



IFMSA

International Federation of
Medical Students' Associations

IFMSA Policy Document Ensuring Access to Safe Abortion

Proposed by Team of Officials

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Policy Statement

Introduction:

The Universal Declaration of Human Rights (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. Access to safe abortion and post-abortion care is crucial to achieve this right among individuals able to get pregnant; it has been proven to reduce complications and 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 and emphasizing crisis situations.
- Review and reform restrictive laws and regulations that limit access to safe abortion, adopt evidence-based policies and eliminate unnecessary and discriminatory requirements such as mandatory waiting periods, thor-party authorizations, and invasive medical exams that hinder access to safe abortion.

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 de-stigmatization 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 sustainable 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 rights.
- 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 understand how to communicate and understand the differing needs of patient populations who may have further limited access to termination services.

Media, including social media workers 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 securing abortion rights and reproductive health and fights against discrimination and stigma, hence promoting a community with no barriers to accessing abortion.
- Advocate for the elimination of any insensitive and anti-abortion material in the 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 using their local dialect to bridge any communication gaps.
- 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 emphasizes 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, or 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.”

Every year, nearly half of all pregnancies, amounting to 121 million, are unintended. Around 6 out of 10 unintended pregnancies and approximately 3 out of 10 pregnancies overall result 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.[1]

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. Securing access to evidence-based abortion care, which encompasses safety, respect, and non-discrimination, is crucial for achieving the Sustainable Development Goals (SDGs) related to good health and well-being (SDG3) as well as gender equality (SDG5).. [2]

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. [3]

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 related to human rights regularly call for governments to decriminalize abortion, make it safe and affordable in all cases and ensure access to safe, legal abortion in certain circumstances at a minimum. [4]

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, health, and dignity. Authoritative interpretations of international human rights law clarify that the denial of access to abortion for pregnant individuals constitutes discrimination and poses a threat to various human rights. Human rights law clearly states that the decisions about one's own body are theirs alone, called "bodily autonomy". Countries have an obligation to respect, protect, and fulfill human rights, including those concerning sexual and reproductive health and autonomy. [4]

These rights are outlined in the Universal Declaration of Human Rights and safeguarded in numerous international agreements such as 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). They are also protected through regional treaties in Africa, the Americas, and Europe. [4,5]

Imposing legal restrictions on abortion frequently leads to an increase in illegal abortions, which can be unsafe and contribute to elevated rates of maternal mortality and morbidity. Consequently, the absence of access to safe and legal abortion endangers the lives of pregnant individuals and undermines their ability to exercise their right to life. [4].

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. [6] Most abortions occur before the fetus is 12 weeks gestation as the medication and surgical procedures become less effective after this time point. [7]

Current recommendations

- Medical abortion

For medical abortion, mifepristone and misoprostol are recommended when the fetus is under 12 weeks gestation. 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 combined with mifepristone. [8]

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. [8]

- 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) are recommended. [8]

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. [9] For these reasons, medical abortion methods are becoming more prevalent and more commonly used in high-income countries. [7]

- Self-management of medical abortion

As stated by the WHO Abortion Care Guidelines, self-management of abortion refers to managing the entire process of medical abortion, in whole or in part. This encapsulates self-assessment of the eligibility for medical abortion (determining pregnancy gestations), self-administration of medicines and pain management regimens (usage of the combination regimen of mifepristone and misoprostol or misoprostol alone is recommended) without the direct supervision of a health worker, and self-assessment of the success of the abortion process.[6] This assists people to feel more empowered and autonomous about their own health and increases accessibility for all.[6] When it comes to such practice, there is growing evidence supporting self-management of medical abortions before ten weeks of gestation, requiring all individuals to have access to appropriate services and information.[6]

The WHO stresses on the importance of having accurate information for individuals choosing to engage in self-management of medical abortion, in addition to pain management medicines, the support of trained health workers, and access to a health-care facility and services. Moreover, while it is possible for individuals to self-manage the process by themselves, they drive the decision making process, but this typically co-exists with the supervision and interaction with a trained health worker during this practice. [10]

Furthermore, a recommendation relating to telemedicine referral has been proposed to facilitate self-managed early medical abortions as an alternative to in-person interactions with the health worker, further highlighting the necessity of having experts' support during the procedure.[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. [11] 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. [9] 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. [11] 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.[11] 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 want 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 or complications. Globally, unsafe abortions are among the leading causes of maternal deaths each year [12].

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 the abortion is medical or surgical and how long 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) [13]. Thus, abortions performed under safe, sterile, and controlled conditions pose a minimal risk of medical consequences. Extensive research has proven that abortions pose little to no long-term adverse effects 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 [14].

While abortions, if performed in accordance with the guidelines, are safe, the WHO estimates that annually 20 million of the 42 million abortions taking place 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 mortality and suffering from complications brought about by unsafe abortions. PAC included five major elements: treatment of incomplete 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 and the legal indications of safe abortions [15]. The guidelines were updated in 2021 and now have 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 reducing unsafe abortions and, therefore, the subsequent complications that may occur [16].

Access to information on abortion

Access to information about abortions, being a considerable 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) [17] advocates for information to be available for all individuals without discriminating against any group. Considering age 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 [18], health systems 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) [19] recommends that any counseling on the topic of abortion should be impartial, non-judgmental and inclusive. Neither society nor healthcare team members should use their own convictions to impact pregnant individuals' decisions.

According to studies conducted on the subject, the incorporation of Comprehensive Sexual Education from early school stages reduces the risk of unwanted pregnancies, while also providing greater knowledge about contraceptive methods and barrier methods, thus preventing the transmission of STIs [20,21].

Compulsory pre and post abortion care

Access to safe abortion can also be compromised through an over medicalisation of the procedure. Pre-abortion care in the form of a compulsory ultrasound increases the direct costs of the abortion process and thus limits its accessibility. Compulsory pre-abortion ultrasounds are frequently used to assess the gestational age in countries with gestational age based limitations, which the WHO recommends against. Complying with this guideline would significantly reduce the need for pre-abortion ultrasounds, thus not exposing people who require abortions to unnecessary medical procedures as well as to increased costs and waiting time.[6]

Another frequent component of pre-abortion care legislation are compulsory reflection periods and third party authorization requirements. These pose threats to the gestating person's autonomy, and are directly recommended against in WHO's 2021 guidelines regarding access to safe abortion. Compulsory reflection periods pose an additional barrier to accessing safe abortion, as complying with them frequently requires stay in distant cities or villages to one's home, forcing a need for work leave and assurance of one's responsibilities in the home setting, as well as the financial capacity to travel and grant stay during the required reflection period.[22]

Imposing the mandatory requirement of pre-abortion counseling not only violates essential human rights of women, such as the right to self-determination and reproductive autonomy, but it could also discourage numerous women from seeking safe abortion services and lead them to resort to clandestine providers. Pre-abortion counseling could play a valuable role in providing clarity and enhancing the individual's understanding of the risks involved in the process, as well as addressing specific needs related to social, psychological, and contraceptive aspects. However, at present, this perspective is unattainable.[23]

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. [24] As of today, there is no objective data on the incidence of unsafe abortion rates in the Global South, but estimates suggest that adolescents aged 15-19 account for 3.7 million unsafe abortion procedures every year. [25]

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. [14][26]

Worldwide, there are several gaps in the provision of health services related to abortion care. For example, minimal adolescent post-abortion care is often 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.) [27]

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. Some of the suggested measures encompass: lowering the prevalence of marriage before reaching 18 years of age; promoting the usage of contraception among adolescents who are at risk of unintended pregnancies; decreasing instances of coerced sexual activity among adolescents; minimizing unsafe abortions among adolescents; and expanding the utilization of skilled antenatal, childbirth, and postnatal care services among this demographic. [28]

Another important correlation we should consider 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. [29][30] 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. [31]

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 diverse 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 hormone replacement therapy or 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. [32] 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. [33] Secondly, accessing safe abortion services while already facing stigma and discrimination for their identity faced by members of the community is even more challenging. [34] 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. [35]

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). [36]

Furthermore, countries like Japan apply forced sterilization laws for transgender individuals upon accessing reproductive health services. [36,37] 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%). [38] Both that study and the study in Mombasa, Kenya [39] 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 associated with abortion, as shown in female sex workers in Russia.[40] That phenomenon can be explained by the fact that most female sex workers already had their children prior to their work. A study [41] conducted by the African Population and Health Research Center in Kenya associates having 1-2 prior births with a higher likelihood of repeating an abortion. The pressure of clients or emotional partners not to use condoms are shown as the main reason for unsafe sexual practice. A cross-sectional study [42] 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. [43]

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. A study 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 and 49. [44]

The major effect of this is seen in individuals from marginalized communities and people of lower income. [45,46] Within the realm of U.S. politics, the Hyde Amendment is a legislative provision that prohibits the utilization of federal funds for covering the expenses of abortion, except in cases where the woman's life is at risk or the pregnancy is a result of incest or rape. Along with this, the Risk Evaluation and Mitigation Strategy (REMS) for mifepristone limits access to mifepristone, one of the two drugs used for medical abortion. [47][48]

In Poland, in 2020, a new rule that declared abortions in cases of fetal impairment unconstitutional was passed. Before this ruling, most abortions performed in public hospitals in Poland were due to fetal anomalies. This decision initiated a near-total ban in the country. [49]

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 changed the constitution, which made it mandatory to have a three-quarters majority to make any change to the existing abortion laws. [49]

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. [50][51]

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 [52,53].

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 significant factor. [46,49]

- 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. [54,55]

- Healthcare providers

In a study of obstetrician-gynecologists, about half (52%) of those who intended to provide abortions before residency were providing them post-residency. The most common reasons cited by the other half for not providing abortion were personal beliefs and practice restrictions. [56] [57] [58]

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 adverse health consequences. They feared disapproval and judgment by community members based on 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 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 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. [59–61]

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 provided 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 with severe shortages of competent professionals, but advancing treatment that might better match pregnant people's and women's needs is also essential. The recommendations presume that the designated health workers will get task-specific competency-based training and that the interventions will comply with current WHO clinical care guidelines.

Healthcare practitioners in nations where abortion is legal are responsible for caring 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 access to legal abortion services is not hindered. Medical personnel must tell patients about the legality of abortion and where to find abortion care.

Gender equality, bodily autonomy and abortion.

Gender equality refers to ensuring that men and women are treated equally and have equal access to opportunities, resources, and rights. It aims to eliminate discrimination and promote fairness in all aspects of life, including education, employment, and social and political participation. Gender equality seeks to create a level playing field where individuals of all genders have the same rights and opportunities.[62]

One of the main struggles pursued by gender equality is the free and safe access to abortion, utilizing as its fundamental basis the fundamental freedom of bodily autonomy and equal access to reproductive health.[63]

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 not only a fundamental right but also serves as the cornerstone for achieving gender equality. [64]

The fundamental right to equality and privacy regarding matters of physical and psychological integrity encompasses the essential right of individuals to make independent decisions regarding their own bodies and reproductive functions. [46,65]

Equality in reproductive health includes access, without discrimination, to affordable, quality contraception, including emergency contraception. Countries where people have the right to terminate pregnancy and are provided with access to information and to all contraception methods 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. [66]

The decision regarding the continuation or termination of a pregnancy is fundamentally and primarily the woman's choice, as it can significantly influence her personal and family life in the future and have a critical impact on the enjoyment of other human rights by individuals involved. 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. [67]

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 determine if 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 can they achieve equality with cis men: cis men don't get pregnant and 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 significantly affects 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. [70]

Women constitute a significant portion of global economic activity. However, they are often compelled to assume caregiving roles for their children, and numerous studies demonstrate that in many communities how motherhood and childcare directly impact women's career development. Furthermore, there exists a global "motherhood penalty" that hinders women's participation in economic decision-making and access to paid work. The Manual of Feminist Economics shows that policies promoting reproductive rights, including access to safe abortion, enhance women's quality of life and their engagement in the economy, leading to an increase in labor market participation by up to 5%. [68][69]

Taking all these factors into account, it can be concluded that individuals with the capability to conceive should have unrestricted access to abortion, enabling them to attain complete parity with cisgender men in terms of political, social, and economic equality. Women require the freedom to choose abortion in order to enjoy the same liberties as men, and they deserve the autonomy to make decisions about their own bodies, including the choice to carry a fetus to term or not. Without this fundamental right, they are deprived of the equivalent moral standing as cisgender men. [70].

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 due to the COVID-19 pandemic. [71] The pandemic is also an aggravating factor of up to 7 million unintended and unwanted pregnancies with serious consequences such as increased 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. [71,72]) 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. [73]

Economic crises and war are other aggravating factors that women must deal with globally 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 providing food, water, shelter, and basic health care, which unfortunately leaves those needs a very low priority. [71,72,74]

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 2022, more than 500 women have sought abortion services in the refuge. An insurmountable barrier to access to safe abortion for those women is extremely harsh and restricts abortion laws in their new country. As of 2020, abortion is legal in Poland only when the mother's life is in danger or if the pregnancy results from rape or incest, which is unfortunately very time-consuming and hard to prove. [75] 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 choose a 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. [76]

Another strong correlation we should consider is the connection between climate change and the risk of losing reproductive choice. Climate change is estimated to displace more than 216 million people, mainly 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 to lead to an additional 6.2 million unintended pregnancies, 2.1 million unsafe abortions, and 5,800 maternal deaths [77][78].

MSI runs many clinics in countries like Nepal and India, 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 these clinics opened up post-lockdown, 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 [79].

In conclusion, it is essential to ensure access to sexual and reproductive health, including access to safe abortion in crisis situations, and to recognize it as an essential service that should not be neglected. Otherwise, it will have a negative impact on health, as has already been seen in various situations.[80]

Positive country-level solutions

At a global level, a significant 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. Countries with programs and laws that promote safe and equal access to abortion services can be examined to showcase the diversity of approaches to improve access to safe abortion [81].

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 18 being able to readily and safely access abortion services [82,83].

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 people face when accessing safe abortion services. Individuals can now self-refer to a service provider, and a more comprehensive range of health professionals (doctors, registered nurses and midwives) can now provide abortions. Furthermore, abortions are no longer required to occur at a licensed premise, allowing for access via telehealth [84][85].

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. [86][87][88]. These laws were first introduced due to a high maternal mortality rate that was associated with unsafe abortion practices. [89] 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 [90].

Colombia

Colombia is an example of a country that has recently seen a significant 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 pregnancies for specific grounds. This historical decision overturned previous laws, which, before 2006, punished people for inducing an abortion. These changes to the constitution of Columbia highlight positive healthcare reform achieved through ongoing advocacy work. [91] 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 [92,93].

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 [94], 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 to improve the socioeconomic status of Tunisia's citizens. This decision was based on a political agenda, not promoting 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. [95,96]

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. [97] 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. [6][98]

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 based on 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 reproductive 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. Small Working Groups 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 (Maternal Health and Access to Safe Abortion) Camp-April 2021
4. Regional Challenges in Access to Safe Abortion in the Americas Regional Meeting 2020
5. Africa Regional Meeting 2021 - 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), Eastern Mediterranean Region (3), and Americas (1). No activities from Europe were enrolled. One year later, the number dropped to 4 activities globally, with one activity per region, except for Europe, with no activity on access to safe abortion at all [99–101].

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