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MEDICAL ABORTION MATTERS

Sharing global perspectives

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INNOVATIONS: *Harm reduction: A novel approach to addressing unsafe abortion*

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Most people associate the public health model called harm reduction with the innovative clean needle exchange programs started in the 1980s to curb HIV infection among intravenous drug users. Since then, however, harm reduction has become an evidence-based approach to reducing public health risksâ€"including those from unsafe abortion.

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WHAT MATTERS TO YOU?

Q: *What are the most important updates on medical abortion from the World Health Organization?*

A: The World Health Organization's second edition of *Safe abortion: Technical and policy guidance for health systems* includes many important new guidelines for medical abortion provision. In addition to updated dosing regimens, the guidance offers evidence-based recommendations to improve women's access to services and eliminate unnecessary requirements. Significantly, the guidance also stresses that women should have a choice of abortion methods. Ipas's Dr. Dalia Brahmi, senior clinical adviser, has summarized key recommendations for *Medical Abortion Matters*.

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COUNTRY MATTERS: *Safe abortion services gain a foothold in Zambian communities*

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In 2009, Zambia's Ministry of Health, University Teaching Hospital in Lusaka, Ipas and local collaborating partners undertook a two-year operations research study in Zambia. The purpose: to introduce medical abortion and to explore service delivery and community intervention models to increase access to safe abortion. Providers in 28 hospitals and health centers were trained in safe abortion and postabortion care (PAC), and eight community-based organizations worked to raise awareness of how to access safe services.

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PERSPECTIVES: *'It was worth the sacrifice': Kenya's Dr. John Nyamu on why he spent a year in prison*

A newly ratified Kenyan constitution allows for legal abortion on much broader groundsâ€"and, when the new law is fully implemented, it stands to dramatically increase women's ability to exercise their reproductive rights. Ipas's senior clinical advisor Mary Fjerstad recently sat down with Kenya's much-respected Dr. John Nyamu to discuss the long and difficult path he and so many other Kenyans have traveled to get where they are today.

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FEATURED ORGANIZATION: *Menstrual Regulation with Medication (MRM) Working Group, Bangladesh*

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In Bangladesh, menstrual regulation (MR) refers to a procedure for inducing menstruation to "establish non-pregnancy" for a woman who thinks she might be pregnant. MR in Bangladesh is typically provided by vacuum aspiration. Formed by a group of nongovernmental organizations in 2006, Bangladesh's Menstrual Regulation with Medication (MRM) Working Group advocates for government approval of menstrual regulation with medication using mifepristone with misoprostol.

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RESOURCE SPOTLIGHT: *Interactive website from Mexico offers information on pregnancy termination*

Available in Spanish and intended primarily for young women, this visually engaging and interactive website presents the story of Claudia and Pedro, a young couple facing an unwanted pregnancy and seeking information on abortion. Through their narrative, the website poses questions that lead users to information about pregnancy identification, estimating gestational age, and pregnancy options including misoprostol for pregnancy termination.

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RESOURCE SPOTLIGHT: *Medical Abortion Supply Guidance*

Available in English, Spanish and French, the Ipas *MA Supply Guidance Tool* allows you to quickly and easily calculate your facility's average monthly use of misoprostol (and mifepristone, depending on your setting) and recommended minimum and maximum inventory levels. This simple supply management tool can be successfully used in service delivery settings offering misoprostol for PAC, misoprostol for induced abortion, and mifepristone with misoprostol for induced abortion. Visit www.masupplyguidance.org to use the online version or download the tool to your desktop. To request the tool on CD-ROM,

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'It was worth the sacrifice': Kenya's Dr. John Nyamu on why he spent a year in prison

Kenya's Dr. John Nyamu is a long-time advocate for women's reproductive rights.

Until 2011, abortion was illegal in Kenya except to save a woman's life. For years the climate of fear and secrecy surrounding abortion hurt women, their families, and health-care providers. Unsafe abortion in Kenya still causes an estimated 30 percent of maternal deaths and countless other injuries.

Now, a newly ratified Kenyan constitution allows for legal abortion on much broader terms—and, when the new law is fully implemented, it stands to dramatically increase women's ability to exercise their reproductive rights.

Ipas's senior clinical advisor Mary Fjerstad recently sat down with Kenya's much-respected Dr. John Nyamu to discuss the long and difficult path he and so many other Kenyans have traveled to get where they are today.

Mary Fjerstad: **Doctor Nyamu, would you tell me what the situation was like in Kenya when abortion was considered a criminal act?** [*Editor's note: Before constitutional reform, abortion in Kenya was highly restricted with few legal indications for having the procedure.*]

Dr. John Nyamu: Most health-care workers were afraid of talking about it openly. Abortion was never performed in government hospitals unless the life of the woman was in real danger. Even then it was very bureaucratic as one doctor could only do the procedure with permission in writing from two other doctors; one doctor had to be a psychiatrist and the other doctor had to be a senior doctor in the hospital. Abortions were performed by D&C or induction. In reality, these legal abortions were provided almost exclusively at Kenyatta National Hospital, provincial hospitals and very rarely in district hospitals. (Kenyatta National Hospital is the major teaching hospital in Nairobi).

There were wards in hospitals where women who had unsafe abortions were treated for uterine and bowel damage due to perforations and developed sepsis, brain damage and many women died.

There was tremendous secrecy about abortion, women were aborting late. The penalty for a doctor who performed an [illegal] abortion was 14 years [in prison]; pharmacists could be imprisoned for three years for giving abortifacient medicines and women themselves could be imprisoned for seven years for having an abortion.

Some private clinics were providing safe abortion. They were harassed regularly by local police, usually by extortion. They were used virtually as the personal ATMs of the police [*ATM = Automatic Teller Machine, a*

banking machine from which you can withdraw cash using a bank card]. A policeman would say, "I'm short of cash, give me your cash or I'll arrest you." The entire staff, including nurses, doctors and women seeking abortion could be arrested. Due to the fear, the providers kept servicing [the police] to buy their freedom.

Your case was profiled by The Center for Reproductive Rights' paper in 2010, "In Harm's Way: the Impact of Kenya's Restrictive Abortion Law." Can you briefly describe what happened to you that led to this paper?

In 2004, [data were shared] which showed worrying trends and consequences of unsafe abortion in Kenya. This was followed by a major crackdown on clinics, hunts for women who had abortions, some clinics were closed and I was targeted. There were 15 fetuses found along a major road with some documents from a hospital I had worked at previously but had since closed. My clinic was raided and two nurses and I were arrested. This appeared to have been very well organized with all the media including print, radio and TV present to report on the matter. When we were asked to pay bribes, we refused—because we knew the fetuses were not from our clinic and the documents were planted on the road—and we were locked up. [*Editor's note: subsequent pathology examinations found that the fetuses were still-born fetuses, not aborted fetuses.*]

The three of us were ultimately charged with two counts of murder, rather than an abortion-specific offense. Since murder is a non-bailable offense in Kenya, we had to stay in remand prison pending our trial. We all spent a year in prison. One of the nurses was six months pregnant and delivered while she was in prison. One of the nurses still works for me and the other got her green card and has since immigrated to

the United States.

A senior doctor, a gynecologist, was instructed by the Director of Medical Services of the Ministry of Health to accompany the police and inspect the two clinics operated by Reproductive Health Services. The purpose of the inspection was to verify if there was any abortifacient equipment. He gave witness in court that the two facilities had legal equipment normally found in a gynecologist's clinic and he would be surprised if he did not find it as he uses the same equipment for his work. The police forensic department was asked to look for DNA on the equipment from the clinic. DNA was taken from any instruments or equipment with blood on them—even the couches and lab coats were confiscated. The results from the government chemist found that there was no DNA linkage between the fetuses found on the road and any blood specimens from the clinic. The doctor also found that the clinic was duly registered and all staff had proper and up-to-date licenses.

The case was eventually ruled as improper [*Editor's note: They were acquitted of all charges*]. With that ruling, the attorney general decided not to pursue prosecution due to lack of evidence.

Was it horrible being in prison for a year?

Yes, it was horrible, but it was worth the sacrifice. I was held at the Kamiti Maximum Prison, which is where the hard-core criminals are remanded. I was confined in a small cell for a whole year. I really felt persecuted, but as I said, it was worth the sacrifice.

Why do you say it was worth the sacrifice?

My arrest and imprisonment was in the media virtually every day. The publicity was an opening for people to realize the magnitude and consequences of unsafe abortion in Kenya; women were dying in great

numbers. Before that, abortion was never spoken of in public. There are only about 250 OB/GYNs in Kenya; some districts have none. The media sensation from this case galvanized the Kenya Obstetrical and Gynaecological Society (KOGS), the National Nurses Association of Kenya, the Federation of Women Lawyers, human rights advocates, women's rights organizations and many others to form an alliance of reproductive health rights advocates.

This alliance exists to date and is known as the Reproductive Health and Rights Alliance (RHRA). The RHRA is an advocacy platform to agitate for the reduction of maternal mortality and morbidity due to unsafe abortion. This alliance also offers technical support to abortion service providers through Reproductive Health Network (RHN). The public became aware of abortion and the toll of unsafe abortion. The window was open to the public to realize the terrible toll of unsafe abortion in Kenya.

This debate extended to the drafting of a new Constitution in 2010. The Constitution says that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including *reproductive health care*."

My arrest, imprisonment and [the resulting] publicity generated a public awareness that led to a transformation in the understanding that safe abortion is essential to preventing maternal morbidity and mortality.

Is there any further action in your own case?

Yes, I have since sued the government for malicious prosecution and subsequent confinement for one year in remand prison. The case has been in court for the last six years without yet being assigned a hearing.

What does the expansive definition of health in the new constitution mean in terms of when an abortion is considered legal?

Abortion is legal if the pregnancy endangers the life of the woman; as an emergency treatment; or when it endangers health, with health defined broadly: physical, social and mental. If in the opinion of a trained health professional an abortion is provided in good faith (in other words, where the pregnancy jeopardizes the woman's physical, social or mental health), it is legal. [*Editor's note: Under the new law, a woman can make her abortion decision with one health-care provider; others are not required to be involved or sign-off on the decision.*]

What categories of health-care providers can perform legal abortion?

Physicians, nurses, midwives and clinical officers [who have completed training to perform abortion services] can now perform legal abortions.

What are the next steps in transforming the policies to establish safe, legal abortion in Kenya?

Ipas and other organizations took the lead in writing a document called, "Standards and guidelines for reducing morbidity and mortality from unsafe abortion." The title is taken from a similar document from Zimbabwe and is brilliant. Kenya, like other countries, wants to achieve the Millennium Development Goal of 75-percent reduction in maternal mortality; this can't be achieved if safe abortion isn't available.

The other milestone on transformation is the revision of codes of ethics and scope of practice for all the professional associations in Kenya. These have been done and are waiting to be launched.

This transformation to legal abortion access in Kenya is a testament to very brave, inspired people dedicated to the common good who have sacrificed a lot. How have all the changes we've discussed affected providers of safe abortion and women?

Providers are now aware of the enhanced protections that have been offered by the constitution. This in turn has increased access to safe abortion services and thereby enabled women to realize their reproductive health rights. In addition, incidences of provider harassment are now on the decrease.

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Medical Abortion (MA) Supply Guidance

The Ipas *MA Supply Guidance Tool* is a simple supply management tool that can be successfully used in service delivery settings that use misoprostol for postabortion care (PAC) as well as in settings where both misoprostol for PAC and induced abortion are available. This tool will enable you to quickly and easily calculate your facility's average monthly consumption of misoprostol (and mifepristone, depending on your setting) and recommended minimum and maximum inventory levels. This tool was developed by Ipas.

The *MA Supply Guidance Tool* is also available:

- online in Spanish and
- for download in Zip and Excel format in English, French and Spanish .

To Launch The Tool, Choose Your Type of Facility:

*Please ensure popup blockers are OFF.

My facility uses misoprostol for PAC and other indications, but NOT for induced abortion.

Launch The Tool

My facility uses misoprostol for PAC and other indications, and our services include induced abortion.

Launch The Tool

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Menstrual Regulation with Medication (MRM) Working Group, Bangladesh

In Bangladesh, menstrual regulation (MR) refers to a procedure for inducing menstruation to "establish non-pregnancy" for a woman who thinks she might be pregnant. MR in Bangladesh is typically provided by vacuum aspiration.

Formed by a group of nongovernmental organizations in 2006, Bangladesh's Menstrual Regulation with Medication (MRM) Working Group advocates for government approval of menstrual regulation with medication using mifepristone with misoprostol. Although MRM using the mifepristone-misoprostol regimen is being studied, mifepristone is not yet approved in Bangladesh. However, misoprostol is widely available and approved for a range of indications, including postabortion care. Through outreach, advocacy and research efforts, the Working Group is actively pursuing approval and introduction of MRM as a safe, simple and affordable option for women.

Founded by Marie Stopes Bangladesh; the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B); Bangladesh Women's Health Coalition (BWHC); Bangladesh Association of Prevention of Septic Abortion (BAPSA); Reproductive Health Services Training and Education Program (RHSTEP) and the Family Planning Association of Bangladesh (FPAB), the MRM working group now also includes Ipas Bangladesh and the Obstetrical and Gynaecological Society of Bangladesh (OGSB), and is chaired by the Directorate General of Family Planning (of the Ministry of Health).

To learn more, read ICDDR,B's factsheet on acceptability and feasibility of MRM in Bangladesh.

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Safe abortion services gain a foothold in Zambian communities

Agnes Kalumba* sits outside her house watching children play with a soccer ball and occasionally waving to passing neighbors. Agnes is by all means an ordinary community member who is known by almost everyone in the village, including for her ability to help women procure abortions.

"I am very well known in my community, but I regret that I am also known for the wrong reasons. I used to help women and girls procure unsafe abortions using local herbs. I thought I was helping them a lot," she says.

Agnes shares that because of her role as a well-known community worker, women used to come to her for all sorts of advice, including how to terminate unwanted pregnancies. She knew of local herbs that could be used, and she charged for her services. At the time, she says, she was convinced she was helping these desperate women.

“Most women came to me as their last resort. Even girls whose lives and future [were] at risk came to me and referred others to me,” Agnes says. “However, this has changed as I have come to realize the level of damage and risk I put these women through.”

Agnes’s story is typical in Zambia. Even though Zambia’s Termination of Pregnancy Act of 1972 permits abortion for health reasons and on socioeconomic grounds, many women still resort to dangerous, clandestine procedures because of the social stigma and myths surrounding abortion, the cost of the procedure and lack of knowledge about the abortion law. Many women are also not aware that safe abortion services are available in the public sector hospitals and clinics.

Research study introduces medical abortion—and builds community awareness

In 2007, it was estimated that 591 maternal deaths occurred for every 100,000 live births in Zambia.[1] A study on adolescent sexual and reproductive health in urban Zambia found that an estimated two-thirds of unwanted pregnancies ended in unsafe abortion, and that young people rejected the use of formal services because of perceived lack of privacy and confidentiality, often opting instead to self-induce by overdosing on chloroquine or using traditional medicines.[2] Many women—especially young women—are also driven to seek unsafe abortions because they lack access to contraception and because pregnancy outside of marriage is highly stigmatized.

In 2009, Zambia’s Ministry of Health, University Teaching Hospital in Lusaka, Ipas and a number of local collaborating partners undertook a two-year operations research study in Zambia, primarily to introduce medical abortion and to explore service

delivery and community intervention models to increase access to safe abortion.

During the study, providers in 28 hospitals and health centers in Lusaka, Kafue and Copperbelt were trained to provide postabortion care (PAC) for women who have unsafe abortions and to provide safe and legal abortion services.

In addition, eight local community-based organizations were selected to raise awareness in communities on the prevention of unplanned pregnancy, the dangers of unsafe abortion, the abortion law in Zambia, and where to access safe abortion services.

In some areas, local pharmacy workers were also trained to respond to clients seeking information on unplanned pregnancy in a compassionate manner, to provide accurate information on regimens and usage of medical abortion pills and to provide referral information to women seeking information about safe abortion services in a health facility.

In the participating health centers, women less than 9 weeks pregnant were offered a choice of abortion method, and 73 percent of women interviewed had a medical abortion, usually with mifepristone and misoprostol. However, study results indicate that providers seem to prefer MA for pregnancy termination —sometimes causing women to feel that they themselves did not choose their own abortion method.

Approximately 50 percent of MA clients returned for their follow-up appointments, a point of initial concern to providers that diminished over time as they became more comfortable with the method.

The drug supply for medical abortion was problematic during the study as mifepristone was yet to be integrated into the Medical Stores procurement and delivery system. Stock-outs were common during the

early part of the intervention and have continued to curb the expansion of MA throughout the intervention sites. Maintaining a consistent supply of mifepristone is essential to ensuring consistent service availability as more women learn about and seek out MA services. However, MA distribution during the intervention improved networking and collaboration among facilities; to avoid stock-outs, hospitals became drop-off and distribution points for drugs and took on a mentoring and on-site training role to nearby health centers.

Community involvement engenders positive change

By the end of the intervention period, evidence showed that cases of abortion complications had decreased in some communities where safe and legal abortion services are increasing—potentially indicating a decline in unsafe abortions as women begin to know about and seek safe and legal abortion services.

Thanks to a community intervention, Agnes participated in the study too: “A local Neighborhood Committee identified me for a meeting where they were discussing the dangers of unsafe abortion. After attending several meetings, I decided to stop providing unsafe abortions and joined the group, and now girls and women come to me for advice and escort services to the local clinic where they can be attended to by trained doctors.”

Agnes is now a reproductive health educator in her community. She admits the change has been hard for her because she has lost income. Plus, she is afraid of community backlash, including women not trusting her. Some fear she is now working with local law enforcement to hunt down women who need safe abortions. Agnes says she is working hard to change that perception, but she is also happy that women and girls still view her as a resource for information on

reproductive health issues.

There are several reproductive health organizations—such as Planned Parenthood Association Zambia (PPAZ), Marie Stopes International (MSI) Zambia and Youth Vision Zambia—working to decrease the stigma surrounding abortion, raise awareness of how safe abortion saves women's lives, and increase the capacity of public health hospitals and clinics to ensure women area able to access safe services.

"At first, it was scary for women to walk into the clinic and ask for these services," Agnes explains. Now, along with other community members, Agnes advocates for higher-quality services in her local clinic.

"I would not be working on this issue had it not been for the community intervention; I think I would still be performing clandestine abortions," she says. "The best part of this is that we are not simply talking about unsafe abortion, but that we are able to refer women to safe, affordable services ... and that is the good thing about our law here in Zambia."

**Name has been changed.*

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1. Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, & Macro International Inc. 2009. *Zambia demographic and health survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inc.
2. Webb, D. Attitudes to 'Kaponya Mafumo': the terminators of pregnancy in urban Zambia. 2000. *Health Policy and Planning*, 15 (2): 186-193.

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What are the most important updates on medical abortion from the World Health Organization?

The World Health Organization published its second edition of *Safe abortion: Technical and policy guidance for health systems* in June 2012, including many important new guidelines for medical abortion provision. Significantly, the guidance stresses that women should have a choice of abortion methods.

This evidence-based document can be used to inform the revision of national standards, guidelines, and clinical protocols, as well as to reform legally restrictive abortion laws. The guidance also uses an integrated human rights and public health approach to support women's reproductive rights and advance access to safe abortion.

In addition to updated dosing regimens, the new guidance offers the following evidence-based recommendations to improve women's access to services and eliminate unnecessary requirements. Here Ipas's Dr. Dalia Brahmi, senior clinical adviser, has summarized key recommendations for *Medical Abortion Matters*:

- Use of routine pre-abortion ultrasound scanning is not necessary.

- Medication for pain management (e.g. non-steroidal anti-inflammatory drugs like ibuprofen and diclofenac) should always be offered for medical abortion and provided without delay to women who desire it. Paracetamol (similar to acetaminophen) is not recommended for pain management during medical abortion as it has been shown to be ineffective.

- Offering contraceptive information and services is an essential part of abortion care. Specifically:
  - Women may start hormonal contraception as early as the time of taking the first pill of a medical abortion regimen; this applies to a regimen of repeated doses of misoprostol and also to mifepristone followed by misoprostol.
  - Following medical abortion, an intrauterine device (IUD) may be inserted when it is reasonably certain that the woman is no longer pregnant.
- There is no medical need for a routine follow-up visit after any uncomplicated medical abortion using mifepristone followed by misoprostol. Due to the higher rates of on-going pregnancy after misoprostol-only regimens, follow-up to confirm successful pregnancy termination is still encouraged. Regardless of whether women followup, women should be advised that additional services are available to them if needed or desired.

- Safe abortion services—for both first- and second-trimester pregnancy terminations—should be readily available and affordable to all women, including young women and adolescents, to the full extent of the law.

- Any trained provider, including nurses and auxiliary nurse midwives, can safely provide medical abortion.

- National standards and guidelines and clinical protocols for safe abortion care should be evidence-based and periodically updated. Standards and guidelines should facilitate equitable access to high-

quality care.

New dosing regimens

Mifepristone and misoprostol

Gestational Age	Mifepristone Dose	Misoprostol Dose, Route and Timing
Up to 9 weeks*	200mg orally	After 24-48 hours, 800mcg buccally, sublingually or vaginally for one dose
Between 9-12 weeks	200mg orally	After 36-48 hours, 800mcg vaginally followed by 400mcg vaginally or sublingually every 3 hours for a maximum of 5 doses of misoprostol, administered in a health-care facility
Above 12 weeks**	200mg orally	After 36-48 hours, 400mcg orally or 800mcg vaginally followed by 400mcg vaginally or sublingually every 3 hours for a maximum of 5 doses of misoprostol,

		administered in a health-care facility

Misoprostol-only regimens where mifepristone is not available

Gestational Age	Misoprostol Dose and Route	Misoprostol Timing
Up to 12 weeks	800mcg sublingually or vaginally	Follow initial dose with two additional doses of misoprostol 800mcg sublingually or vaginally at least every 3 hours (but no more than 12 hours) up to 2 additional doses***
Above 12 weeks**	400mcg sublingually**** or vaginally	Repeat 400mcg misoprostol sublingually or vaginally every 3 hours for up to 5 total doses

Misoprostol for treatment of incomplete abortion < 13 weeks gestation or equivalent uterine size

Misoprostol	Dose Route	Timing
600mcg	Orally	Single dose
OR		
400mcg	Sublingually	Single dose
(Incomplete abortion: An abortion—whether spontaneous or induced—in which some pregnancy tissue passes out of the		

uterus but some remains; treatment often referred to as postabortion care.)

* WHO Guidance also includes a dosing regimen for gestational age up to 7 weeks.

** For pregnancies beyond 24 weeks, the dose of misoprostol should be reduced. When using medical abortion methods after 20 weeks gestation, inducing pre-procedure fetal demise should be considered.

*** For example: Misoprostol 800mcg repeated sublingually every 3 hours for 3 doses.

**** Sublingual administration appears to be less effective in nulliparous women.

Learn more

For Ipas's quick overview of the entire WHO guidance, consult this factsheet.

A forthcoming WHO publication called *Clinical practice handbook for safe abortion care* will serve as a practical tool for providers of abortion services and as a companion document to the second edition of *Safe abortion: Technical and policy guidance for health systems*.

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Harm reduction: A novel approach to addressing unsafe abortion

Most people associate the public health model called harm reduction with the innovative clean needle exchange programs started in the 1980s to curb HIV infection among intravenous drug users. Since then, however, harm reduction has become an evidence-based approach to reducing public health risks—including those from unsafe abortion.

"In broad terms, a harm reduction approach is one that supports the lessening of harms associated with an activity or behavior, without assigning any moral judgment to the behavior itself," explains Alexandra Teixeira, Ipas community access associate for Asia programs.

In the case of abortion, reproductive health advocates are beginning to apply a harm reduction framework to women's use of misoprostol without the oversight of a trained clinician. Such an approach acknowledges that for women who face legal, economic, social or cultural barriers to accessing abortion services within the health system, misoprostol use outside the health system is

safer than the methods to which these women may otherwise resort. Further, a harm reduction approach specifies that women have a right to accurate information about misoprostol and to understand the risks involved.

"The harm-reducing act of terminating a pregnancy with misoprostol instead of by other prevalent and harmful methods started with women, not the health-system—that's one reason why it's so innovative," Teixeira says. "This isn't the diffusion of an innovation from the health-care system out to the masses; rather, women took it into their own hands. Now we can look for ways to bring health-care systems on board to help amplify the benefits that women are already receiving from misoprostol self-use."

Three core principles define harm reduction

According to an article in the *International Journal of Gynecology and Obstetrics* by Joanna Erdman, the MacBain Chair in Health Law and Policy at Canada's Dalhousie University, "three core principles of harm reduction" can be applied to self-administered misoprostol: neutrality, humanism and pragmatism.

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

“Part of harm reduction’s mandate is to meet women where they are,” says Alyson Hyman, Ipas community access senior associate. “We can never know all the factors that have influenced a woman’s decision to use misoprostol outside the health system, so it’s important not to judge. A woman could be dealing with domestic violence, a community that severely stigmatizes abortion, or any number of other factors that could make using misoprostol outside of the clinic the safest abortion choice for her.”

Harm reduction fuels innovative strategies for informing women

Even though women’s self-use of misoprostol “has made unsafe abortion ‘safer,’” Erdman’s article asserts that more can still be done: “While much information on the safe and effective use of misoprostol is available, women often lack access to this information. This includes information on dosage and routes of administration, gestational range of use, possible side effects, and complications.”

Women’s need for accurate information on how to safely use misoprostol presents a huge opportunity to affect change at the community level, and advocates, nongovernmental organizations and even governments have been developing harm reduction strategies to meet this need.

For example, the nonprofit organizations Women on Waves and Women on Web support safe abortion hotlines in Latin America, Asia and Africa where women face considerable barriers to abortion access. And Uruguay’s program *Iniciativas sanitarias contra el aborto provocado en condiciones de riesgo* (Health initiatives against abortion in unsafe conditions) has been providing women with information on safer self-induced abortion methods despite the many legal restrictions on abortion (some of which would change with the recently passed reforms in October, but many restrictions will remain, especially for women seeking to

terminate pregnancies after 12 weeks). In fact, the program is well known for having won the support of the national Ministry of Health, and it was implemented in all public-sector health facilities. Another creative harm reduction approach employed by a group in Latin America uses trained "accompaniers" who meet in person with every woman they help to provide counseling, guidance and support before, during and after the medical abortion process.

A new way of looking at things

In addition to helping women, employing a harm reduction approach to curbing unsafe abortion also allows reproductive health professionals a new lens through which to assess—and promote—their efforts.

"The value of using this framework is that you're able to think through the three core principles and figure out how you can strengthen what you're already doing," Hyman explains. "And at the level of health-care professionals, advocates and policymakers, using a harm reduction framework to talk about our work will help us make more strides because we can demonstrate how this approach has worked in other fields. It's a way of turning people's thinking and getting them to approach a topic they may otherwise have some reservations about."

While policymakers and health-system officials may not support abortion, a harm reduction approach allows them to rally together in support of reducing maternal deaths from unsafe abortion. "The values expressed and promoted, those of protecting life and health, are so widely accepted, they are seen as neutral social goods on which consensus can be found," Erdman writes.

Because effective harm reduction strategies stand to notably decrease the number of deaths and injuries from unsafe abortion in places where abortion is legally restricted, some experts worry that such success may end up weakening a country's political will for longer-

term reform of restrictive laws.

To avoid this consequence, experts say a focus on human rights advocacy can benefit any harm reduction approach. “While meeting the needs of women, harm reduction does not discharge government of its responsibility to address the abusive, repressive, or limiting constraints that create these needs,” Erdman writes. “Meeting these needs [should not] relieve efforts to challenge the legal and political orders that endanger, degrade, and oppress women in violation of their human rights.”

And in fact, the three core principles of harm reduction—neutrality, humanism and pragmatism—support the work of advocates for human rights and reproductive justice just as much as the work of health professionals. The legal and ethical framework provided by a harm reduction approach can serve as a powerful tool to strengthen political will for change that benefits women.

“The bottom line is this: We know women are using misoprostol,” Hyman says. “Harm reduction can help us work together to ensure they have the information, resources and support to do it safely."

Share your work

Are you or your organization doing harm reduction work? The staff leading Ipas’s harm reduction work would love to hear about it. Please email medicalabortion@ipas.org.

Additional resource: The full text of Joanna Erdman's article "Access to information on safe abortion: A harm reduction and human rights approach," published in the *Harvard Journal of Law and Gender*, is available online.

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