, discrimination and rurality. We believe that abortion services should attain the highest standards, utilize evidence-based practices, and respect patients' informed decisions regarding the maintenance or termination of their pregnancy. The IFMSA acknowledges that self-managed abortion is a safe practice if performed with the guidance of a medical practitioner and with the products included in the WHO guidelines. We also reprove actions, attitudes and behaviors that contribute to reinforcing social stigma around abortion.

### Call to Action:

Therefore, the IFMSA calls for:

#### Governments to:

- Ensure that programs on Reproductive Health encompass information on comprehensive abortion care and are made available to everyone irrespective of gender, race, religion or social status.
- Collaborate with community and religious leaders to reduce the stigmatization surrounding abortion by providing accurate information about safe abortion and the harmful effects of unsafe abortion.
- Provide community access to sexual and reproductive health care services that include comprehensive abortion care that is safe, confidential and free from discrimination.
- Carry out more research and implement evidence-based measures to decrease maternal mortality and morbidity rates by improving access to safe abortion services.
- Promote access to safe abortion by providing infrastructure, working equipment and the healthcare workforce to ensure the timely delivery of services, guaranteeing regional equality by investing in rural areas.
- Decriminalize abortion and reduce legal restrictions that limit access by reviewing the criminal and penal codes regarding abortion, amending them and enforcing new laws that do not criminalize seeking or providing abortion services.

#### NGOs and international agencies to:

- Implement an evidence-based and health-focused approach to reproductive health and rights while acknowledging the autonomy regarding reproductive decisions.
- Promote the destigmatization of abortion and recognize the health consequences associated with stigma and the long-term contribution to the mental health burden.
- Improve the information communities receive about the harmful effects of unsafe abortion through a steady collaboration with religious and community leaders.
- Promote and implement evidence-based information and education programs on abortion, and help to connect individuals and communities with sexual and reproductive health services that are free, accessible, age-responsive, non-discriminatory, and do not require third-party authorization.

**Healthcare sectors to:**

- Respect, protect and fulfill patients' human rights, including the autonomy to make decisions regarding their sexual and reproductive health.
- Acknowledge abortion as a highly safe procedure when performed or instructed by persons with the necessary skills and in an environment that conforms to, at least, minimum medical standards
- Provide all patients with safe access to evidence-based medical care, abortion counseling and post-abortion care in an environment that meets, at least, all minimal medical standards.
- Advocate for the elimination of stigma associated with abortion amongst the healthcare community, promoting an environment where both patients and providers feel safe without the fear of discrimination or prosecution.
- Ensure that when a health worker cannot provide abortion care, a referral is made to another safe, available and accessible service provider who does not conscientiously object.
- Promote or advocate for the development of the safest, most effective, appropriate and acceptable reproductive health technologies, including a broad choice of contraceptive and abortion methods.

**Medical schools to:**

- Encourage and assist medical students in their efforts to promote rights for safe Abortion, post-abortion care and treatment, as well as other issues relating to sexual and reproductive health and health.
- Include sexual and reproductive health in the medical curriculum to give students a foundation for learning about autonomy, consent, safe abortion, and other crucial issues.
- Provide medical students with opportunities for training by professionals on topics surrounding Sexual and reproductive health, including but not limited to contraception, safe abortion and post-abortion care.
- Ensure students have an understanding of how to communicate and understand the differing needs of patient populations who may have further limited access to termination services.

**Media and the general public to:**

- Hold government officials and healthcare professionals accountable for their actions or omissions concerning accessibility to abortion services, its rights and post-abortion care.
- Meaningfully participate in decision-making, monitoring, implementation, and reporting on the progress made on access to safe abortion and collaborate with different stakeholders.
- Collect local disaggregated data and conduct participatory community-led research to identify the issues and gaps and inform decision-makers.
- Actively work towards a society that secures abortion rights and reproductive health and fights against discrimination and stigma, hence promoting a society with no barriers to accessing abortion.
- Advocate for the elimination of any insensitive and anti-abortion material in media.
- Advocate for laws and policies that ensure adequate and safe access to abortion for people with a uterus, including trans and non-binary individuals.

**Medical students and IFMSA National Member Organizations to:**

- Create grassroots awareness campaigns about all issues pertaining to access to safe abortion and inform about these topics by using their local dialect to bridge any communication gaps that exist.
- Inform other students and the public about the need for safe abortion access as a component of women's healthcare through medical exhibitions, outreach programs, and online awareness campaigns.
- Encourage full participation in activities towards advocating for access to better and quality sexual and reproductive healthcare at all levels.
- Engage in policy creation that advocates and places emphasis on the right of people to have full autonomy in their sexual and reproductive health.

## Position Paper

### Background information:

The following terms will be often used in this policy paper. Thus, they have been simplified here for ease of understanding.

**Abortion:** The World Health Organization (WHO) defines abortion as “pregnancy termination prior to 20 weeks gestation. Generally, abortion is a term that refers to the termination of a pregnancy, whether it occurs with medical intervention, such as medications or surgical procedures or whether it occurs on its own, such as a miscarriage”. In this policy, the use of abortion refers to abortion through medical intervention.

**Unsafe abortion:** The World Health Organization defines “unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both”.

**Legal abortion:** The Centers for Disease Control (CDC) defines a “legally induced abortion “as an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, physician assistant) within the limits of state regulations that are intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth”.

Each year, almost half of all pregnancies – 121 million – are unintended; 6 out of 10 unintended pregnancies and 3 out of 10 of all pregnancies end in induced abortion. When performed using a technique advised by the WHO, appropriate for the stage of pregnancy, and by a qualified individual, abortion is one of the safest medical procedures. However, when people with unwanted pregnancies encounter hurdles to obtaining quality abortions (legal, financial, social or structural), they frequently turn to less safe practices.

According to the World Health Organization, people should have access to high-quality healthcare, which includes comprehensive abortion care services, which includes information, management of abortion, and post-abortion care, in order to achieve the goals of health for all and the progressive realization of human rights.

Ensuring that people have access to abortion care that is evidence-based – which includes being safe, respectful and non-discriminatory – is fundamental to meeting the Sustainable Development Goals (SDGs) relating to good health and well-being (SDG3) and gender equality (SDG5). [1]

Tragically, only around half of all abortions occur in safe settings; unsafe abortions result in over 39,000 fatalities a year and cause complications to millions of women. The majority of these fatalities are concentrated in low-income nations, with over 60% occurring in Africa and 30% occurring in Asia, especially among the left-behind populations that, due to systemic and social marginalization, are at a higher risk. [2]

The Human Rights Watch sees access to safe and legal abortion as a matter of human rights and its availability as the best way to protect autonomy and reduce maternal mortality and morbidity. International documents that relate to human rights regularly call for governments to decriminalize abortion and make it safe and affordable in all cases, and ensure access to safe, legal abortion in certain circumstances at a minimum. [3]

## Discussion

### Abortion and international agreement

Access to safe abortion services is a form of ensuring human rights. According to the Universal Declaration of Human Rights, everyone has a right to life, to health, and to be free from violence, discrimination, torture or cruel, inhuman and degrading treatment. Authoritative interpretations of international human rights law establish that denying pregnant people access to abortion is a form of discrimination and jeopardizes a range of human rights. Human rights law clearly states that the decisions about one's own body are theirs alone, and this is called "bodily autonomy". Countries have an obligation to respect, protect, and fulfill human rights, including those concerning sexual and reproductive health and autonomy.

These rights are set out in the Universal Declaration of Human Rights and protected in many international treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention Against Torture (CAT), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC), as well as in regional level treaties in Africa, the Americas, and Europe.

Legal restrictions on abortion often result in more illegal abortions, which may also be unsafe and may drive higher maternal mortality and morbidity. As a result, the lack of access to safe and legal abortion puts the lives of pregnant people at risk, jeopardizing people's exercise of the right to life [3].

### Abortion methods overview

Abortion can be safely and effectively managed using medication or surgical procedures. The recommended method of abortion is guided by a range of factors, including personal preference and gestational age. Annually, approximately 73 million induced abortions occur worldwide; however, it is estimated 45% of induced abortions are unsafe and not performed in accordance with abortion safe care guidelines. Developing countries are most affected by unsafe abortion procedures, where an estimated 97% of all unsafe abortion practices occur. [4] Most abortions occur before the fetus is 12 weeks gestation as the medication and surgical procedures become less effective after this time point. [5]

#### *Current recommendations*

- Medical abortion

For medical abortion when the fetus is less than 12 weeks gestation, the use of mifepristone and misoprostol is recommended. The advised dosages are 200 mg mifepristone administered orally followed by, 1–2 days later, 800 µg misoprostol, which is to be administered vaginally, sublingually or buccally. 800 µg misoprostol can be administered alone; however, it has been found to be most successful when used in combination with mifepristone. [6]

The use of the combination regimen of letrozole plus misoprostol is also a newly recommended method by the WHO. This regimen consists of 3 days of daily letrozole (10 mg orally) followed by misoprostol 800 µg sublingually on the fourth day. [6]

- Surgical methods

For surgical abortion less than 14 weeks gestation, vacuum aspiration is recommended. For termination of pregnancies that are less than 14 weeks gestation, dilation and curettage are not advised due to the

invasive nature and associated pain of the procedure. For surgical abortion occurring over 14 weeks gestation, dilatation and evacuation (D&E) is recommended. [6]

Medical abortion methods have an over 95% success rate, which is slightly lower than surgical methods, with a 99% success rate. However, medical management of abortion offers a more readily accessible option and gives greater autonomy and privacy to women as it can be self-administered. [7] For these reasons, medical abortion methods are becoming more prevalent and more commonly used in high-income countries. [5]

- Self-management of medical abortion

There is growing support and evidence for self-management of abortion before 10 weeks gestation. As stated by the *WHO Abortion Care Guidelines*, self-management of medical abortion is recommended when using the combination regimen of mifepristone and misoprostol or misoprostol alone. Self-management of abortion medication gives individuals the option to self-administer the medication outside of a healthcare facility and without any supervision. This assists individuals to feel more empowered and autonomous about their own health and increases accessibility for all.[6]

Self-management of abortion also encapsulates self-assessment of eligibility (e.g. determining pregnancy gestations) and self-assessment of success of abortion care. This requires all individuals to have access to appropriate services and information. [6]

### Abortion and health

As reported by the WHO, approximately 73 million abortions occur annually, which makes up 29% of all pregnancies that are terminated via an abortion. (4) The significance of abortion is not only affiliated with the process of the abortion itself but also the care and considerations prior to an abortion, as well as those following one and the subsequent effects. This includes, but is not limited to, the impact on physical health, mental health, and relationships of various kinds.

Giving attention and regard to the mental health of the person undergoing an abortion is essential to providing quality health care. However, it is also important to realize that understanding the mental health of the individual must be done independently of the decision they are about to undertake while also paying attention to the mental health and feelings of the individual prior to the abortion scenario. [8] When deciding to undergo an abortion, many individuals may initially experience a variety of emotions, ranging from guilt, confusion, sadness, fear, etc. Receiving an abortion can also trigger a variety of disorders, including sleep disorders, eating disorders, etc. [7] Anti-abortionists have argued that there is a direct causation relationship between abortions and mental health disorders. This stems from a lack of understanding and a lack of support, and understanding for the conditions leading to and the consequences following an abortion. Meanwhile, several studies have shown that receiving a wanted abortion is not directly correlated to the development of mental health disorders.

The recent Turnaway study followed over 800 individuals and compared persons who received a wanted abortion to those who were denied access to safe abortion. The study found no significant differences between the groups in regards to a variety of mental health disorders, such as depression, anxiety, self-esteem, etc. [8] Conversely, however, individuals that were denied access to safe abortions expressed having experienced negative consequences to mental health and even included the impact that this had on their ability to maintain relationships or to remove themselves from abusive relationships.[8] The Turnaway study presents evidence that states that the most common emotion felt by individuals five years after a desired abortion was, in fact, relief. Additionally, individuals who desire an

abortion but are denied access to safe abortion or post-abortion care are left with no other choice than an unsafe abortion, thereby increasing the risk of adverse impacts on health and/or complications. Globally, unsafe abortions are among the leading causes of maternal deaths each year [9].

In discussions regarding abortions, the physiological health of the individual undergoing the abortion is always a matter of debate. According to the NHS, short-term physiological consequences depend on whether it is medical or surgical and how many weeks the pregnancy has lasted. Before 14 weeks of pregnancy, the immediate short-term risks of medical and surgical abortions include additional surgery to remove remnants of the pregnancy (7% of medical abortions and 3.5% of surgical abortions), heavy bleeding, damage to the womb or sepsis (0.1% of medical and surgical abortions). From 14 weeks of pregnancy, the immediate short-term risks include additional surgery to remove remnants of the pregnancy (13% of medical abortions and 3% of surgical abortions) and infection or injury to the womb (very rarely). [10] From this, it can thus be seen that abortions that are performed under safe, sterile, and controlled conditions pose a very limited risk of medical consequences. Extensive research has proven that abortions pose little to no long-term consequences on the health of the individual undertaking the abortion. Primary concerns regarding undertaking an abortion include fertility, the viability of future pregnancy, the risk of breast cancer, mental health disorders, and premature death. National registry data from Finland found no association between abortion and secondary infertility, as well as spontaneous abortions and stillbirth. [11]

While abortions, if performed in accordance with the guidelines, are safe, the WHO estimates that 20 million of the 42 million abortions taking place annually are unsafe due to a lack of skills or medical standards, or both. In an effort to reduce the number of unsafe abortions, the WHO issued guidelines in 2003 known as Comprehensive Abortion Care (CAC), by which they hoped to improve the capacity of all parties to provide safe abortions. Subsequently, Postabortion Care (PAC) was also implemented with the aim of reducing mortalities and suffering from complications brought about by unsafe abortions. PAC included 5 major elements namely, treatment of incomplete and/or unsafe abortion procedures, counseling, contraceptive and family planning, availability of reproductive and other health services, and community partnerships. CAC also includes the mentioned elements, as well as the legal indications of safe abortions [12]. The guidelines were then updated in 2021 and now include all WHO recommendations regarding law and policy, clinical services, and service delivery. (4) A study regarding CAC conducted in Ethiopia proved that increased availability of CAC services contributes to the reduction of unsafe abortions and, therefore, the subsequent complications that may occur [13].

### Access to information on abortion

Access to information about abortions, being a huge part of reproductive health and rights, should include information about safe, legal abortion services. Provided information must be evidence-based and should break down stereotypes and misconceptions. The Committee on Economic, Social and Cultural Rights (ESCR Committee) [14] advocates for those pieces of information to be available for all individuals without discriminating against any group of people. Taking age into consideration while redistributing information on sexual health and abortion is also a role of the Committee on the Rights of the Child (CRC Committee).

According to WHO [15], health system and access barriers, regulatory policies, practices and laws contribute to unsafe abortion, limiting availability, increasing costs and deterring from seeking health care. Those barriers concerning access to information revolve around prohibiting or failing to provide public information on legal abortion services and withholding or intentionally misrepresenting health-related information on abortion.

International Federation of Gynaecology and Obstetrics (FIGO) [16] recommends that any counseling on the topic of abortion should be impartial, non-judgmental and inclusive. Neither society nor members of the health care team should use their own convictions trying to impact pregnant individuals' decisions.

### Abortion and left-behind populations

Access to safe abortion overlaps with many other social factors affecting pregnant individuals. Social perceptions, financial burdens and legal barriers prevent them from accessing safe abortion services, and those issues are even more prominent in the young population. Restrictive abortion laws are even greatly exacerbated for adolescents as they usually require additional parental consent, which puts them at a much higher risk of unsafe abortion. [17] As of today, there is no objective data incidence of unsafe abortion rates in the Global South, but estimates suggest that adolescents ages 15-19 account for 3.7 million unsafe abortion procedures every year. [18]

There is a clear association between unsafe abortion rates and abortion criminalization. Regions where most countries criminalize abortion, such as sub-Saharan Africa, Latin America, and East Asia, showed extremely high unsafe abortion rates. Research shows that 14 unsafe abortions are performed each year for every 100 births in Africa, and out of 2 million unsafe abortions performed in Indonesia every year, 30% are performed on adolescent girls. [11][19]

Worldwide, there are several gaps in the provision of health services related to abortion care. For example, there is often minimal adolescent post-abortion care provided, leading to a treatment that is neither comprehensive nor addresses the specific needs of a unique patient population. Research has shown that due to social, financial, and legal barriers, adolescents and young women have second-trimester abortions more often than adults and are more commonly practicing unsafe self-inducing strategies. (Both second-trimester abortion and self-inducing strategies have a higher risk of complications and greater mortality rate.) [20]

Based on the WHO guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries, recommendations have been adopted to reduce adolescent pregnancy rates and, thus, putting young people in need of abortion that often, due to existing barriers, is unsafe. These recommendations include: reducing marriage before the age of 18 years; increasing the use of contraception by adolescents at risk of unintended pregnancy; reducing coerced sex among adolescents; reducing unsafe abortion among adolescents; and increasing the use of skilled antenatal, childbirth, and postnatal care among adolescents. [21]

Another important correlation we should take into consideration is the connection between rural areas and the inaccessibility of safe abortion. The lack of trained healthcare providers, especially in the public sector, greatly limits the availability of abortion services in rural areas. Many other logistical factors, such as inadequate supplies of commodities and medications, lack of transportation, and maldistribution of facilities, also present a great barrier to the provision of quality abortion care in rural settings. [22][23] An unfortunate example of that can be found in India, where the prevalence of unsafe abortion in rural areas is 7.2% higher than in its urban counterparts. [24]

LGBTQIA+-phobia is another aggravating factor that individuals who are able to get pregnant must deal with globally while trying to gain access to safe abortion. Individuals who were assigned female at birth do not necessarily identify with the same gender. This broad category includes transgender men, gender non-binary people, gender non-conforming individuals, and other people with the ability to gestate. Some of these individuals may choose not to affirm their gender, either temporarily or permanently. This might



be achieved by avoiding the use of hormone replacement therapy or by choosing not to undergo gender affirmation surgery. Thus, these individuals are capable of becoming pregnant. Such pregnancies might arise through sexual intercourse or the use of assisted reproductive technologies and might be intended or unintended. These individuals face a multitude of barriers to accessing safe abortions. [25] Firstly, healthcare professionals are largely ignorant of gender-diverse individuals' capability to gestate and of their needs. There is a belief among healthcare professionals and the general population that they cannot get pregnant as only 'women' are capable of gestation, which leads to mislabeling patients as women and mothers rather than acknowledging their identified gender as well as detecting their pregnancy much later than usual. [26] Secondly, accessing safe abortion services while already facing stigma and discrimination for their identity faced by members of the community is even more challenging. [27] 2019 study in the United States discovered that over one-third of pregnant transgender, nonbinary, and gender non-conforming people had considered ending the pregnancy without medical help out of fear of discrimination and lack of insurance coverage. [28]

There is also an issue of legal barriers for these individuals across the world, which include criminalization of their identities, infringement on their dignity as well as lack of civil rights (e.g., access to free reproductive healthcare due to incorrect gender on their legal documentation). [29]

Furthermore, countries like Japan apply forced sterilization laws for transgender individuals upon accessing reproductive health services. [29,30] There is also an unwillingness among some healthcare providers to provide inclusive healthcare services. The intersections of these barriers result in an unfortunate experience that is exclusive to LGBTQIA+ individuals when attempting to access safe abortion services. Therefore, there is a necessity to recognize access to safe abortion as a human right and ensure the inclusion of LGBTQIA+ individuals in safe abortion provisions.

Data from two Beninese cross-sectional surveys show that most pregnancies of female sex workers ended with an abortion (67.6%). [31] Both that study and the study in Mombasa, Kenya [32] show that younger age, longer duration in sex work, previous HIV testing, having an emotional partner and using traditional or no contraception or condoms only are independent indicators of a higher risk of unintended pregnancy in sex workers. However, older age is usually a factor associated with abortion, as shown in female sex workers in Russia.[33] That phenomenon can be explained by the fact that most female sex workers already had their children prior to their work. A study [34] conducted by the African Population and Health Research Center in Kenya is associating having 1-2 prior births with a higher likelihood of repeating an abortion. The pressure of clients and/or emotional partner not to use condoms are shown as the main reason for unsafe sexual practice. A cross-sectional study [35] in Eastern Ethiopia showed that one hundred thirty-eight (88.5%) of participants were engaged in unsafe sexual practices at least once since their engagement in sex work, which ultimately is connected to the higher frequency of having abortions.

### Barriers to safe abortion

Dr. Bela Ganatra, Head of WHO's Prevention of Unsafe Abortion Unit, while issuing new guidelines on abortion for developing countries, says, "It's vital that abortion is safe in medical terms. But that's not enough on its own. As with any other health service, abortion care needs to respect the decisions and needs of women and girls, ensuring that they are treated with dignity and without stigma or judgment. No one should be exposed to abuse or harm like being reported to the police or put in jail because they have sought or provided abortion care." The need of the hour is to provide safe abortions overcoming the many barriers encountered at various levels- legislation, social stigma, and finances, among others. Most individuals face barriers to accessing safe abortions at one or more levels. [36]

### *Policy-level barriers*

Implementing laws that ban abortion does nothing but promote unsafe, unethical, and illegal abortions. It restricts reproductive autonomy, negatively impacting the health of the community. When individuals with a uterus are denied timely access to safe and effective abortion services, they are more likely to resort to unsafe means. For decades we have known that criminalizing abortion is not effective in reducing its rate, but it assists in increasing abortion-related morbidity and mortality. In a study, it was observed that the abortion rate for countries where abortion is restricted was 36 per 1000 women aged between 15–49 years, and the abortion rate was similar regardless of the type of legal restriction. For countries where abortion is broadly legal, the abortion rate was 40 per 1000 women aged between 15–49 years.[37]

The major effect of this is seen in individuals from marginalized communities and people of lower income. [38][39]

In U.S. politics, the Hyde Amendment is a legislative provision barring the use of federal funds to pay for abortion except to save the life of the woman or if the pregnancy arises from incest or rape. Along with this, the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone limits access to mifepristone which is one of the two drugs used for medical abortion. [40][41]

In Poland, in 2020, a new rule that declared abortions in cases of fetal impairment unconstitutional was passed. Before this ruling, most of the abortions performed in public hospitals in Poland were due to fetal anomalies. This decision initiated a near-total ban in the country. [42]

The Central American country of Honduras is home to one of the world's strictest abortion laws. Abortion has been banned in the country since 1985. In 2021, the lawmakers made a change in the constitution, which made it mandatory to have a three-quarters majority to make any change to the existing abortion laws. [42]

Apart from these countries, many countries have a total or near-total ban on abortions.

There is a lack of inclusion of persons with disability, trans and non-binary individuals, and persons from marginalized communities in the existing policies, which obstruct their access to abortion and contraceptive services.

In addition to all the barriers described in this section, the main specific barrier that trans and non-binary people face while accessing abortion services - the reluctance of providers to frame their services in trans-inclusive ways. This is mainly seen in the 'women-only' clinics. There are a few clinics that are exceptions to this policy. These clinics accept trans women as clients and employees. But trans men and non-binary people are excluded altogether. A view of trans-inclusivity like this, one which focuses exclusively on including people based on their gender identity, will be inadequate. Trans men and non-binary folks should not just be treated as patients but also should be employed. [43][44]

Another barrier affecting policies globally is the global gag rule (Mexico City policy) that was rescinded in January 2021 but for years impacted the advocacy on access to safe abortion. The global gag rule prevents foreign nongovernmental organizations (NGOs) from using their own non-U.S. funds to provide abortion services, information, counseling, referrals or advocacy. This policy restricts access to essential reproductive clinical services. It also affects the relationship between the healthcare provider and their patients as they cannot openly provide them with the necessary information. A survey was done in 2018-2019, and the previously existing research leads us to conclude that the policy negatively impacted women's health in Uganda. President Biden rescinded this rule in January 2021, but the impact of these disruptions may be felt for years to come [45,46].

*Service-delivery level barriers:*

- Facilities:

In many countries, such as China, Argentina, and Mexico, abortion has been legal or has been decriminalized in the recent past. In such countries, even though the law permits safe abortion, abortion seekers face barriers in terms of resources and accessibility. There is a lack of functional infrastructure and trained staff for providing surgical abortions. Limited supplies and equipment also add to the problem. Many public sector hospitals, especially in low- and middle-income countries, have a shortage of resources causing individuals to either seek help from private clinics or resort to unsafe methods. The higher cost of private clinics also acts as a major factor. [42,47]

- Lack of awareness

An additional barrier is the lack of knowledge about the existing laws and rights regarding contraception and abortions.

The information regarding the available methods and facilities of abortion is not shared efficiently. Effective framing and implementation of public health policies are essential. In a study about the approaches, barriers, and facilitators to abortion-related work in U.S. health departments, the key barriers and facilitators were found to be political climate, funding opportunities and restrictions, and departmental leadership. [48,49]

- Healthcare providers

In a study of obstetrician-gynecologists, about half (52%) of those who intended to provide abortions before residency was providing them post-residency. The most common reasons cited by the other half for not providing abortion were personal beliefs and practice restrictions. [50] [51] [52]

*Community and family level barriers:*

A study was conducted in Kenya and India about abortion-related fears, expectations, and perceptions of stigma among people who have obtained abortion services. Most participants expected to be judged during care and feared the service would be ineffective or would lead to negative health consequences. They feared disapproval and judgment by community members based on their age or marital status. Factors contributing to fear and low expectations included the perceived stigma, current societal norms, negative stories, and in general, the secrecy around abortion.

Simply being accused of an abortion-related offense can negatively impact a person's relationship with their family, employer, school, and community. If there is an investigation, prosecution, and imprisonment involved, it is an added stress, and it will all the more cause harm to her physical and mental health. Abortion-related stigma also affects abortion providers and those who discuss and work on related policies. Such stigma affects the way policymakers and opinion leaders deal with abortion.

A new report by the National Abortion Federation stated that the attacks on abortion providers increased significantly in 2021 as compared to 2020 for most kinds of crimes- including stalking, invasions of facilities and assault. The United States of America department of justice released a list of recent acts of violence against reproductive healthcare providers. In 2022, a California man was charged with causing damage to a Los Angeles area abortion clinic by firing multiple pellets from a pellet gun. In 2022, 10 defendants were indicted in connection with a 2020 planned blockade of a District of Columbia area abortion clinic. The defendants bound themselves with chains and locks and physically obstructed clinic staff and patients during the blockade, which was live-streamed on social media. [53–55]

### Medical professionals' role in safe abortion

Although there are safe, effective, evidence-based therapies that are straightforward enough to be offered at the primary care level, safe abortion is still typically only offered by doctors, frequently just gynecologists, in many areas of the world. WHO's new guideline on health worker roles in providing safe abortion care and post-abortion contraception highlights that moving beyond specialists and enabling a wide range of health workers in safe abortion care promotes rational use of the available health workforce and facilitates equitable and timely access to care. This is crucial in environments where there are severe shortages of competent professionals, but it is also important to advance treatment that might better match women's needs. The recommendations presume that the designated health workers will get task-specific competency-based training and that the interventions will be carried out in compliance with current WHO clinical care guidelines.

Healthcare practitioners in nations where abortion is legal have a responsibility of care to for women, girls, and pregnant persons who want to get an abortion and must not let their personal beliefs prevent them from getting the care they need. In many countries, medical professionals have the freedom to decline to participate in abortions owing to personal beliefs and convictions. Despite this, all healthcare providers have a duty to make appropriate recommendations to ensure a woman's access to legal abortion services is not hindered. Medical personnel must tell patients about the legality of abortion and where to find abortion care.

### Abortion and gender equity

Gender equity is a concept that recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalances between genders. This may include equal treatment or treatment that addresses different needs and existing gaps. Though often used interchangeably, equality and equity are two very distinct concepts. While international human rights treaties refer to 'equality', in other sectors, the term 'equity' is often used. The term 'gender equity' has sometimes been used in a way that perpetuates stereotypes about women's role in society, suggesting that women should be treated 'fairly' in accordance with the roles that they carry out. [56]

Another term that is related to the issue is bodily autonomy. Bodily autonomy is defined as the right to "make decisions about one's own life and future." It's about choice, and it's about dignity. Bodily autonomy is the foundation for gender equality, and above all, it's a fundamental right. [57]

The right of a person to make autonomous decisions about their own body and reproductive functions is at the very core of the fundamental right to equality and privacy concerning intimate matters of physical and psychological integrity. [51][58] Equality in reproductive health includes access, without discrimination, to affordable, quality contraception, including emergency contraception. Countries, where women have the right to termination of pregnancy and are provided with access to information and to all methods of contraception, have the lowest rates of termination of pregnancy. Unfortunately, according to WHO, an estimated 225 million women are deprived of access to essential modern contraception. [59]

The decision as to whether to continue a pregnancy or terminate it is fundamentally and primarily the woman's decision, as it may shape her whole future personal life as well as family life and has a crucial impact on people's enjoyment of other human rights. Bringing a child into the world, raising and nurturing children, and building families and communities are, for many, among the most joyful and meaningful

experiences in life. At the same time, these life-changing events bring challenges and risks. That is why, for people who can become pregnant, control over fertility and decisions about their body and health care are critical for determining if, when, and how to start or expand a family and for preserving their own life and health. [60]

Pregnant people have the right to decide what they can and can't do with their bodies. Since the fetus exists inside the person's body, a pregnant person has the right to decide whether the fetus remains in their body, and therefore, they have the right to abort the fetus.

If a pregnant person is not allowed to have an abortion, they are not only forced to continue the pregnancy to birth but are also expected by society to support and look after the resulting child for many years to come (unless they can get someone else to do so). If the pregnant person has the right to choose whether or not to have children, only then they can achieve equality with cis men: cis men don't get pregnant, and so aren't restricted in the same way. Furthermore, people's freedom and life choices are limited by bearing children, and the stereotypes, social customs, and oppressive duties that go with it. Pregnancy also has serious effects on the person's body, and they have the right to choose if they want to go through the changes necessary for the body's preparation process for the fetus. Considering all these, it can be stated that people able to get pregnant need free access to abortion in order to achieve full political, social, and economic equality with cis men; women need the right to abortion in order to have the same freedoms as men; they need the right to abortion to have full rights over their own bodies (including the right to decide whether or not to carry a fetus to birth) - without this right, they do not have the same moral status as cis men [61].

### Effects of crises

As total cases of COVID-19 have risen to more than 648 million worldwide from the start of the pandemic to the end of 2022, healthcare has shifted its attention to the prevention of viral spreading, emergent medicine, and the development of treatments and vaccines. The unfortunate effect of this change is the neglect of other essential medical services, such as access to safe abortion.

It is estimated that more than 2.7 million additional unsafe abortions happened globally as a result of the COVID-19 pandemic. [62] The pandemic is also an aggravating factor of up to 7 million unintended and unwanted pregnancies with serious consequences such as an increase in maternal and neonatal morbidity and mortality, post-traumatic stress disorder, depression, suicide, and intimate partner violence. These problems disproportionately affect marginalized groups and low- and middle-income countries, especially in sub-Saharan Africa. [62,63] As the pandemic progressed, many countries proclaimed abortion services non-essential, which made access to safe abortion even more strenuous than usual. Telemedicine and medication abortion played a key role in ensuring access to safe abortion during the worst periods of the COVID-19 pandemic. Research shows that 95% of women who had undergone a telemedical obtained medical abortion in the USA had a complete abortion without complications and interventions. [64]

Economic crises and war are other aggravating factors that women must deal with globally while trying to gain access to safe abortion. More than 20% of women refugees will experience some form of sexual violence which vastly increases their need for contraceptive and abortive methods. Still, the main focus of international and local relief agencies during wars and conflicts has always been the provision of food, water, shelter, and basic health care, which unfortunately leaves those needs a very low priority. [62,63,65]

As the war in Ukraine picks up, the supply chain of modern contraception has been cut off, and reports of the rape of Ukrainian women continue to pour in daily. It is estimated that since March of 2022, more than 500 women have sought out abortion services in the refuge. An insurmountable barrier to access to safe abortion for those women is extremely harsh and restricting abortion laws in their new country. As of 2020, abortion is legal in Poland only in the case when the mother's life is in danger or if the pregnancy is a result of rape or incest, which is unfortunately very time-consuming and hard to prove. [66] Although there is limited conflict-period data, Yemen is another war-stricken country with an urgent and unmet need for access to safe abortion. Medical professionals report that more and more Yemeni women want to have a choice of safe abortion. Still, war and consequent economic crisis have made the price of safe and professionally performed abortion unattainable for the majority of the population. [67]

Another important correlation we should take into consideration is the connection between climate change and the risk of losing reproductive choice. It is estimated that climate change could displace more than 216 million people, mostly from the Global South, by 2050. The consequence of that climate-related displacement would be 14 million women losing their access to modern contraception and safe abortion services. If their right to reproductive choice is taken away, it is estimated that it would lead to an additional 6.2 million unintended pregnancies, 2.1 million unsafe abortions, and 5,800 maternal deaths [68][69].

In countries like Nepal and India, MSI runs many clinics providing safe abortions and contraception. When the pandemic began, countrywide lockdowns were imposed for several months, restricting the access of both providers and clients to reach these clinics. Even though post lockdown, these clinics opened up, it had already caused enough damage to many people. The Foundation for Reproductive Health Services India, an affiliate of MSI, estimated that the cessation of essential reproductive services would lead to an additional 2.3 million unintended pregnancies and over 800 000 unsafe abortions, the third leading cause of maternal deaths in India [70].

### Positive country-level solutions

At a global level, a great disparity remains in the level of access people have to safe abortions. In 2022, only 60% of women globally can legally access abortion on broad social or economic grounds or by request. To improve this inequity in access, countries with programs and laws that promote safe and equal access to abortion services can be examined [71].

#### *United Kingdom*

Within the United Kingdom, people are able to access abortion services upon request, which are available through the National Health Service (NHS) for no cost. With developments of the COVID-19 pandemic and to improve access to abortion services, new legislation passed in August 2022 that now permits early medical termination of pregnancy to take place in the patient's home for gestation up to 9 weeks and 6 days. allows access to medical abortion via a telephone consult. Focus has also been placed on girls under the age of 18 being able to readily and safely access abortion services [72,73].

#### *New Zealand*

Abortion services are available for all individuals at their request, and most services are free for eligible individuals. In March 2020, significant changes were made to the *Abortion Legislation Act 2020* and abortion was decriminalized. These changes aim to reduce the barriers faced by people when accessing safe abortion services. Individuals are now able to self-refer to a service provider, and a wider range of health professionals (doctors, registered nurses and midwives) are now able to provide abortions.

Furthermore, abortions are no longer required to occur at a licensed premise, allowing for access via telehealth [74][75].

#### *Cambodia*

Since October 1997, medical abortion has been legalized in Cambodia for up to 9 weeks gestation and surgical abortion for up to 12 weeks gestation. Access to abortion services after these periods must be approved under specific circumstances, including; whether the fetus is causing risk to the pregnant person's life, the fetus is at risk of serious disease, or the pregnancy is a result of rape. [76][77][78]. These laws were first introduced due to a high maternal mortality rate that was associated with unsafe abortion practices. [79] Reform to abortion laws and improved access to abortion services have contributed to the continuing decline in Cambodia's maternal mortality ratio. The most recent data in 2017 recorded the maternal mortality ratio to be 160 deaths in 100,000 births. These figures are evidence of how improved access to abortion services and maternal health can be achieved through legal and healthcare reform [80].

#### *Colombia*

Colombia is an example of a country that has recently seen a great improvement in access to safe abortion methods and changes to abortion laws. In February 2022, the Constitutional Court of Columbia decriminalized abortion under 24 weeks of gestation and decriminalized abortion for all gestations for specific grounds. This was a historical decision that overturned previous laws, which, before 2006, punished people for inducing an abortion. These changes to the constitution of Columbia highlight positive healthcare reform that has been achieved through ongoing advocacy work. [81] The broader social context of this decision is also important to acknowledge, as these changes followed the decriminalization of abortion in other neighboring countries within the Latin American region (Argentina, Chile and Mexico) in 2021. This shifting legal landscape and development in ensuring access to safe abortion for all show promise for continued progress in the future [82,83].

#### *Argentina*

Argentina is one of the few countries in Latin America to allow access to safe and free abortion, and they were also the pioneers of the green tide in this part of the world. On the 30th of December 2020, the Argentine Senate approved Law No. 27,610 [84], which regulates the Voluntary Interruption of Pregnancy, after a long and intense debate. Enacted on January 14, 2021, the law establishes the right of women and "persons of other gender identities with gestational capacity" to voluntarily terminate their pregnancies up to and including the 14th week. This marked a historic moment for the entire Latin American community. The law on voluntary termination of pregnancy refers to the "autonomy of will," and this means a substantive change concerning how non-punishable abortions were being provided until the end of 2020. The legalization of abortion guarantees a right and proposes new research topics, areas of intervention, and spaces for meeting and collective debate that allow us to generate comprehensive care policies, inclusive and with social justice.

#### *Tunisia*

Within the Eastern Mediterranean region, Tunisia is the only country where abortion is legal and decriminalized. Under the Penal Code, abortion is permitted during the first three months of pregnancy when performed by a doctor in a hospital or licensed clinic. The decriminalization of abortion occurred in 1965, as there was a political focus on reducing the fertility rate with the aim of improving the socioeconomic status of Tunisia's citizens. This decision was based upon a political agenda and not for the promotion of women's rights. For this reason, access to abortion services remains contentious within

society for both social and religious beliefs. This highlights that safe access to abortion for all individuals requires more than legalization and constitutional approval. [85,86]

### *South Africa*

Changes to the *Choice on Termination of Pregnancy Act of 1996* legalized abortion for all reasons up until 13 weeks gestation. Past 13 weeks gestations, abortion services are only approved under specific circumstances, including; rape or incest, a non-viable fetus, a threat to the pregnant person's life or effects their socioeconomic status. [87] South Africa is one of the few African nations to legalize abortion on request as abortion services within many other countries within Africa are still heavily restricted. It is estimated that over 75% of abortions carried out in sub-Saharan Africa are considered unsafe, and nearly 50% of abortions occur under the least safe circumstances. For this reason, changes to abortion laws in the South African constitution highlight the future change that can occur within neighboring countries. [4][88]

### IFMSA Contributions to Ensuring ASA

The IFMSA recognizes that people all around the world have a variety of ethical and religious stances on abortion. However, the IFMSA adheres to an evidence-based philosophy and promotes safe abortion on the grounds of economics, human rights, and public health.

The IFMSA has had a number of activities that align with ensuring access to safe abortion. It has consistently advocated for safe abortion as a component of a fundamental women's right, and it makes a point of urging greater accessibility to both legalized abortion and secure, reasonably priced abortion services in all contexts. The activities include:

1. IFMSA Policy document on Ensuring access to safe Abortion - March 2022
2. SWG on the International Day of Access to Safe Abortion - September 2020. Infographics were shared, 3 IPAS training sessions were delivered, and an artwork competition and webinar were delivered with a guest speaker from Ipas Cecilia Espinoza.
3. Special Ipas sessions in the 1st edition of IFMSA MHASA Camp-April 2021
4. Regional Challenges in Access to Safe Abortion in the AmRM20
5. ARM 21 - Advocacy on safe abortion Male infertility with a focus area on access to safe abortion.

In the period 2020-2021, the IFMSA had 13 officially enrolled activities on access to safe abortion, with the highest representation in Africa (5), followed by Asia-Pacific (4), EMR (3), and Americas (1). No activities from Europe were enrolled. One year later, the number dropped to 4 activities globally, with 1 activity per region, except for Europe, with no activity on access to safe abortion at all [89][90].

### **References:**

- [1] Abortion n.d. [https://www.who.int/health-topics/abortion#tab=tab\\_1](https://www.who.int/health-topics/abortion#tab=tab_1) (accessed December 23, 2022).
- [2] Mar 9. WHO issues new guidelines on abortion to help countries deliver lifesaving care n.d. <https://www.paho.org/en/news/9-3-2022-who-issues-new-guidelines-abortion-help-countries-deliver-lifesaving-care> (accessed December 23, 2022).
- [3] Q&A: Access to Abortion is a Human Right. Human Rights Watch 2022. <https://www.hrw.org/news/2022/06/24/qa-access-abortion-human-right> (accessed December 23, 2022).
- [4] Abortion n.d. <https://www.who.int/news-room/fact-sheets/detail/abortion> (accessed December



13, 2022).

[5] Nine out of 10 abortions done before 12 weeks in many high-income countries 2019. <https://www.bmj.com/company/newsroom/nine-out-of-10-abortions-done-before-12-weeks-in-many-high-income-countries/> (accessed January 3, 2023).

[6] Abortion care guideline 2022. <https://www.who.int/publications/i/item/9789240039483> (accessed December 13, 2022).

[7] Safety and effectiveness. Ipas 2021. <https://www.ipas.org/clinical-update/english/recommendations-for-abortion-before-13-weeks-gestation/medical-abortion/safety-and-effectiveness/> (accessed December 13, 2022).

[8] Abortion care guideline 2022. <https://www.who.int/publications/i/item/9789240039483> (accessed December 23, 2022).

[9] Netshinombelo M, Maputle MS, Ramathuba DU. Women's Perceived Barriers to Accessing Post-Abortion Care Services in Selected Districts in KwaZulu Natal Province, South Africa: A Qualitative Study. *Annals of Global Health* 2022;88. <https://doi.org/10.5334/aogh.3888>.

[10] ABORTION AMONG ADOLESCENTS AND GIRLS n.d. <https://www.ipas.org/wp-content/uploads/2020/07/CSEADG-E19.pdf> (accessed December 23, 2022).

[11] Adolescent pregnancy. UNFPA ESARO 2014. <https://esaro.unfpa.org/en/topics/adolescent-pregnancy> (accessed December 11, 2022).

[12] Comprehensive Abortion Care. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review, Inter-agency Working Group on Reproductive Health in Crises; 2010.

[13] Prata N, Bell S, Gessesew A. Comprehensive abortion care: evidence of improvements in hospital-level indicators in Tigray, Ethiopia. *BMJ Open* 2013;3. <https://doi.org/10.1136/bmjopen-2013-002873>.

[14] Law and Policy Guide: The Right to Information on Abortion. Center for Reproductive Rights 2022.

<https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-the-right-to-information-on-abortion/> (accessed February 1, 2023).

[15] WHO. Safe abortion: Technical & policy guidance for health systems n.d. [https://apps.who.int/iris/bitstream/handle/10665/173586/WHO\\_RHR\\_15.04\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf) (accessed February 1, 2023).

[16] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. *Gynecol Obstet Invest* 1999 n.d.;48:73–7.

[17] Parental Involvement in Minors' Abortions. Guttmacher Institute 2016. <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions> (accessed December 23, 2022).

[18] Abortion among adolescents and girls. Ipas; 2019.

[19] Hang NT, Vung ND. Knowledge and experiences of abortion among adolescent girls in Asia: a scoping review from 2010 to 2020. *Tạp Chí Nghiên Cứu Y Học* 2021;148:165–78. <https://doi.org/10.52852/tcnycyh.v148i12.223>.

[20] Adolescents' Need for and Use of Abortion Services In Developing Countries. Guttmacher Institute 2016. <https://www.guttmacher.org/fact-sheet/adolescents-need-and-use-abortion-services-developing-countries> (accessed December 11, 2022).

[21] Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries 2011. <https://www.who.int/publications/i/item/9789241502214> (accessed December 11, 2022).

- [22] Culwell KR, Hurwitz M. Addressing barriers to safe abortion. *Int J Gynaecol Obstet* 2013;121 Suppl 1:S16–9.
- [23] Shah IH, Åhman E, Ortayli N. Access to safe abortion: progress and challenges since the 1994 International Conference on Population and Development (ICPD). *Contraception* 2014;90:S39–48.
- [24] Rahaman M, Das P, Chouhan P, Das KC, Roy A, Kapasia N. Examining the rural-urban divide in predisposing, enabling, and need factors of unsafe abortion in India using Andersen's behavioral model. *BMC Public Health* 2022;22:1–14.
- [25] Trans-inclusive Abortion Services Manual. Fédération du Québec pour le planning des naissances (FQPN); 2019.
- [26] Besse M, Lampe NM, Mann ES. Experiences with Achieving Pregnancy and Giving Birth Among Transgender Men: A Narrative Literature Review. *Yale J Biol Med* 2020;93:517–28.
- [27] Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I don't think this is theoretical; this is our lives": how erasure impacts health care for transgender people. *J Assoc Nurses AIDS Care* 2009;20:348–61.
- [28] Moseson H, Fix L, Gerdts C, Ragosta S, Hastings J, Stoeffler A, et al. Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States. *BMJ Sex Reprod Health* 2022;48:e22–30.
- [29] Not Up for Debate: LGBTQ People Need and Deserve Tailored Sexual and Reproductive Health Care 2020. <https://doi.org/10.1363/2020.32112>.
- [30] Doi K. Japan: Compelled Sterilization of Transgender People. Human Rights Watch 2019. <https://www.hrw.org/news/2019/03/19/japan-compelled-sterilization-transgender-people> (accessed December 11, 2022).
- [31] Perrault Sullivan, G., Guédou, F.A., Batona, G. et al. Overview and factors associated with pregnancies and abortions occurring in sex workers in Benin. *BMC Women's Health* 20, 248 (2020) n.d. <https://doi.org/10.1186/s12905-020-01091-6>.
- [32] Luchters S, Bosire W, Feng A, Richter ML, King'ola N, Ampt F, et al. "A Baby Was an Added Burden": Predictors and Consequences of Unintended Pregnancies for Female Sex Workers in Mombasa, Kenya: A Mixed-Methods Study. *PLoS One* 2016;11. <https://doi.org/10.1371/journal.pone.0162871>.
- [33] Decker MR, Yam EA, Wirtz AL, Baral SD, Peryshkina A, Mogilnyi V, et al. Induced abortion, contraceptive use, and dual protection among female sex workers in Moscow, Russia. *Int J Gynaecol Obstet* 2013;120:27.
- [34] Maina BW, Mutua MM, Sidze EM. Factors associated with repeat induced abortion in Kenya. *BMC Public Health* 2015;15:1048.
- [35] Workie HM, Kassie TW, Hailegiyorgis TT. Knowledge, risk perception, and condom utilization pattern among female sex workers in Dire Dawa, Eastern Ethiopia 2016: a cross-sectional study. *Pan Afr Med J* 2019;32:185.
- [36] WHO issues new guidelines on abortion to help countries deliver lifesaving care n.d. <https://www.who.int/news/item/09-03-2022-access-to-safe-abortion-critical-for-health-of-women-and-girls> (accessed December 12, 2022).
- [37] ClinicalKey n.d. <https://www.clinicalkey.com/> (accessed December 23, 2022).
- [38] Jones RK, Jerman J. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014. *Am J Public Health* 2022;112:1284–96.
- [39] Addressing Barriers to Safe Abortion. Figo n.d. [https://www.figo.org/resources/figo-statements/addressing-barriers-safe-abortion#\\_edn4](https://www.figo.org/resources/figo-statements/addressing-barriers-safe-abortion#_edn4) (accessed December 12, 2022).
- [40] Hyde Amendment 2007. [https://en.wikipedia.org/wiki/Hyde\\_Amendment](https://en.wikipedia.org/wiki/Hyde_Amendment) (accessed December 13, 2022).

- [41] Zettler PJ, Sarpatwari A. State Restrictions on Mifepristone Access – The Case for Federal Preemption. *New England Journal of Medicine* 2022;386:705–7. <https://doi.org/10.1056/nejmp2118696>.
- [42] Abortion Law: Global Comparisons. Council on Foreign Relations 2019. <https://www.cfr.org/article/abortion-law-global-comparisons> (accessed December 13, 2022).
- [43] Dietz E. Abortion, Disability Rights, and Reproductive Justice. *The Disability Bioethics Reader* 2022;95–102. <https://doi.org/10.4324/9781003289487-14>.
- [44] Trans-Inclusive Abortion Care n.d. <https://transpregnancy.leeds.ac.uk/wp-content/uploads/sites/70/2020/03/FQPN19-Manual-US-Web.pdf> (accessed December 23, 2022).
- [45] Ahmed Z. The Unprecedented Expansion of the Global Gag Rule: Trampling Rights, Health and Free Speech. Guttmacher Institute 2020. <https://doi.org/10.1363/2020.31346>.
- [46] Giorgio M, Makumbi F, Kibira SPS, Bell SO, Chiu DW, Firestein L, et al. An investigation of the impact of the Global Gag Rule on women's sexual and reproductive health outcomes in Uganda: a difference-in-differences analysis. *Sexual and Reproductive Health Matters* 2022;30. <https://doi.org/10.1080/26410397.2022.2122938>.
- [47] Addressing Barriers to Safe Abortion. FIGO n.d. [https://www.figo.org/resources/figo-statements/addressing-barriers-safe-abortion#\\_edn4](https://www.figo.org/resources/figo-statements/addressing-barriers-safe-abortion#_edn4) (accessed December 23, 2022).
- [48] ipas. the impact on YOUNG WOMEN When abortion is a crime n.d. <https://www.ipas.org/wp-content/uploads/2020/06/FSCRYTHE14-ImpactonYoungWomen.pdf> (accessed December 12, 2022).
- [49] Berglas NF, Wingo E, Woodruff K, Roberts SCM. Approaches, barriers, and facilitators to abortion-related work in U.S. health departments: perspectives of maternal and child health and family planning professionals. *BMC Public Health* 2020;20. <https://doi.org/10.1186/s12889-020-8389-2>.
- [50] Steinauer J, Landy U, Filippone H, Laube D, Darney PD, Jackson RA. Predictors of abortion provision among practicing obstetrician-gynecologists: a national survey. *Am J Obstet Gynecol* 2008;198:39.e1–6.
- [51] Barriers to abortion provision in primary care in New England, 2019–2020: A qualitative study. *Contraception* 2023;117:39–44.
- [52] Davy Z. *Recognizing Transsexuals: Personal, Political and Medicolegal Embodiment*. Routledge; 2016.
- [53] Faundes A, Comendant R, Dilbaz B, Jaldesa G, Leke R, Mukherjee B, et al. Preventing unsafe abortion: Achievements and challenges of a global FIGO initiative. *Best Pract Res Clin Obstet Gynaecol* 2020;62:101–12.
- [54] Fowler M. National Abortion Federation Releases 2021 Violence & Disruption Report. National Abortion Federation 2022. <https://prochoice.org/national-abortion-federation-releases-2021-violence-disruption-report/> (accessed December 23, 2022).
- [55] Recent Cases on Violence Against Reproductive Health Care Providers 2021. <https://www.justice.gov/crt/recent-cases-violence-against-reproductive-health-care-providers> (accessed December 23, 2022).
- [56] gender equity. European Institute for Gender Equality n.d. <https://eige.europa.eu/thesaurus/terms/1175> (accessed February 1, 2023).
- [57] Bodily autonomy: A fundamental right. United Nations Population Fund n.d. <https://www.unfpa.org/press/bodily-autonomy-fundamental-right> (accessed December 23, 2022).
- [58] United Nations Human Rights Instruments. International Covenant on Civil and Political Rights

n.d.

<https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>.

[59] WHO. Ensuring human rights in the provision of contraceptive information and services n.d. [https://apps.who.int/iris/bitstream/handle/10665/102539/9789241506748\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/102539/9789241506748_eng.pdf) (accessed December 23, 2022).

[60] Center for Reproductive Rights. The Constitutional Right to Reproductive Autonomy: Realizing the Promise of the 14th Amendment n.d. <https://reproductiverights.org/wp-content/uploads/2022/07/Final-14th-Amendment-Report-7.26.22.pdf>.

[61] Arguments in favour of abortion n.d. [https://www.bbc.co.uk/ethics/abortion/mother/for\\_1.shtml](https://www.bbc.co.uk/ethics/abortion/mother/for_1.shtml) (accessed December 23, 2022).

[62] Wenham C, Smith J, Davies SE, Feng H, Grépin KA, Harman S, et al. Women are most affected by pandemics - lessons from past outbreaks. *Nature* 2020;583:194–8.

[63] Aly J, Haeger KO, Christy AY, Johnson AM. Contraception access during the COVID-19 pandemic. *Contraception and Reproductive Medicine* 2020;5. <https://doi.org/10.1186/s40834-020-00114-9>.

[64] Upadhyay UD, Koenig LR, Meckstroth KR. Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic. *JAMA Netw Open* 2021;4:e2122320.

[65] Reproductive Health of War-Affected Populations: What Do We Know? 2005. <https://doi.org/10.1363/2000.13930>.

[66] Ciobanu C. Ukrainian War Rape Victims Abandoned by Polish State. *Balkan Insight* 2022. <https://balkaninsight.com/2022/07/12/ukrainian-war-rape-victims-abandoned-by-polish-state/> (accessed December 11, 2022).

[67] Correspondents MEE. Abortion in war time: How women break taboos in Yemen. *Middle East Eye* n.d. <http://www.middleeasteye.net/news/abortion-war-time-how-women-break-taboos-yemen> (accessed December 11, 2022).

[68] Supporting those on the frontline of the climate crisis with choice. Marie Stopes International n.d. <https://www.mschoices.org/what-we-do/supporting-those-on-the-frontline-of-the-climate-crisis-with-choice/> (accessed December 11, 2022).

[69] The Link Between Climate Change and Sexual and Reproductive Health and Rights. *Women Deliver*; 2021.

[70] Cousins S. COVID-19 has “devastating” effect on women and girls. *Lancet* 2020;396:301–2.

[71] The World’s Abortion Laws. Center for Reproductive Rights 2022. <https://reproductiverights.org/maps/worlds-abortion-laws/> (accessed December 13, 2022).

[72] Department of Health, Care S. At home early medical abortions made permanent in England and Wales. GOVUK 2022. <https://www.gov.uk/government/news/at-home-early-medical-abortions-made-permanent-in-england-and-wales> (accessed December 13, 2022).

[73] Abortion statistics, England and Wales: 2021. GOVUK n.d. <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021> (accessed December 13, 2022).

[74] Information on abortion. Ministry of Health NZ n.d. <https://www.health.govt.nz/your-health/healthy-living/sexual-health/information-abortion> (accessed December 13, 2022).

[75] Abortion legislation. Ministry of Health NZ n.d. <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/abortion-services-information-health-practitioners/abortion-legislation> (accessed December 13, 2022).

[76] CAMBODIA - As stigma wanes, (safe) abortions rise - International Campaign for Women's Right to Safe Abortion (SAWR). International Campaign for Women's Right to Safe Abortion (SAWR) 2020. <https://www.safeabortionwomensright.org/news/cambodia-as-stigma-wanes-safe-abortions-rise/> (accessed December 23, 2022).

[77] Abortion Laws in Cambodia n.d. <https://www.howtouseabortionpill.org/abortion-laws-by-country/cambodia/> (accessed December 23, 2022).

[78] Law on Abortion n.d. [http://www.skpcambodia.com/storage/uploads/files/Health\\_Medicine\\_Disabilities/Law%20on%20Abortion%20Law\\_Eng.pdf](http://www.skpcambodia.com/storage/uploads/files/Health_Medicine_Disabilities/Law%20on%20Abortion%20Law_Eng.pdf) (accessed December 23, 2022).

[79] Petitet PH. Abortion politics in Cambodia social history, local forms and transnational issues. *Glob Public Health* 2018. <https://doi.org/10.1080/17441692.2017.1354228>.

[80] Maternal mortality ratio (modeled estimate, per 100,000 live births) - Cambodia n.d. <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=KH> (accessed December 24, 2022).

[81] Sobol V. Colombia: Historic Advancement in the Decriminalization of Abortion. Center for Reproductive Rights 2022. <https://reproductiverights.org/colombia-historic-advancement-decriminalization-abortion/> (accessed December 13, 2022).

[82] Sobol V. Mexico Supreme Court Recognizes a Constitutional Right to Abortion. Center for Reproductive Rights 2021. <https://reproductiverights.org/mexico-supreme-court-decriminalizes-abortion/> (accessed December 13, 2022).

[83] Goldberg J. In Historic Victory, Argentina Legalizes Abortion. Center for Reproductive Rights 2021. <https://reproductiverights.org/historic-vote-argentina-legalize-abortion/> (accessed December 13, 2022).

[84] Felitti K. It is already law: background and challenges of abortion legalization in Argentina n.d. <https://doi.org/10.4000/cal.11830>.

[85] Warda M, Zribi N. Abortion in Tunisia: a groundbreaking law, yet without any guarantees n.d. <https://inkyfada.com/en/2022/06/13/abortion-tunisia-law-groundbreaking-right-no-guarantee/> (accessed December 23, 2022).

[86] Maffi I, Affes M. The Right to Abortion in Tunisia after the Revolution of 2011: Legal, Medical, and Social Arrangements as Seen through Seven Abortion Stories. *Health Hum Rights* 2019;21:69.

[87] Terminate pregnancy n.d. <https://www.gov.za/services/birth/terminate-pregnancy> (accessed December 24, 2022).

[88] Abortion in Sub-Saharan Africa. Guttmacher Institute 2020. <https://www.guttmacher.org/fact-sheet/abortion-subsaharan-africa> (accessed December 24, 2022).