



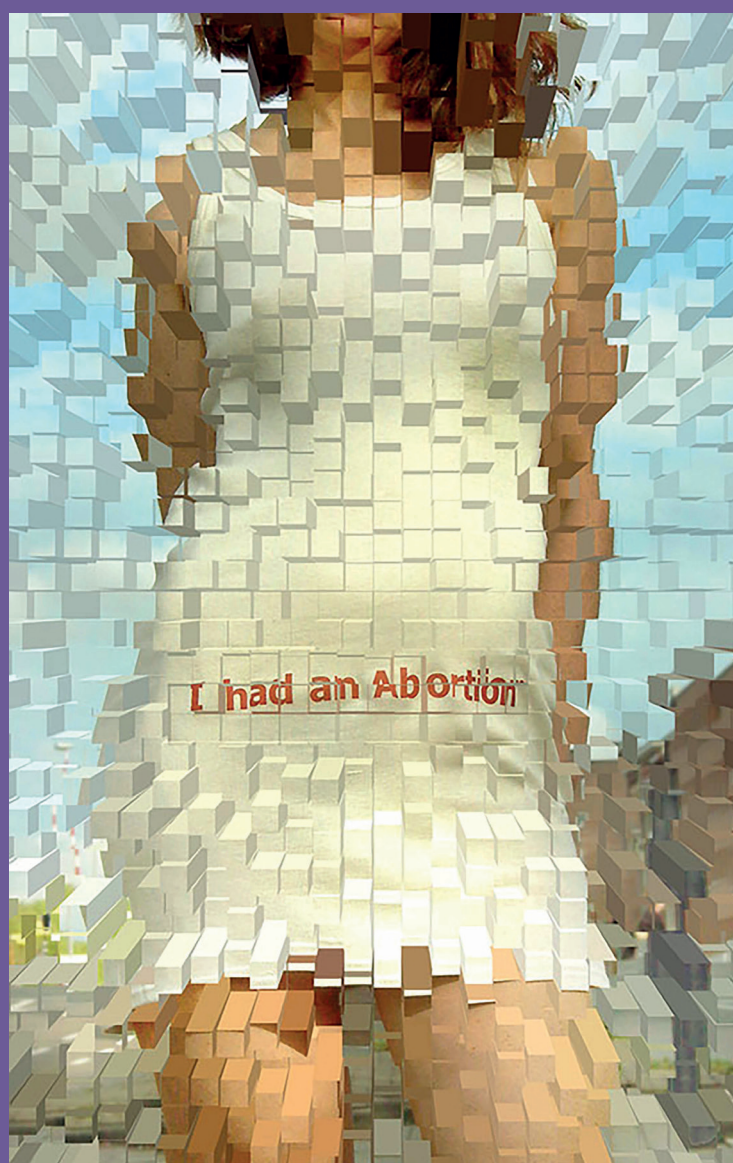
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WHO DECIDES? We trust women

Abortion in the developing world and the UK

A report by the UK All-Party Parliamentary Group (APPAG) on
Population, Development and Reproductive Health

March 2018



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The UK All-Party Parliamentary Group on Population, Development and Reproductive Health

The UK All-Party Parliamentary Group (APPG) on Population, Development and Reproductive Health is a cross-party platform for Peers and MPs. Its purpose is to raise awareness on key development and rights issues, with a specific focus on population and sexual and reproductive health and rights. The group was established in 1979 and is one of the oldest APPGs in Westminster. It has more than 80 members with representation from all major political parties, and from both Houses in the UK Parliament.



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FOREWORD

My mother, during the Blitz in the Second World War suddenly realised that she had not had a period for some time. With two little boys already and Hitler expected to invade within a few weeks, she wondered how on earth she could bring another child into what seemed a very



dangerous situation. Her elder sister reassured her and said that a hot bath and plenty of gin would soon start her period. It didn't and I was the result – with a lifelong love of gin!

Other women in even more desperate situations would have risked their lives by having unsafe abortions, as they still do in many parts of the world. Gin ('Mothers' Ruin'), coat hangers, syringes, soapy water – a selection of methods used to induce miscarriage at various times and places – are all dirty and dangerous, leading to death for many women.

It is not widely known that abortion rates are roughly the same in countries where it is legally available (34 abortions per 1,000 women of childbearing ageⁱ) and countries where it is banned (37 per 1,000) and yet, 68,000 desperate women die from unsafe abortion every year in countries with no provision for safe abortion procedures. It is disgraceful that they are so condemned by their governments' failures.

There is hope however, in the increasing use of medical abortion before 12 weeks, when abortion can be safely carried out in the woman's own home. Roll on the day when a quick prescription for someone in my mother's situation all those years ago, will end the need for such intrusive medical intervention.

I hope our country will follow where Canada has led and bring our laws up to date, and encourage other countries worldwide to do likewise.

Women deserve to make their own decisions and be in control. We trust women.

Jenny Tonge

ⁱ According to the Guttmacher Institute, women of childbearing age include those aged 15 to 44 years.

EXECUTIVE SUMMARY

“It is no longer politically or morally acceptable for governments or international bodies to use arguments of culture or religion to avoid creating a supportive policy and legal framework for safe abortion that would eliminate a major cause of maternal death and injury.”

Gillian Kane, Ipas

“Access to therapeutic or induced abortion is essential to allow women to participate fully in modern life and bear only the children they wish and feel able to raise.... Women will take things into their own hands if you do not assist them and I know from bitter experience that they can die in the process.”

*Wendy Savage, retired UK obstetrician and gynaecologist,
Doctors for Choice*



Abortion rates are roughly the same in countries where abortion is legally restricted (37 per 1000 women of childbearing age) as in countries where it is readily available (34 per 1000 women)ⁱ. Restrictive abortion laws do not prevent women from seeking abortion; they only endanger women’s health and lives as women seek unsafe procedures. There is a correlation between restrictive abortion laws and higher rates of maternal mortality and morbidity. Abortion and maternal mortality rates from unsafe abortion are the lowest in Western Europe, where the most permissive abortion laws are foundⁱⁱ. The World Health Organization (WHO) has approved self-use of medical abortion pills with appropriate information and medicines: “After initial contact with a trained person to assess eligibility, women can self-manage the medical abortion process without direct supervision of a provider”ⁱⁱⁱ. Safe abortion services carry very low health risks.

Canada decriminalised abortion completely in 1988 rather than have a list of conditions that specified under what circumstances abortion was ‘legal’. Canada’s abortion rate is lower than the UK’s and Canada enjoys the lowest maternal mortality rate from abortion in the world.

Canada has managed abortion as part of standard health practice for several decades and there is no control by any civil or criminal law.



In the UK, it is time for change. The 1967 Abortion Act is now seen as outdated and no longer fit for purpose—partly as a result of new abortion technology. Patient autonomy and respect for women to make their own decisions is now seen as more important than in 1967. Paternalistic frameworks are no longer relevant in current UK healthcare and there is widespread recognition that women have the right to make decisions about their own lives and bodies.

In developing countries, the proportion of maternal mortality that is due to unsafe abortion ranges from 8 to 18%^{iv}. Maternal morbidity from the consequences of unsafe abortion is common, especially when abortion is restricted. Developing countries, particularly in Africa, bear the brunt of unsafe abortion deaths, estimated to be 22,500 to 44,000 in 2014^v. In the group of countries where abortion is completely banned or allowed in narrow circumstances, only one in four abortions are safe. Young women, poor women, and women in conflict situations are particularly vulnerable. There are many obstacles to safe abortion care including religion, stigma, lack of access, lack of information and trained personnel and anti-choice activity.

Medical abortion is making huge inroads globally and making more abortions safer. While this is good news, there is considerable work to do to train health providers and pharmacists and to ensure women know their options. While some developing countries have liberalised their abortion laws, this careful policy work continues to need support.



The UK APPG on Population, Development and Reproductive Health summary recommendations:

INTERNATIONAL

The UK Department for International Development (DFID) is commended for taking a global leadership position in abortion and for its broad portfolio of global work

- 1. DFID should do even more to support willing countries to expand access to safe and legal abortion**
- 2. Expand availability of medical abortion globally**
- 3. Work to broaden the laws to permit community and primary care health workers, pharmacists, nurses and midwives to provide abortion**
- 4. Continue to ensure access to safe abortion to the full extent of the law, particularly in developing countries and in conflict situations**
- 5. Increase funding for family planning and the wider sexual and reproductive health and rights agenda to 10% of official development assistance and 10% of national development budgets**
- 6. DFID should reiterate its 2014 policy concerning abortions in conflict situations and international humanitarian law to humanitarian and other partners**
- 7. The UK should use their voice to reinforce the importance and centrality of abortion to women's human rights and equality**
- 8. Ensure adolescent girls and young women have access to youth-friendly and non-judgmental sexual and reproductive health services, including abortion care**
- 9. Work to take abortion out of the criminal law and towards the release of all imprisoned women and girls and healthcare professionals who are incarcerated because of punitive abortion laws**
- 10. Support comprehensive sexuality education through in-school and out-of-school programmes for adolescents that promote comprehensive sexuality education including information on contraception and abortion**

UK

1. Decriminalise abortion completely — as Canada has done
2. The Department of Health should follow WHO guidelines and define the home as a safe place to take abortion medication in England (as is already taking place in Scotland)
3. If there are National Health Service (NHS) contracts to independent providers, they must include a commitment to training with joint contracts that allow clinicians to move seamlessly across both the independent and NHS sectors
4. Follow WHO guidelines to allow primary care workers such as nurses and midwives to manage both surgical and medical abortion in the first trimester
5. The National Institute for Health and Care Excellence (NICE) is best placed to develop appropriate clinical care pathways
6. Coordinate NHS abortion planning across the nations of the UK, so that women have timely access to high quality services. For example, a fair tariff for various types of abortion services should be agreed so there is no disincentive to treat second trimester and complex cases
7. Stop the erosion of family planning and sexual health services and instead ensure family planning and sexual health services are readily available, reducing the need for abortion overall
8. Increase understanding among politicians and policy makers with better education and information about abortion and the impact on women of restricting it and keeping it criminalised

NORTHERN IRELAND

1. The UK Government must give clear guidance on funding and a care pathway for women travelling from Northern Ireland (NI) to England for an abortion
2. Medical professionals of NI must be clear about their legal obligations to women seeking abortions
3. Build coalitions to decriminalise abortion in NI – using the momentum of the possible up and coming changes in the Republic of Ireland
4. Support research and campaign activities to combat misinformation and myths surrounding abortion in NI

ABORTION GLOBALLY AND IN THE UK

INTERNATIONAL SITUATION, IN BRIEF

One in four pregnancies worldwide ended in an abortion in 2010-2014^{vi}. While abortion rates have been declining in the developed world since 1990, the rate in developing countries has remained fairly constant (see Figure 1). An estimated 56 million abortions occur worldwide each year and three-quarters of these take place among married women^{vii}. **Abortion rates are roughly the same in countries where abortion is legally restricted (37 per 1000 women of childbearing age) as in countries where it is liberally available (34 per 1000 women)^{viii}. Restrictive abortion laws do not prevent women from seeking abortion, they only endanger women's health and lives as women seek unsafe procedures. There is a correlation between restrictive abortion laws and higher rates of maternal mortality and morbidity.** In the group of countries where abortion is completely banned or allowed in narrow circumstances, three out of four abortions are unsafe. Lack of money prevents women and girls from accessing safe abortion in the private sector, and in addition the fear of being reported to the police prevents women and girls from seeking medical attention when they are faced with life-threatening complications due to unsafe abortion^{ix}.

Figure 1. Abortion rates remain high in the developing countries



Safe abortion can be provided by a range of non-physician providers at primary care level. WHO has approved self-use with appropriate information and medication: “After initial contact with a trained person to assess eligibility, women can self-manage the medical abortion process without direct supervision of a provider”. Safe abortion services carry very low health risks: WHO estimates that a safe abortion has a lower risk than an injection of penicillin^x.

INTERNATIONAL POLICY ON ABORTION



The Sustainable Development Goals (SDGs) do not mention abortion explicitly, as it is only part of the package of sexual and reproductive health (SRH) services in countries where it is not legally restricted. By 2030, target 3.7 specifies, countries will “ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs”

and target 5.6 elaborates countries' commitment to:
“Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action”. That these SRH services within the SDGs need to be reaching young people, in particular, is a positive and useful step. **However, that abortion services can still be separated or omitted from the rest of SRH services by some governments and donors is a negative. The fact remains: in order to be able to fulfil the 2030 SDGs, governments and civil society must act to reform laws that criminalise abortion or stop women from acting on their reproductive rights.**

The International Conference on Population and Development (ICPD) remains the gold standard on setting and defining SRH policy. The ICPD Programme of Action agrees that where abortion is legal, it should be safely accessible at the primary level. The Programme of Action also recommended “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law” and “to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS” and “Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion”^{xi}.

At the regional level, the abortion policy language is even more promising. The Montevideo consensus^{xiii} is signed by 38 Latin American countries and mentions explicitly: “the prevention of teenage pregnancy and eliminating unsafe abortion and allowing abortion in cases where abortion is legal”. **In Africa, the Maputo Protocol^{xiii} is an African human rights instrument introduced in 2003 (ratified by most countries—and legally binding) offers “To protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.”**

UK ABORTION HISTORY AND CURRENT SITUATION

“You cannot possibly convince women with an unwanted pregnancy to carry an unwanted pregnancy to term. It is impossible. All you do with restrictions is delay access to abortion. The UK is last when it comes to gestational age in abortion in Europe because women are just delayed for no benefit at all.”
Christian Fiala, Gynmed Clinic, Vienna, Austria



History: The 1967 Abortion Act no longer fit for purpose

Before the 1967 Abortion Act, unsafe abortion was a leading cause of maternal mortality in the UK and was



responsible for about 14% of the UK's maternal mortality. In the UK, abortion was criminalised in sections 58 and 59 of the Offences against the Person Act of 1861. One aspect was further clarified in the Infant Life Preservation Act of 1929. In the 1967 Abortion Act, legal grounds for abortion were set out as exceptions to the criminal law; therefore, the 1861 act is still being used to legally prosecute abortions today. **The 1967 Abortion Act, while revolutionary at the time, stipulated the signature of two doctors and also stipulated that the abortion had to take place in a clinical facility.** The Act was passed to save women and make abortion safer, as abortions were often performed by unqualified individuals

outside of healthcare facilities. This is why the Abortion Act limits the location where abortion can be provided and the personnel who can perform them. To ensure doctors did not offer inappropriate terminations, there was a peer

review requirement — thus the need for a second signatory. And in the 1960s, doctors may well have still believed that their decision-making role and (perhaps) unwillingness to perform abortions needed to be protected — and they also wanted protection from being accused of breaking the law. Finally, the concept of being a Conscientious Objector was introduced (see Box 1).



Ch. 87

Box 1. The concept of Conscientious Objection began in the UK in 1967

In 1967, it is clear that David Steel helped to pass a progressive and ground breaking act. And yet, conversations with his local Catholic Seminary led to the introduction of the concept of Conscientious Objection (CO). As the global initiator of CO laws, the UK let this genie out of the bag. A relatively new phenomenon, CO (defined as the refusal by a healthcare professional to provide a legal medical service for which they would normally be responsible based on their objection to the treatment for personal or religious reasons) has passed to other reproductive health services, institutions, and entire countries. There is little research on how CO has affected women but many questions remain about how often they are refused, where they go when health providers exercise CO, and what they might do. It would seem that any provider studying gynaecology would know that some of their clients would be experiencing unwanted pregnancies and should be willing and prepared to perform abortion.

Time for change. The 1967 Act is now seen as outdated and no longer fit for purpose — partly as a result of new abortion technology. Patient autonomy and respect for women to make their own decisions are now seen as more important than they were in 1967. Paternalistic frameworks are no longer relevant in current UK healthcare and there is widespread recognition that women have the right to make their own decisions about their pregnancy. In the current regulation of health services, there must be two aims: patient safety and efficacy, and efficiency of service provision. The current Abortion Act impedes both patient safety and efficiency. Medical abortion (MA) can be safely delivered by nurses or midwives so the unnecessary doctor signatures only serve to delay services. Currently, the UK requires a woman to go to a clinic twice for an early MA—an extremely burdensome requirement. Women should be allowed to take the pills at home—a procedure already declared safe by WHO. Currently, women are required to take the pills in the presence of the healthcare provider, possibly leading to bleeding on the journey home and associated distress. Indeed, a DoH review in 2008 found that women would want to take the pills at home and declared this to be safe. The Secretary of State for health is currently in breach of the Health and Social Care Act, as he is failing to improve the safety and efficacy of abortion services by not allowing home use. The 1967 Act is no longer fit for purpose. In addition, while NICE is in the process of developing new clinically effective guidance on abortion, legal restrictions make it more difficult.



Current situation is variable by area

“ I teach health law [in the UK] and my students are shocked by the way that abortion is regulated. That is because we are dealing with an 1861 statute which prohibits the procurement of miscarriage, regardless of who performs it and which imposed the harshest criminal sanction for abortion throughout Europe, which is life imprisonment...



the students are particularly shocked because they have studied in criminal law, the fact that the territory of criminal law should be very strictly limited. We are dealing with very serious harms and with people who act with criminal intent, so they become quite shocked when doctors are subject to this criminal regime... The current consensus is around the decriminalisation of abortion.” -

*Marie Fox, University of Liverpool,
School of Law and Justice*

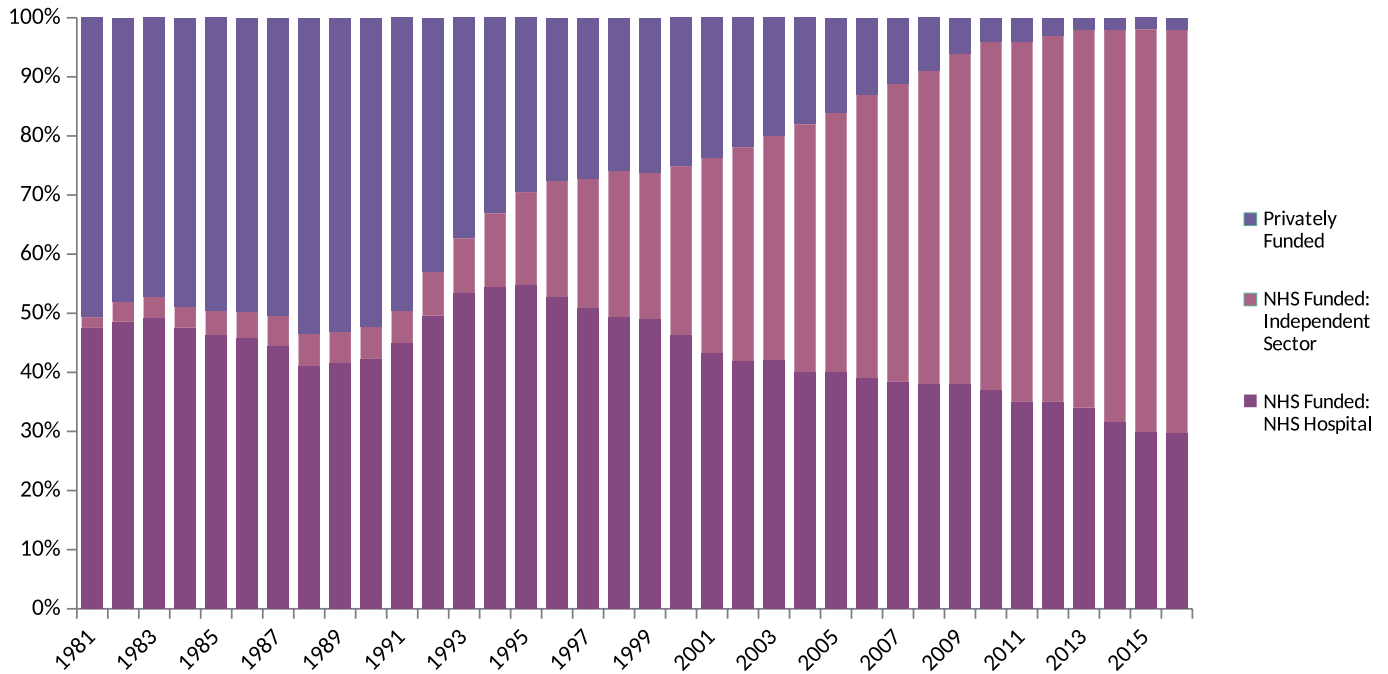
Abortion is the most common procedure that women of reproductive age undergo and one in three women in Britain under the age of 45, will have an abortion in her lifetime. That said, the UK abortion rate is stable and women try hard to avoid an unplanned pregnancy. In England and Wales, 30% of abortions were conducted within the NHS in 2016, 68% were conducted within the independent sector (private but non-profit) and 2% were conducted privately (compared to half of all abortions



done privately in 1981). Figure 2 shows how the proportion of abortions competitively contracted-out to the independent sector has grown over time. **This unusual situation where there is competition for abortion contracts in the independent sector is not optimal, as abortion providers should be collaborating rather than competing. Such collaboration could ensure that the skills and facilities are best provided for the clients where they are**

most needed. Competition would imply that abortion costs are a place where savings can be accrued when, in fact, abortion services need to be valued. In fact, abortion should be in the public sector so that General Practitioners (GP), GP nurses, Family Planning nurses, pharmacists and midwives can provide MA and MVA (manual vacuum aspiration) at primary level.

Figure 2. An increasing proportion of abortions are carried out by the independent sector: England and Wales, 1981-2016



Source: DoH, Abortion Statistics 2016, England and Wales

Follow Scotland’s example. Scotland has led the way in medical abortion and has now declared that medical abortion can be self-administered at home. Table 1 shows that these progressive policies have no impact on abortion rates or second trimester abortions.

Table 1. Comparing more progressive Scotland to England

	Scotland	England
Medical abortions	83%	62%
Rate of abortion (per 1000 women)	12	16
Abortions after 20 weeks	1.2%	2%
Able to take MA at home	Yes	Not yet

Irish women are not simply poorly served, they are not served at all. The 1967 Abortion Act was never extended to Northern Ireland (NI) and in the Republic of Ireland, the Protection of Life during Pregnancy Act of 2013 imposed an almost total criminalisation of abortion. Women in NI are still being pursued and jailed as the penalty in NI for the woman undergoing an abortion and any individual who assists her is life imprisonment — the harshest in Europe and, indeed, one of the harshest in the world. A woman with an unwanted pregnancy in NI must either: a) travel to England; or b) procure abortion pills online. Over 700 women travelled last year from NI to access abortion in England or Scotland. A woman who travels must often go without the support of friends or family and take time off work and (often) find childcare. When she has been diagnosed as having a foetal abnormality, she faces both significant costs, emotional consequences, and a lack of follow-up care. All of this is a breach of these women’s human rights under Article 8 of the European Convention on Human Rights (ECHR).

The number of women who have accessed pills online is difficult to obtain (Women on Web has sent pills to about 1000 women over the last two years in NI) and there have been at least nine prosecutions for women accessing pills online since 2010^{xiv}. There is a current case pending judicial review of a 15-year-old girl whose mother procured abortion pills for her daughter online. The girl’s case was referred to social services, as she was in an abusive relationship and somehow the GP notes were turned over to the police. Even with a suspended sentence, this young woman will have a criminal conviction^{xv}. And criminal law in NI is left unclear and, with no Legislative Assembly in place, who will be responsible for implementing whatever verdict is upheld?

On a more positive note, 200 NI women activists who had either obtained abortion pills online or helped procure pills for other people signed a document stating their actions. These signatures were turned over to the Belfast police: no activists have been arrested to date. And, most recently, Stella Creasy MP's amendment has forced the UK Government to pay for the Northern Irish women, who come across the channel for abortions.

The UK national tariff (the reimbursement received for carrying out an abortion) is also a disincentive, as Clinical Commissioning Groups (CCGs) sometimes lack the knowledge they need to commission abortion services. The national tariff for abortion services is the same for medical, surgical, and complex cases. This gives the NHS trusts little incentive to commission abortion services as second trimester abortions are more costly and complex cases, and invariably carried out in the public sector.

UK Abortion Task Force. The Royal College of Obstetricians and Gynaecologists (RCOG) has established an Abortion Task Force led by Professor Lesley Regan to work collaboratively with the main independent providers to develop system-wide solutions to UK women's access to high quality sustainable abortion care. NICE has commissioned the National Guideline Alliance (hosted by the RCOG) to update the current clinical guidelines on the care of women seeking abortion (the previous version was published in 2011). Branded by both NICE and the RCOG, this will be the first time that NICE has published a co-branded guideline.

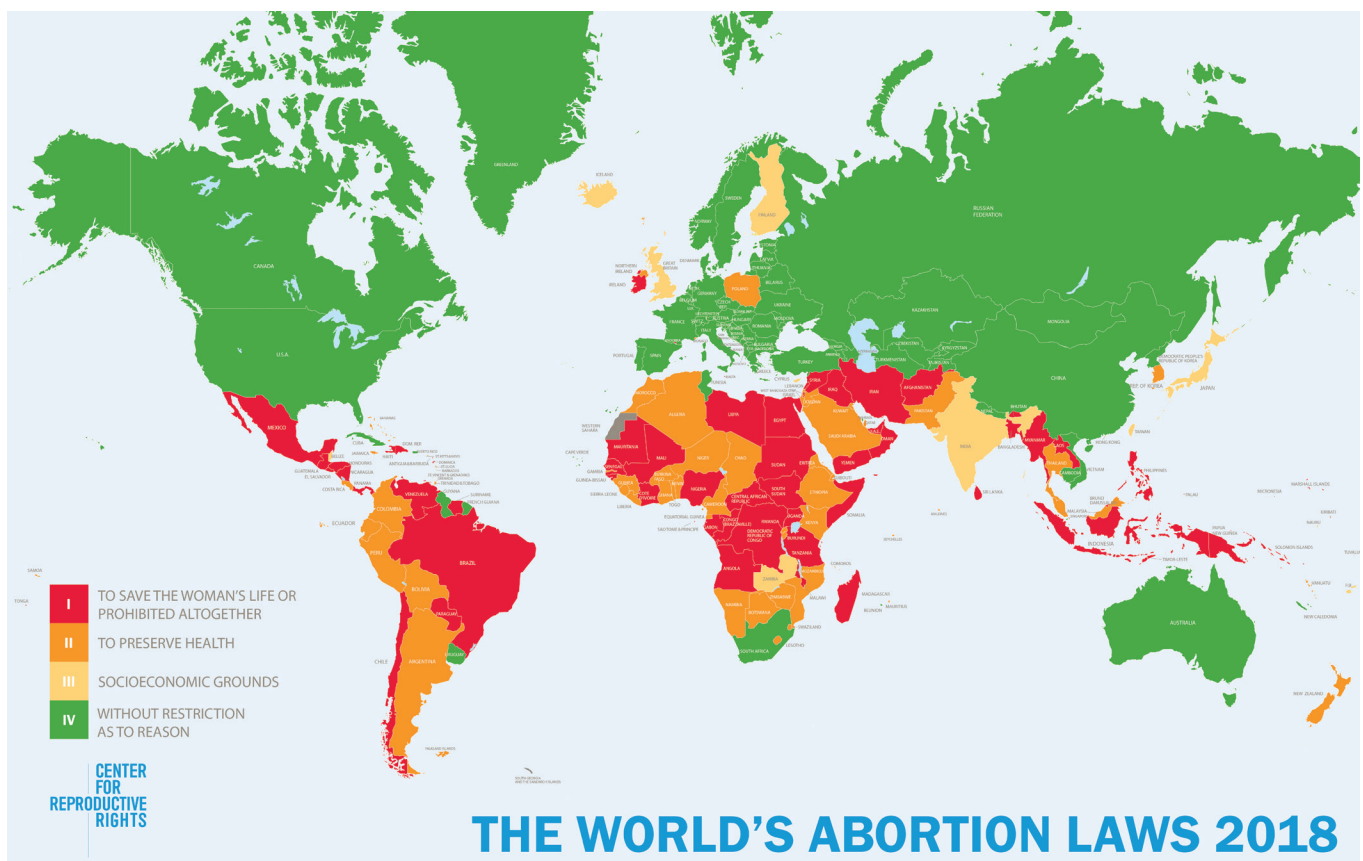
ABORTION REFORM

WORLD SITUATION GIVES WOMEN LITTLE LEEWAY

Currently:

- 98% of all countries permit abortion to save the life of the woman;
- 63% of countries to preserve the woman's physical health;
- 62% to preserve the woman's mental health;
- 43% in cases of rape, sexual abuse or incest;
- 39% for foetal anomaly;
- 33% economic or social reasons; and
- 27% on request.

Of the countries with abortion on request, 65% are in developed countries and 14% are in developing countries.



For detailed individual country information, see the WHO Global Abortion policies database website.

Box 2. DFID's position on international abortion demonstrates global leadership

The UK Department for International Development (DFID) has indicated that it considers safe and legal abortion a right. The 2014 publication, 'Safe and unsafe abortion: The UK's policy position on safe and unsafe abortion in developing countries' states: "Women and adolescent girls must have the right to make their own decisions about their sexual and reproductive health and well-being, and be able to choose whether, when and how many children to have... Safe abortion reduces recourse to unsafe abortion and saves maternal lives... In countries where it is highly restricted and maternal mortality and morbidity are high, we can help make the consequences of unsafe abortion more widely understood, and can consider supporting processes of legal and policy reform".

DFID's policy paper can be found at: www.gov.uk/government/publications/safe-and-unsafe-abortion-uks-policy-position-on-safe-and-unsafe-abortion-in-developing-countries

HUMAN RIGHTS ARGUMENTS ARE COMPELLING

Human rights bodies recognise that to protect the basic rights and dignity of women and girls, it is necessary to increase access to quality reproductive health services. The Committee on Economic Social and Cultural Rights has said the right to health must include necessary SRH services, including safe, legal abortion care^{xvi}. Human rights bodies have affirmed that laws restricting abortion access contravenes human rights standards. For example, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) committee has found that it is discriminatory to fail to provide health services that only women need. Also, the special rapporteur on torture has repeatedly found that denying women access to abortion can lead to physical or mental suffering that may constitute ill treatment or torture.

Bolivia recently experienced a heated national debate on abortion (and has since passed a new more liberal law^{xvii}). In August 2017, seven women in five cities were accused of having obtained abortions and were detained by police. In each case, the women had been turned in by their healthcare providers. For example, a 16-year-old



girl had arrived in hospital haemorrhaging and was later apprehended when accused of having had an abortion by hospital staff. There is evidence that providers are driven

to report women because of fear, stigma, religious intolerance, and a misunderstanding of the law. By failing to protect the confidentiality of their clients, they have become the entry point for women into the criminal justice system. **According to international and regional authorities, criminalising abortion not only violates human rights, but leaves women susceptible to injury, death, and imprisonment. The new law in Bolivia allows abortion in the first eight weeks of pregnancy**

for a broad range of circumstances. This is a great step forward for the reproductive rights of women in Bolivia.



HEALTH AND ECONOMIC ARGUMENTS ARE ALSO COMPELLING

The proportion of developing countries' maternal mortality that is due to unsafe abortion range from 8 to 18%^{xviii}. Maternal morbidity from the consequences of unsafe abortion are also common, especially when abortion is restricted. In 2012, nearly 7 million women were treated for abortion complications; it is estimated that many women — some 40% — who need treatment never received it. The burden on the health systems in developing countries are high. It is estimated that in 2014 the cost on health systems in the developing countries was as high as US\$232 million. (And if the women who needed treatment were able to receive it, the costs would more than doubled, to US\$562 million^{xix}). Developing countries, particularly in Africa, bear the brunt of unsafe abortion deaths estimated to be 22,500 to 44,000 in 2014^{xx}.



More positively, the WHO has recently changed their classifications of abortion safety (see Box 3). This is because the use of misoprostol worldwide has made the procedure safer for women and fewer women are dying.

Box 3. WHO classification of abortion safety has broadened because of widespread self-use of medical abortion

- Safe abortion: use of a WHO recommended method provided/ supported by a trained person
- Less safe abortion: Use of outdated method by trained provider OR self-use of medical abortion drugs without appropriate information or access to a trained person
- Least safe abortion: Use of dangerous methods, such as ingestion of caustic substances, insertion of foreign bodies or use of traditional concoctions by untrained persons

Source: Ganatra et al, 2017^{xxi}

POLICY REFORM: TO DECRIMINALISE

“Fear of being reported to the police prevents women and girls from seeking the medical attention they need for life-threatening abortion complications. This, in turn, leads to high rates of maternal mortality and morbidity. This vicious cycle plays out all over the world wherever abortion is restricted.”

Gillian Kane, Ipas

Most country abortion policies are made up of lists of when abortion is allowed or ‘legal’. By definition, abortion outside these lists is a criminal act. The criminal sanctions vary from country to country. In El Salvador, some women may be in prison for what could have been a miscarriage (as it is difficult for medical staff to distinguish between a spontaneous and an induced abortion, and medical staff

often assume that the abortion was induced). In NI, young girls who are caught ordering abortion pills online could be imprisoned and will certainly have a criminal record.



On the other hand, **Canada decriminalised abortion completely in 1988 rather than have a list of conditions where abortion is ‘legal’.** Canada’s abortion rate is lower than the UK’s and there have been few issues as a result; in fact, **Canada enjoys the lowest maternal mortality rate from abortion in the**

world. Since 1988, Canada has managed abortion as part of standard health practice and there is no control by any civil or criminal law (see Box 4 for more on Canada).

Two states in Australia have also decriminalised abortion up to 24 weeks^{xxii}. Sweden allows abortion on request up to 18 weeks and there are almost no requests for abortions after 18 weeks, as abortion is so accessible earlier. This is compelling evidence to say that the UK should follow the Canadian path and fully decriminalise abortion. It is not clear that the “plethora of convoluted laws and restrictions surrounding abortion make any legal or public health sense. What makes abortion safe is simple and is irrefutable—when it is available on the woman’s

request and is universally affordable and accessible^{xxiii}. Making such a change in the UK, would involve building huge support among health professionals, legal experts, parliamentarians and with women themselves to build such a movement.



Box 4. Canada has decriminalised abortion completely... and women have remained safe

Canada has had no criminal laws around abortion for 29 years and has shown that women and doctors act responsibly without criminal laws to control them. The Canadian abortion rate has continuously declined since 2000 and Canada now has an annual rate of 14 abortions per 1000 women of childbearing age. (The corresponding rate in the UK is 16 per 1000 women aged 15-44 in 2015 and 2016). There is no gestational law in Canada and 90% of abortions take place in the first trimester and less than 0.5% take place after 20 weeks. Canadian doctors are accountable to their professional associations and the majority of women present as early as possible for abortion. The situation is governed by Canadian Medical Association policies, clinical protocols and codes of ethics — as with all healthcare. The decline in the abortion rate in Canada is seen primarily as a result of good access to contraception.

Source: Ganatra et al, 2017

Internationally, there is some recent good news, with Chile, Mozambique and Benin relaxing some restrictions on access to safe abortion. Abortion is legally accessible in many parts of South Asia (India, Nepal, and ‘menstrual regulation’ in Bangladesh up to 10 weeks), although it is not always accessible. In Africa, abortion is permissible and reasonably accessible in South Africa and Ethiopia. Still, while the Ethiopian law was liberalised in 2005, it took a long time to make sure that the population was aware of the new freedoms, but access to services has been increasing steadily and mortality and morbidity declining at the same time. Major efforts have been made to prepare guidelines, equipment, healthcare provider training, and information. These efforts are now beginning to bear fruit.

In many countries, however, there are confusing and ambiguous abortion policy situations, which leave healthcare providers and citizens confused and unsure. This serves the anti-abortion cause well. The US Global Gag Rule (see Box 7) adds to the confusion. Multiple texts over many years with conflicting provisions and obscure and outdated language means, that no one is sure when abortion is actually allowed and when it isn't; this is likely to stop abortion being provide safely at all^{xxiv}. Table 2 gives examples of country situations discussed by those who gave testimony to the APPG on Population, Development and Reproductive Health.



Table 2. Country abortion policy situations vary greatly and often conflict

NAME	POLICY	IMPLICATIONS
Peru	Abortion is regulated by the medical code, set up when there was armed conflict in the country.	Healthcare providers are obligated to report an illegal activity, including abortion.
Rwanda	Since 2012, abortion is permitted in cases of rape, incest, forced marriage or risk to the health of the woman or foetus. However, the reformed penal code still has burdensome requirements, including approvals.	Women with unwanted pregnancies regularly resort to unsafe abortion and Rwandan police unjustly arrest and imprison hundreds of women and girls on abortion-related charges each year (making up 25% of the female prison population). The majority of these are young, poor and were turned in to police by their neighbours or their healthcare providers. Women with resources were not affected. Also, those imprisoned when under age 16 were amnestied and released last year.
Sierra Leone	Revoked the 1861 Offences against the Persons Act in 2016 (act passed but not yet signed into law). No implementation.	Abortion now allowed on request during the first 12 weeks of pregnancy and until week 24 in cases of rape, incest and health of the foetus or the woman/girl.
Zambia	Termination of Pregnancy Act of 1972 is a liberal law, but requires the signatures of three doctors to approve a termination and there are few doctors in Zambia. Anti-choice activism is making the situation very challenging.	Enlightened guidelines published in 2009 state that mid-level providers can provide abortion in the first trimester. And yet, high rates of unsafe abortion persist because a lack of knowledge within the community and high levels of stigma among healthcare providers.
Uganda	The Penal code and the Constitution, conflict with each other.	Abortion is legal to protect women's health and life. The 'Standards and Evidence-based Guidelines on the Prevention of Unsafe Abortion' were withdrawn in 2016 due to religious and political opposition. National abortion laws are often used to harass and extort money and no legal abortions are carried out.
Uruguay	Harm reduction approach.	Doctors give women information and prescriptions, which the women fill and take medication at home up to 12 weeks. Doctors then provide follow-up, if required.

ABORTION SERVICE DELIVERY

Much has changed in the past decade in abortion service delivery, as medical abortion has begun to become a more popular method. This section compares Manual Vacuum Aspiration (MVA) and Medical Abortion (MA), examines how these services might be delivered, the workforce implications and considers service delivery to the harder to reach — those in conflict settings, the poorest, and adolescents.



ABORTION METHODS: MA AND MVA

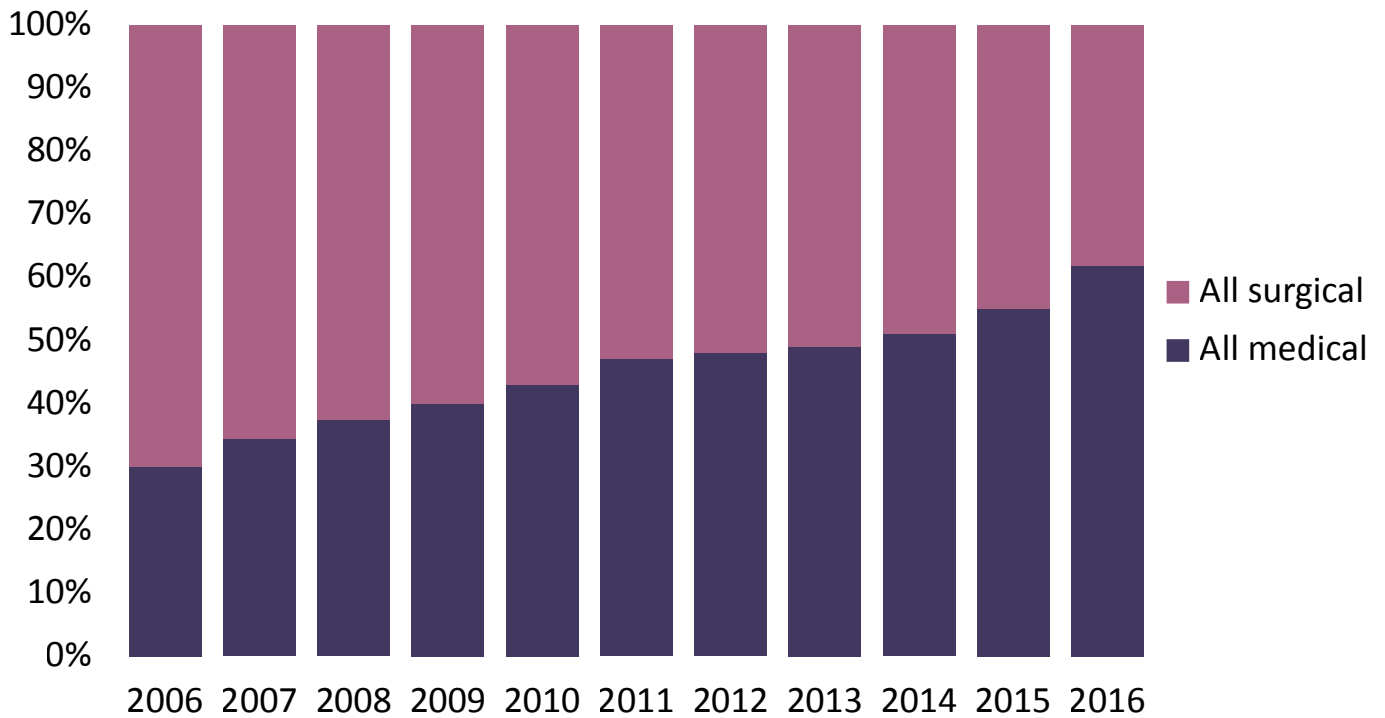
“It is essentially a primary care level procedure and, increasingly, the future is seeing medical abortion move outside the facilities to become a user-controlled method.” - *Bela Ganatra, WHO*

According to WHO's service delivery guide, abortion methods include:

- Methods of vacuum aspiration which include: MVA and electric vacuum aspiration (EVA); or
- Medical abortion (up to 9 weeks) involves a single dose of Mifepristone, 200 mg, taken orally, followed by a single dose of Misoprostol, 800 µg, taken vaginally, by mouth or under the tongue.

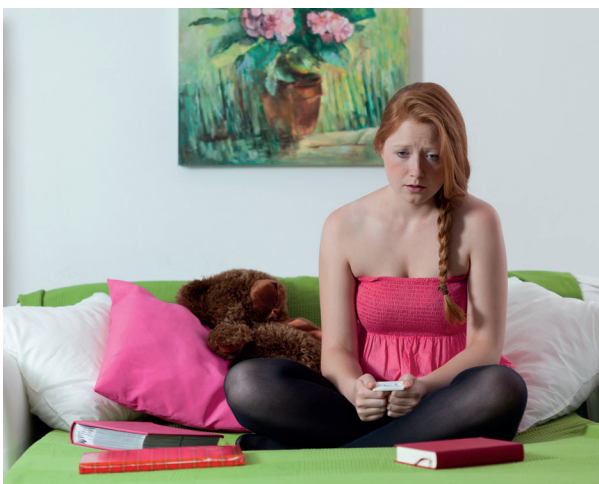


Figure 3. Medical abortion is increasing as a proportion of all abortions in England and Wales, 2006-2016



Source: DoH, Abortion Statistics 2016, England and Wales.

Ideally, women are able to choose the abortion method that suits them. Some women may want the certainty of a surgical procedure that is completed in a short amount of time and therefore easier to conceal from family members. Others, may want to avoid an intimate surgical procedure and would prefer to take pills in the privacy of their own home. Figure 3 shows that more women in England and Wales are choosing MA.



Box 5. Home Self-Use of Medical Abortion (up to 9 weeks) is approved by the WHO

“Medical abortion is a multistep process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol alone). Mifepristone with misoprostol is more effective than misoprostol used alone, and is associated with fewer side-effects. Allowing home use of misoprostol following provision of mifepristone at a health care facility can improve the privacy, convenience and acceptability of services, without compromising on safety. Facility-based abortion care should be reserved for the management of medical abortion for pregnancies over nine weeks (63 days) and management of severe abortion complications. Women must be able to access advice and emergency care in the event of complications, if necessary.

Medical Abortion:

- Avoids surgery
- Mimics the process of miscarriage
- Controlled by the woman and may take place at home (< 9 weeks)
- Takes time (hours to days) to complete abortion, and the timing may not be predictable
- Women experience bleeding and cramping, and potentially some other side-effects (nausea, vomiting)
- May require more clinic visits than [surgical abortion]”

WHO (2014) Clinical Practice for Safe Abortion

ABORTION SERVICE DELIVERY METHODS

Clinical services still needed

Abortion has traditionally been a clinical method, carried out (ideally) in a clean and safe medical facility. Indeed, one of the main reasons for the UK 1967 Abortion Act was to bring abortion out of the back alley and into safe facilities. In some countries, however, surgical abortions are becoming fewer, as the majority of women opt for MA. In addition, dedicated abortion clinics (if not fully integrated into the health system), can become targets for anti-abortion protesters. Clinical services will remain important, as surgical abortion will continue to be an option for women who prefer it; also second trimester abortion needs to be carried out in a clinical setting.



Pharmacies take a bigger role

In developing countries, pharmacies have increasingly become providers of medical abortion, as the medication to induce miscarriage, is sold over the counter. While this sale may or may not be legal, many countries turn a blind eye. There are many Non-Governmental Organisations (NGOs) working with pharmacists to train them properly, greatly increasing women's access to safe abortion. For example, pharmacists have been successfully trained and equipped in Nepal, where they are playing an important role in dispensing MA. Training of pharmacists is important for them to be able to give women the right information and advice; there is considerable experience of pharmacists selling incorrect doses of misoprostol (sometimes) for inflated prices, leaving a woman with no money and inadequate medication to carry out the procedure.



Online MA access is expanding internationally

An increasingly popular method involves ordering abortion medication online for discreet delivery to the home. There is evidence that women—even in countries like the US where abortion is legal—are doing this for convenience or because they find it difficult to access services, even when it technically breaks the law. In countries where abortion is severely restricted, this has become an increasingly popular method and there is evidence that this is a widespread practice in much of Latin America. Women in Ireland are increasingly ordering drugs online and having safe abortions at home (even when it is a criminal activity). UK women also attempted (unsuccessfully) to obtain abortion pills online (see Box 6 for the reasons why).

Black market will continue

In developing countries, abortion is big business. **Doctors and midwives can considerably augment their income by offering abortion in their premises outside of regular service hours. And MA drugs are available the world over on the black market, some of good quality and some of dubious quality. This is an extremely difficult world to control or understand but it is (increasingly) a bigger player as the value of misoprostol is more widely understood.**

Box 6. UK women attempting to access (currently illegal) abortion pills online: Why?

Women in England, Scotland and Wales are attempting to access abortion pills online, despite living in countries where abortion is legal and available. These women were prepared to break the current UK law to access online pills. To find out the reasons why, data from 519 women who contacted Woman on the Web between November 2016 and March 2017 were analysed. Their answers for why they wanted to obtain online medical abortion fell into three main categories:

- 49%: Access barriers including waiting time, long distance to services, work or childcare issues, and prior bad experiences with abortion care;
- 30%: concerns of privacy including stigma, privacy and wanting to use pills at home and a perceived lack of confidentiality; and
- 18%: Controlling partners or family, including violent partners.

These findings highlight the need for a more woman-centred approach to abortion services in the UK.

Source: Aiken et al (2018)^{xxv}

WORKFORCE

“Abortion services should be free of coercion and offered in a respectful and non-judgemental manner.”
- *WHO abortion guidelines, 2017.*

Healthcare provider skills

There is a critical shortage of trained staff, willing to provide abortions globally, but particularly in Africa. Providers often work in isolation and experience stigma from colleagues and managers. Even in South Africa, where abortion has been liberalised since 1996, many healthcare providers remain resistant (see Stigma section, below). **In the UK, skills shortages cause reduced access to abortion services, as abortion care has low status in obstetrics and gynaecology and is not recognised as providing an important service for women and girls.**

There will be an imminent UK-wide skills shortage when the current generation of the workforce retires, as NHS doctors do not get enough exposure to abortion services (as 70% of UK abortion services are contracted out to the private sector). The advanced skills modules introduced 10 years ago have only yielded 33 trainees^{xxvi}. For women with complex needs (usually foetal abnormality) between 19 and 24 weeks' gestation, some of them have

been unable to access care, because of long distances or lengthy waiting times. At a gestation of 15 weeks, there are 18 hospitals in England and Wales that can manage a medical abortion and 11 hospitals that can perform a surgical abortion. From 21 weeks, there are only two hospitals— both based in London — that can manage the procedures. Every week a UK woman with medical conditions is unable to get the abortion she needs^{xxvii}.

Task-shifting from doctors to nurses, midwives, and community health workers

WHO in its recent document ‘Health worker roles in providing safe abortion care and post-abortion contraception’ (2015) is clear, that abortion can be carried out on an outpatient basis at the primary care level by a wide range of health workers, especially in the first trimester of pregnancy .



“The emergence of medical abortion (i.e. non-surgical abortion using medications) as a safe and effective option has resulted in the further simplification of the appropriate standards and health worker skills required for safe abortion provision, making it possible to consider expanding the roles of a much wider range of health workers in the provision of safe abortion^{xxviii}”.

An additional challenge for the healthcare workforce is Conscientious Objection; this will be discussed under Obstacles to Safe Abortion Delivery.

WOMEN WHO ARE DIFFICULT TO REACH



Conflict settings make the need for abortions more urgent

Women in conflict settings badly need access to abortion care, as these women are particularly vulnerable to sexual violence, child marriage, and trafficking — all vulnerabilities leading to unintended pregnancies. The UK has been a leader as, in 2014, the UK amended its humanitarian aid policy to acknowledge safe abortion services, as part of international humanitarian law's protections^{xxix}. This means that abortion care can be provided for victims of armed conflict, instead of relegating such medical care to national laws. However, there remains much work to ensure coherent global policy and that these policies are actually put into practice. In practice, few safe abortions are yet delivered in conflict situations. In 2016, Doctors without Borders said they faced over 16,000 cases of unsafe abortion in the contexts in which they work. And this is just one organisation among many working in conflict areas.

Poor women are least served

Rich women are likely to be able to access safe abortion services whatever the legal framework in which they live. This is not true for the poorest women, who are least likely to have the information they need, the funds to procure, or the ability to access safe abortion services. These are the women who are still using the least safe abortion methods and are the most likely to require post-abortion care.

Young women and girls are most at risk

It is estimated that 38 million adolescent girls (aged 15-19) in developing countries are sexually active and an estimated 3.9 million adolescents have unsafe abortions each year^{xxx}. Adolescents are less likely to obtain safe abortion, more likely to terminate their pregnancies after the first trimester when the procedure is more dangerous, and more likely to delay seeking medical help for abortion complications and are less likely to know their rights^{xxxi}. Adolescents are also the least likely to have partner support or the support of their families (although their mothers may be supportive). In the UK or internationally, these young people need the best support when they present with an unintended pregnancy.



OBSTACLES TO SAFE ABORTION DELIVERY

The obstacles to safe abortion delivery are varied and many. This includes restrictive laws, poor availability of services, high cost, stigma, and refusal to care by healthcare providers, non-medical requirements such as third-party authorisation, mandatory waiting periods and counselling. Some of these will be discussed below.

LACK OF ACCESS EVEN IF THE POLICIES ARE SOUND

Even in countries with liberal laws, abortion services may be hard to find. **The liberalisation of abortion law is no guarantee of good abortion availability in the UK or in developing countries. A study in Zambia showed that, even with a relatively supportive legal environment, only 16% of women had access to Termination of Pregnancy services in facilities^{xxxii}.** In Zambia Central Province, there is one medical doctor for more the 110,000 patients. Good abortion services require trained and equipped staff and woman who know that the service is available and safe (see next).



LACK OF INFORMATION STOPS WOMEN FROM SEEKING SAFE ABORTION

Abortion is surrounded by secrecy. In the village, to whom is a woman with an unwanted pregnancy going to speak? With low levels of knowledge that the legal termination of pregnancy is possible, the woman has no choice but to turn to unsafe providers. In the Zambian study mentioned above, only 40% of women knew that abortion was legally permitted, even in the extreme situation where the woman's life was at risk.

Box 7. The US Global Gag Rule (GGR) and its implications for reproductive health

The Global Gag Rule, also the Mexico City Policy, is an executive order which was first implemented by US President Reagan and extended by President Trump. The policy states that no US funds will go to any organisation that provided, advocated for, or referred women for abortion. Now renamed the 'Protecting Life in Global Health Assistance' policy, it covers all non-US-based NGOs and includes all their activities, including those funded by other donors. Trump has expanded the rule from previous Republican Presidents to cover all US health assistance funds, which amounts to approximately US\$8 billion in 2017 (previously, the Gag Rule only applied to US family planning assistance).

The impact of the GGR will be widespread: it will certainly force clinic closures, staff reductions and reduce access to contraception and safe abortion. Various studies have shown that the GGR has actually increased world-wide abortion rates under previous Republican Presidents. **Marie Stopes International (MSI) estimates that their loss of US funding at present will result (between 2017 and 2020) in 6,500,000 unintended pregnancies, 2,100,000 unsafe abortions and 21,700 maternal deaths.** There will also be an impact on integrated care for HIV, gender-based violence and sexually-transmitted diseases.

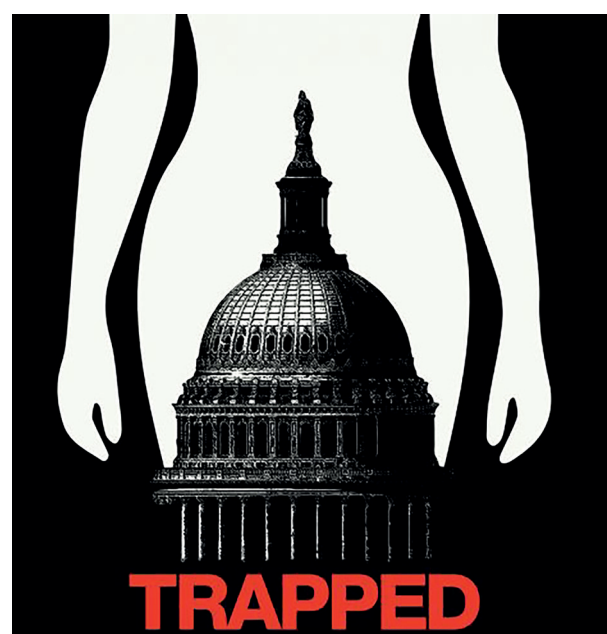
It is important that other donors take proactive measures to see that US anti-choice politicians do not dictate the care that is available to women and girls world-wide. One such action is the 'She Decides' initiative, begun by a group of European donors including the Netherlands, Belgium, Sweden and Denmark. The importance of continued UK leadership in international global abortion cannot be under-emphasised.

ANTI-CHOICE GROUPS HAMPER POLICY-MAKERS, PROVIDERS AND WOMEN

“An abortion law—even a so-called liberal one—is a gift to anti-choice politicians [and groups].”

-Joyce Arthur, *Abortion Rights Coalition of Canada*

Even in Canada, the media and some healthcare providers continue to harass women. If this happens in progressive Canada, what can be expected in countries with restrictive laws? Creating myths such as 'abortion causes breast cancer' are hard to overturn. The facts do not support this, but the rumour is released. In developing countries, rumours are spread that the West is trying to impose western women's human rights. Internationally, intimidating tactics include posting terrible pictures online and picketing clinics where reproductive healthcare is provided. Women are meant to be made to feel guilty about their decisions and the morale of the healthcare profession has been seriously affected.



ABORTION STIGMA IS ABOUT POWER, GENDER STEREOTYPES AND SEXUALITY

Abortion stigma is intertwined with issues around power, gender stereotypes and sexuality^{xxxiii}. Stigma affects the women and those providers who try to help them. In



addition, it drives abortion into the hands of unsafe providers. Women suffer stigma in the community when they ask where they might find safe abortion services — so they don't ask. Women, particularly young women, are frightened to obtain abortion services, because they fear the judgement they will receive from healthcare providers. Healthcare professional's disapproval might take the form of outright refusal of services or abuse of the women.

Providers need to better understand their own attitudes to abortion. South Africa — with one of the most liberal laws on abortion in world — still has healthcare providers that experience burnout from being victimised, stigmatised and isolated from their peers and from their community^{xxxiv}. Training providers to carry out a highly-stigmatised procedure in developing countries remains a challenge. Many healthcare providers are conflicted because they cannot but help to represent the views of the cultures in which they were raised. Values Clarification is a tool that has been used to great effect in many different settings (see Box 8).



Box 8. Helping healthcare providers to use values clarification and provide respectful care

Values Clarification Workshops allow health professionals a safe space in which they can explore their personal doubts, converse about reproductive health issues and empathise with women seeking abortion care services. Providers also acquire knowledge to reaffirm their own values and the ability to develop skills to provide respectful, holistic care to women seeking abortions. In addition, MSI has found that supporting providers with Provider Share Workshops gives safe abortion care providers a safe space for discussing the unique rewards and burdens of their work. Trained facilitators run workshops which allow participants to give voice to their experiences and offer participants support and connection to others.

RELIGION, CLAIMS OF CULTURE THAT AIM TO CONTROL WOMEN AND CONSCIENTIOUS OBJECTION (CO)

“Conscientious objection in reproductive health is not actually CO, but Dishonourable Disobedience to laws and ethical codes. Healthcare providers are using their position of trust and authority to impose their personal beliefs on patients, who are completely dependent on them for essential healthcare.”

- Christian Fiala, Gynmed Clinic, Vienna, Austria

Religious beliefs have no place in evidence-based healthcare.

As mentioned earlier, CO was introduced in 1967 with the UK Abortion Act. Since then, CO has been used worldwide by healthcare providers as an excuse to shirk their duties to care for their patients. The exception is Finland, Iceland and Sweden where there is no provision for refusal to treat. Rather than coming from a deep moral position, it is often noted to be an excuse to avoid a necessary task. The imposition of a doctor's religious beliefs on a vulnerable patient, is a way to harm women and CO nearly always involves services needed by women (contraception and abortion). There is more fundamentalism in all religions currently, this is not only Catholics, as many fundamentalists oppose abortion. Recall that many hospitals — including training hospitals — are run by religious institutions in developing countries. They see that their providers receive no information on family planning or abortion. In the US, the Trump Administration has just created a religious freedom division at the Department of Health and Human Services. **Finally, in the UK, the current system of carrying out the majority of abortions in the private sector represents an abdication of the NHS to provide healthcare in public hospitals.**



FUTURE OF ABORTION

SELF-USE: THE WAVE OF THE FUTURE

As mentioned earlier, WHO guidelines state that a woman can self-manage medical abortion, so long as she has accurate information and access to post-abortion care, if her method fails. In early pregnancy (under nine weeks), a GP should be able to counsel a client, give her information and a prescription, and send her home. Or MA pills can be ordered online with

qualified instructions – sent directly to the woman and taken at home. It could be that simple and safe.



WEB AND PHONE-BASED TELEMEDICINE SERVICES

In countries where the information and medicines are not available, women are ordering MA pills online. The supplies are often sent from the manufacturer directly to the woman's address. Countries

sometimes attempt to intercept these packages with varying degrees of success. For example, Brazil, the Philippines and NI have managed to intercept some of these packages and have prosecuted some women. Surprisingly, this method is growing in popularity in the US, where online providers appear and disappear over time. A study of the quality of the product sent within the US found that the medicines were of high

quality, safe and effective^{xxxv}. Telemedicine services report that Latin American women make up about half their clients. There are safe abortion information hotlines in at least 20 countries, providing women with information on MA and emotional support during the process.



AVAILABILITY/QUALITY MUST BE ENSURED

About 34 countries have carried out regulatory approval for the combination regime of mifepristone and misoprostol. Ideally, pre-qualified ‘Combi-packs’ are available with the correct dose of mifepristone and misoprostol in one double aluminium pack. Efforts to improve access to safe abortion will require work around expanding availability to the combination MA medicines and to seeking regulatory approvals in more countries. Misoprostol alone is 92% effective in inducing a medical abortion and many women, where the combination medicine regime is unavailable, use misoprostol only as widely available in pharmacies for its original purpose of treating gastric ulcers. There are over 80 manufacturers of misoprostol worldwide, but there have been some quality issues with cheaper low quality products, which is of concern. The safest method is to buy misoprostol from a WHO pre-qualified manufacturer (International Planned Parenthood Federation is soon launching a website, that will inform providers and women of safe and reliable drug sources).



MORE FAMILY PLANNING WILL REDUCE ABORTION WORLDWIDE

“Reducing unintended pregnancies by scaling up access to family planning and reducing recourse to unsafe abortion are among the most cost-effective strategies to prevent maternal deaths.”

– Jenny Cresswell, *the London School of Hygiene and Tropical Medicine (LSHTM)*

Family planning and abortion go hand in hand, the one to prevent and the other to address unwanted pregnancy.

Family planning is one of the most cost-effective strategies to prevent maternal deaths and suffering from unsafe abortion. Indeed, the lowest rates of abortion in the world can be found in Germany and Switzerland, where family planning is widely and easily available. Young people are particularly prone to unintended pregnancies and each year many adolescents in developing countries get pregnant and choose to induce a miscarriage unsafely. The expansion of family planning information, counselling and services for young people are urgently needed and would reduce abortion and the risks for these young people^{xxxvi}.



RECOMMENDATIONS



INTERNATIONAL ABORTION AND WHAT THE UK DFID SHOULD DO

DFID is commended for taking a global leadership position in abortion and for its broad portfolio of global work.

- 1. DFID should do even more to support willing countries to expand access to safe and legal abortion where abortion is restricted through policy and legal reform,** addressing discrimination and stigma, ensuring medical abortion (MA) is on national essential medicines lists, and improving quality of care including service provider training and good clinic logistics management.
- 2. Expand availability of medical abortion globally and replace unsafe methods with safe methods, involving a wider range of health workers — including pharmacists — in the provision of safe abortion care.** Safe abortion care should be integrated into primary health care levels to increase access.
- 3. Work to broaden the laws to permit community and primary care health workers, pharmacists, nurses and midwives to provide abortion.** Ensure a full and clear implementation of the WHO best practice recommendations, so that mid-level providers are permitted to manage abortion; this is critical, given the current reality of healthcare provider shortages. Then, train and equip these providers at primary health facility level, especially to extend medical abortion services.
- 4. Continue to ensure access to safe abortion to the full extent of the law, particularly in developing countries and conflict situations.** There is much that can be done to improve access to and safety of abortions in these contexts.

5. **Increase funding for family planning and the wider sexual and reproductive health and rights agenda to 10% of official development assistance and 10% of national development budgets.** DFID should continue to increase investment in the full range of integrated SRHR services, including safe abortion care.
6. **DFID should promote its 2014 policy on abortions in conflict situations and international humanitarian law to humanitarian and other partners.** This can underscore the UK's priorities in protecting victims and medical staff and on protecting children in armed conflict.
7. **The UK should use their voice to reinforce the importance and centrality of abortion to women's human rights and equality.** Work should go toward protecting abortion as a necessary health service, which is part of a continuum of services. This will make it more difficult to marginalise safe abortion care from the rest of family planning and SRH.
8. **Ensure adolescent girls and young women have access to youth-friendly and non-judgmental sexual and reproductive health services, including abortion care.** Services must respect their rights to confidentiality, privacy and informed consent.
9. **Work to take abortion out of the criminal law and towards the release of all imprisoned woman and girls and healthcare professionals who are incarcerated because of punitive abortion laws.** Also, accelerate action to repeal laws that make abortion a crime.
10. **Support comprehensive sexuality education through in-school and out-of-school programmes for adolescents that promote comprehensive sexuality education including information on contraception and abortion.** Ensure that the programmes equip young people with the information and skills to protect themselves, not just morality lectures.

UK: ON THE ROAD TO DECRIMINALISATION

1. **Decriminalise abortion completely^{xxxvii} — as Canada has done —** and allow regulatory and professional standards (in line with other medical procedures) to regulate abortion. Support for Private Members Bills to decriminalise abortion and update the 1967 UK Abortion Act. Eliminate clauses 58 and 59 of the Offences Against the Person Act and the Infant Life (Preservation) Act altogether.
2. **The DoH should follow WHO guidelines and define the home as a safe place to take abortion medication in England (as is already taking place in Scotland).** This would allow women to be in control of their treatment and as comfortable as possible during the procedure.
3. **If there are NHS contracts to independent providers, they must include a commitment to training with joint contracts that allow clinicians to move seamlessly across both the independent and NHS sectors.** An overall NHS abortion training plan needs to be put in place to ensure a short-, middle- and long-term workforce training fix (including training to ensure the removal of stigma). Many more abortions should be managed by the NHS at the primary care level.
4. **Follow WHO guidelines to allow primary care workers such as nurses and midwives to manage both surgical and medical abortion in the first trimester.** The full development of nurse and midwife-led care will free doctors for the more complex cases and make the NHS abortion care more efficient.
5. **NICE is best placed to develop appropriate clinical care pathways.** The Care Quality Commission (CQC) is best placed to regulate practice in hospitals and clinics and the General Medical Council (GMC) is best placed to provide governance and professional standards and conduct.
6. **Coordinate NHS abortion planning across the nations of the UK, so that women have timely access to high quality services. And agree fair tariffs for various types of abortion services, so there is no disincentive to treat second trimester and complex cases.** Develop a central information system for women who are seeking an abortion and refer complex abortion cases to regional centres, where girls and women can find specialist care. Ensure buffer zones outside family planning clinics, as no woman or girl should be intimidated on her way to obtaining a legal health service.
7. **Stop the erosion of family planning and sexual health services and instead ensure family planning and sexual health services are readily available, reducing the need for abortion overall.** These services must be accessible and available on the NHS.
8. **Increase understanding among politicians and policy makers with better education and information about abortion and the impact on women of restricting it and keeping it criminalised.**

NORTHERN IRELAND: WHAT'S THE WAIT?

- 1. The UK Government must give clear guidance on funding and a care pathway for women travelling from Northern Ireland (NI) to England for an abortion.** This will assist women of NI in their journey for better abortion services and their quest for reasonable pre and post abortion care.
- 2. Medical professionals of NI must be clear of their legal obligations to women seeking abortions.** Ongoing work is required to communicate clear guidelines to all healthcare providers.
- 3. Build coalitions to decriminalise abortion in NI** – using the momentum of the possible up and coming changes in the Republic of Ireland. Meanwhile, women will continue to access MA online and travel to England.
- 4. Support research and campaign activities to combat misinformation and myths surrounding abortion in NI.** This will ultimately support legislative reform.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APPG	All-Party Parliamentary Group
CCG	Clinical Commissioning Groups (UK)
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CO	Conscientious Objection
CQC	Care Quality Commission
DOH	Department of Health
ECHR	European Convention on Human Rights
FP	Family planning
GMC	General Medical Council
GP	General Practitioner (of medicine)
HIV	Human Immunodeficiency Virus
ICPD	The International Conference on Population and Development (the landmark 1994 ICPD is mentioned most often)
MA	Medical abortion
MVA	Manual vacuum aspiration
NI	Northern Ireland
NICE	The National Institute for Health and Care Excellence (UK)
RCOG	Royal College of Obstetricians and Gynaecologists
RH	Reproductive health
SRH	Sexual and reproductive health
WHO	World Health Organization

APPENDICES

Appendix 1: List of Written Evidence

- Department for International Development (DFID)
- World Health Organization (WHO)
- United Nations Population Fund (UNFPA)
- International Planned Parenthood Federation (IPPF)
- Marie Stopes International (MSI)
- IPAS
- Doctors of the World (DOTW)
- Center for Reproductive Rights
- Global Justice Center
- International Campaign for Women's Right to Safe Abortion
- What Works Association
- Doctors for a Woman's Choice on Abortion (DWCA)
- SheDecides
- Royal College of Obstetricians and Gynaecologists
- Abortion Rights Coalition of Canada
- Gymned Ambulatorium
- The Reproductive Health and Policy Advisory Group
- Sheelagh McGuinness (University of Bristol)
- Jonathan Montgomery (University College London)
- Marie Fox (University of Liverpool)
- Jenny Cresswell (London School of Hygiene and Tropical Medicine)
- Maya Unnithan and Ben Kasstan (University of Sussex)
- British Pregnancy Advisory Service (BPAS)
- Brook
- Alliance for Choice
- London-Irish Abortion Rights
- Family Planning Association (FPA)

Appendix 2: List of Witnesses

- Marge Berer (International Campaign for Women’s Rights to Safe Abortion)
- Wendy Savage (DWCA)
- Bela Ganatra and Ronald Johnson (WHO)
- Lesley Regan (Royal College of Obstetricians and Gynaecologist)
- Joyce Arthur (Abortion Rights Coalition of Canada)
- Christian Fiala (Gynmed Ambulatorium)
- Gillian Kane (IPAS)
- Akila Radhakrishnan (Global Justice Center)
- Katrine Thomasen and Paola Daher (Center for Reproductive Rights)
- Jenny Cresswell (London School of Hygiene and Tropical Medicine)
- Marie Fox (University of Liverpool)
- Sheelagh McGuinness (University of Bristol)
- Arthur Erken (UNFPA)
- Anna Wechsberg (DFID)
- Rebekka van Roemburg (SheDecides)
- Manuelle Hurwitz and Ana María Bejar (IPPF)
- Mohsina Bilgrami and Catherine Slater-Kirk (MSI)
- Catherine Giboin (DOTW)
- Jill Gay (What Works Association)
- Kellie O’Dowd (Alliance for Choice)
- Polly Barklem and Barbara Davidson (London-Irish Abortion Rights)
- Ruairi Rowan and Laura Russell (FPA)
- Ann Furedi (BPAS)
- Lisa Hallgarten (Brook)
- Lord Steel

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- Box 4. Canada has decriminalised abortion completely...and it made no difference to safety
- Box 5. Home Self-Use of Medical Abortion (up to 9 weeks) is approved by the WHO
- Box 6. UK women attempting to access (currently illegal) abortion pills online: Why?
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WHO DECIDES? We Trust Women

Abortion in the Developing World and the UK

A report by the UK All-Party Parliamentary Group on
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