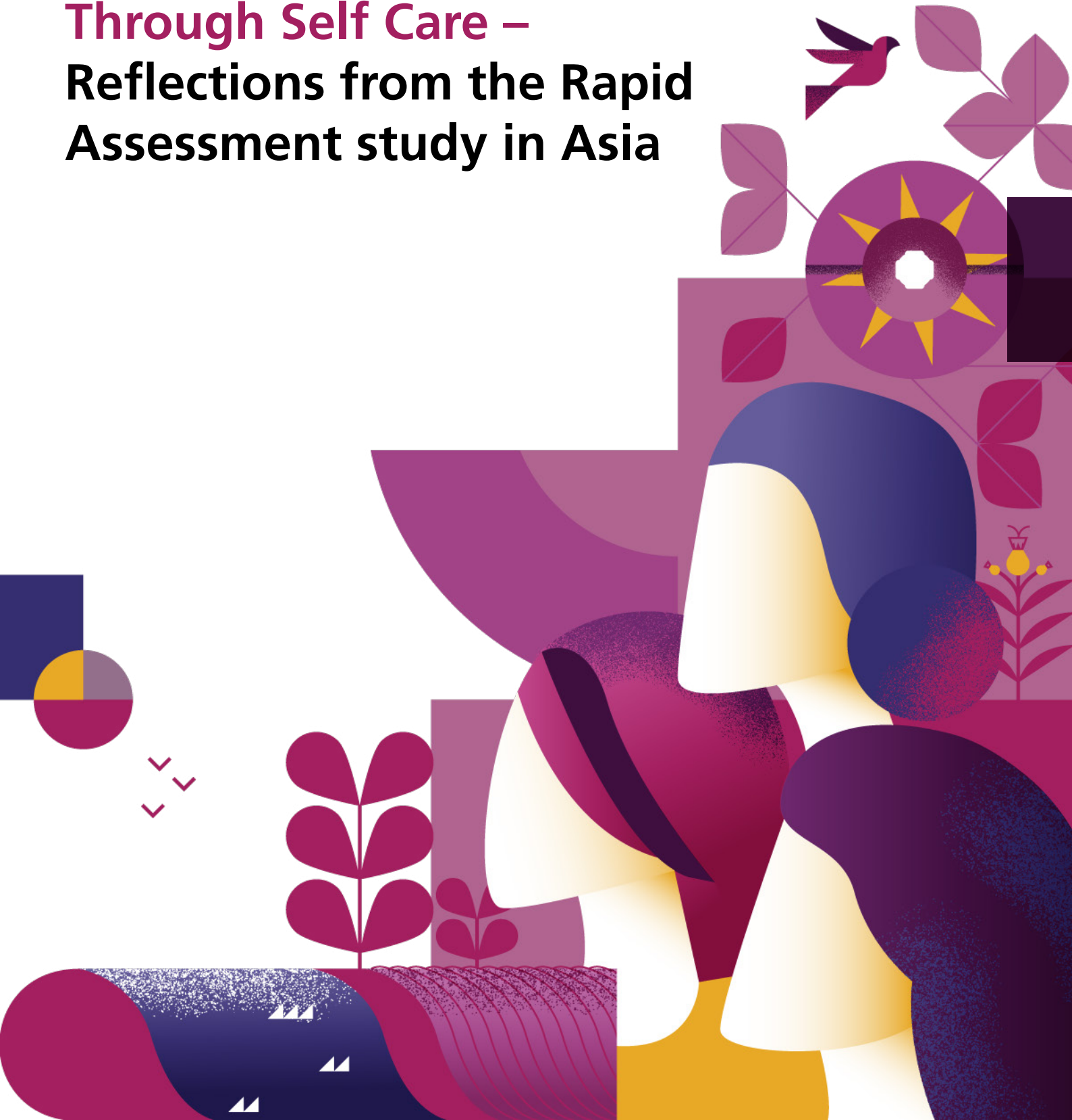


Eliminating Unsafe Abortion Through Self Care – Reflections from the Rapid Assessment study in Asia



Self-Care Interventions can empower clients, particularly young people, and marginalized populations, and increase access to desired sexual and reproductive health services. This study examines and documents the existing legal and policy environment, health system preparedness, opportunities, challenges, and barriers for Self-care Interventions, to inform the policies and services specifically for eliminating unsafe abortion and for providing post-abortion care and contraception in Asia.



Introduction

Medical abortion (or Medical Menstrual Regulation) is a non-invasive, effective method that offers privacy and confidentiality and is an alternative to surgical methods for termination of pregnancies. The established safety of medical abortion has revolutionized access to safe abortions services. The lockdown restrictions and unprecedented strains on health care systems during COVID-19 pandemic made access to health services challenging. Self-care interventions can empower clients in such crisis situations. Medical abortion has the potential to not only enhance autonomy and decision-making with regards to reproductive choices and rights but also offer an easy-to-use self-care option to people in need of these services.

International Planned Parenthood Federation South Asia Regional Office (SARO) in collaboration with East & South East Asia and Oceania Region (ESEAOR) undertook a study supported by WHO South East Asia Regional Office (SEARO) - to examine and document the preparedness, opportunities, and challenges for self-care interventions, to inform the policies and services specifically for eliminating unsafe abortion and providing post-abortion care and contraception in four countries - Bangladesh, Indonesia, Myanmar, and Sri Lanka.

Methodology

Since abortion is a sensitive topic, a mixed method approach was adopted for a comprehensive, in-depth, and empirical inquiry. Primary data was collected through interviews with key stakeholders in each country representing policy influencers, IPPF strategic partners, UN agency, service providers, professional organization, and civil society organization. Semi-structured guides were used, and informed consent was taken for recording the interviews. Secondary data sources included WHO guidelines; country specific laws, policies, service delivery guidelines, government resolutions and orders; services statistics and data; international agreements; published studies and reports.

Challenges and opportunities were explored across key dimensions such as enabling environment, the health system's preparedness, abortion scenario, community perceptions and women's autonomy.



Key Principals

- ① Address structural determinants & barriers
- ② Focus on human rights and gender lens
- ③ Promote a coordinated and coherent response
- ④ Reduce stigma and discrimination
- ⑤ Recognise the centrality – Self within self-care

Key findings: Enabling environment and challenges

Both conducting and undergoing abortion is a crime in these countries, with the quantum of punishment varying with the pregnancy gestation and whether it is self-induced, with the woman's consent and whether the procedure caused the death of the woman. However, indictments under the law have been rarely reported. Since abortion is legally restricted in all the four countries under review, the exact abortion incidence is unknown. The actual number of abortions in the country has exponentially increased since the advent of Over the Counter (OTC) availability of medical abortion drugs. A large proportion of abortions are also conducted by untrained providers, often in unsafe conditions resulting in 5-16 per cent of maternal mortality. According to stakeholders, maternal mortality due to abortions has declined as use of medical abortion pills has reduced unsafe abortions.

All four countries are signatories to international covenants and agreements that recognise that it is the state's responsibility to respect and support the right to self-determination and an obligation to recognise that people have a right to make autonomous decisions about their body and reproduction. However, the consistent advocacy efforts by NGOs, CSOs, lawyers, women, and youth activists as well as medical professionals to review the existing abortion laws have had little impact. Opinions of religious leaders' and community's views on social norms and abortion as a sin and the stigma attached to it continue to have a strong bearing on abortion policy and availability of services.



There is stigma both at the community level and at the provider – doctor – level. She is considered a bad woman as she had sex outside of wedlock.

(Stakeholder, Indonesia)

Nevertheless, demand for services exists and in the legally restrictive environment, word of mouth, websites and NGO helplines emerge as a powerful source of information on place or method of self-termination as those in need of services typically lack awareness about legality and their own entitlement.



We are a deeply religious country. We already have a MR policy in place which meets women's needs. Any attempt to legalise abortion may jeopardise even these services.... We may end up doing disservice for women's cause. I personally think we should focus on improving quality of services and awareness campaign about women coming early for MR.

(Stakeholder, Bangladesh)

At the health system level, the biased, judgmental, abusive, and reluctant attitude of service providers and restriction of services to married couples, leaves out a large proportion of unmarried young people who may be sexually active or survivors of rape/incest. Private gynecologists, particularly, are known to have reservations about service seeker's ability to assess own gestational eligibility and reportedly either deny services or exploit women. Post Abortion Care (PAC) services however are available to persons experiencing abortion complications in all countries. Detailed protocols and guidance are available in Bangladesh and Sri Lanka and are awaiting ministerial approval in Indonesia and Myanmar.



Half a century since the first attempt at liberalising the law and things haven't changed. A few years back we went to the Minister with all the data, evidence, and rationale that we had for liberalising the law for rape, incest and foetal anomalies. He asked us to go and convince the religious leaders.

(Stakeholder, Sri Lanka)

The COVID19 pandemic exacerbated these challenges with closed health facilities and pharmacies, suspended outreach services, and stock outs of contraceptives and medical abortion pills. Attempts to revive services included review of the service guidelines, introduction of Telemedicine and a helpline for maternal health services but not for contraceptive, abortion, or PAC services.



There was a stock out of contraceptive methods and increased violence against women and increase in pregnancies during this (COVID -19) period.

(Stakeholder, Myanmar)

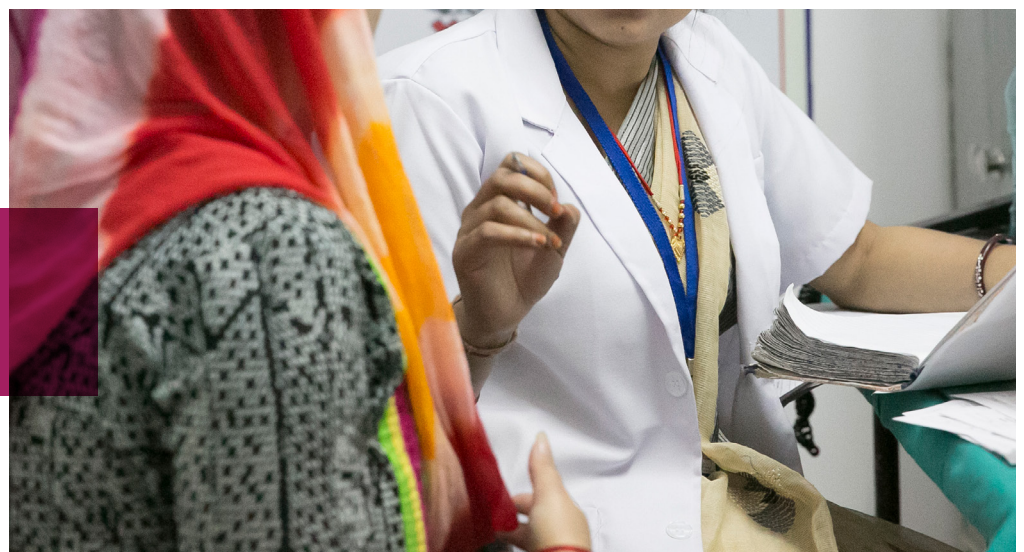
Recommendations for Self-Care Interventions

Based on these findings the recommendations for eliminating unsafe abortion through formal introduction of self-care interventions within the legal and policy contexts of the country are:

Evidence -based service policy and prioritisation that take into account abortion mortality and morbidity as well as women's lived realities; gaps at health system level that include hostile behavior of service providers and nonavailability of drugs at facilities and deter provision of good quality, protocol aligned services even at all legally recognized facilities and the quality and sources of available medical abortion drugs.

Till abortion is decriminalized or grounds for legal abortion are expanded, harm reduction strategies that co-opt local NGOs/CSOs and community level influencers and gatekeepers to lead the discourse on rights and stigma reduction; ensure sources of reliable and easily comprehensible information in simple local language or in pictorial form about legality, rights, entitlements, services, available drugs, helplines and emergency service facilities; regulate and ensure safe and standard web-sourced and telemedicine need to be central to any efforts to eliminate unsafe abortions.

Consistent advocacy efforts that use examples of legal reforms in other countries for bringing religious leaders on board and use nuanced, acceptable language that articulates the issue as more widely acceptable woman's right to choose her health rather than the contentious right to terminate a pregnancy.



For more information related to this study, please contact:

1. Deepesh Gupta, Sr. Technical Advisor -SRHR, IPPF SARO dgupta@ippf.org
2. Sangeetha Permalsamy, Programme Officer, Gender and Safe Abortion Care, IPPF ESEAOR

