Radical Abortion Care in a Pandemic

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Global Policy Review of Abortion in the time of the Covid-19 Pandemic

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About the report: This report forms one of a series of outputs for the project *Radical Abortion Care in a Pandemic (Kenya and Zambia)*. Other reports include: a review of the Kenyan context; a review of the Zambian context and an overall briefing paper. These can be accessed via https://pure.ulster.ac.uk/en/persons/fiona-bloomer/publications/

Section A - Introduction

> "Women's needs do not suddenly stop or diminish during an emergency – they become greater. And as a doctor I have seen only too often the drastic action that women and girls take when they are unable to access contraception and safe abortion." (Rashmi, 7)

Since the outbreak of the Covid-19 global pandemic there have been a number of responses from policy makers across the world regarding the provision of abortion, the following review will incorporate comment and findings on the impact of Covid-19 on abortion services from a wide range of sources: from NGOs, academics, health researches, abortion providers, country-specific health policies, news outlets and global reports. A wide range of countries from all income levels and health disparities will be used as examples to illustrate the wide range of responses to Covid-19, some of which are highly context specific and some which can be categorised within an overarching global strategy. As one might expect, the countries with well-established progressive approaches to abortion provision made efforts to remove barriers caused by Covid-19, whilst countries where abortion was already highly restricted continued to use any opportunity to further restrict access (Baum et al., 2; Nandagiri, Coast and Strong; Senderowicz and Higgins, 147; Bateson et al., 241).

The United Nations Convention on the Elimination of all forms of Discrimination against Women (UN CEDAW) recommendations (UN Human Rights) are highlighted at the outset of this review to establish the framework for the global rights perspective, followed by the World Health Organization (WHO) recommendations to outline the global health perspective and to establish the central role of WHO as the main worldwide source of emergency pandemic advice on reproductive healthcare (WHO). This will help clarify why telemedicine was positioned as one of the central emergency solutions to the global call for Covid-19 appropriate abortion measures issued by WHO and the UN (Assis and Larrea,1); where relevant examples of contexts where this has been successfully utilised will be considered.

Lastly, an overview of the contexts where the pandemic was used as an excuse for either inaction or further restrictions to abortion will be considered as well as evidence as to what, if any, measures were taken to circumnavigate these barriers by abortion seekers.

Section B - Context

As with any crisis, Covid-19 has not created the majority of the discrepancies in abortion healthcare across the globe, merely it shines a revealing light on to existing problems in the legal, healthcare and activist systems in which it exists (Nandagiri, Coast and Strong; Senderowicz and Higgins, 147; Dutch).

In order to mitigate the harm and death toll of unsafe abortion, which is responsible for an estimated 43,684 deaths per year (Kassebaum, 196) the UN, particularly CEDAW, has made a number of unequivocal statements as to the necessity of access to abortion in general and indeed during the Covid-19 crisis. Of particular interest in the following excerpt from their Covid-19 advice is the assertion that when states provide their sexual and reproductive health services, they should be deemed 'essential' and provide,

> "Confidential access to sexual and reproductive health information... safe abortion and post-abortion services and full consent must be ensured to women and girls at all times, through toll-free hotlines and easy-to-access procedures such as online prescriptions, if necessary free of charge." (UN CEDAW, 1)

The highly detailed and prescriptive guidance on medical protocols provided by CEDAW. Whilst the exact term 'telemedicine' is not used specifically in the text, its characteristics are clearly implied in the content of the guidance. Although the tone of the guidance may seem prescriptive, the document should be read with UN concerns in mind, of the reproductive health crises and extent of long-term disability and death caused to women and girls subject to restrictions after the Zika and Ebola outbreaks.

> "...when schools were closed during the Ebola crisis, there was a steep increase in unintended teenage pregnancies and a staggering 75% increase in maternal mortality over just 18 months" (Plan International, 2).

Plan International's report also highlights the particular global impact on teen girls, already at a greater disadvantage for accessing reproductive healthcare. With the closure of schools these teens are even less likely to encounter any sexual health education in a virtual learning environment, for those fortunate enough to have a virtual learning option.

The World Health Organization (WHO) has become a more familiar public presence since the outbreak of Covid-19, as a reputable source of medical and health information, their guidance during a pandemic is vital to policy makers globally. On 1st June 2020, the WHO published emergency guidance for health systems and gave a stark warning as to the worldwide impact of a disruption to abortion services.

> "Even a 10% reduction in these services could result in an estimated 15 million unintended pregnancies, 3.3 million unsafe abortions and 29 000 additional maternal deaths during the next 12 months" (WHO, 29).

It is clear there is a public health duty to ensure access to Sexual and Reproductive Health (SRH) services are not disrupted more than necessary during this crisis, but given the added demands on medical staff and other resources, the WHO have a number of strategies they offered as alternatives to current abortion care, suggesting each country provides these right up to the limits of their laws:

- Consider reducing barriers that could delay care and therefore increase risk for adolescents, rape survivors and others particularly vulnerable in this context.
- Consider the option of using non-invasive medical methods for managing safe abortion and incomplete abortion.
- Minimize facility visits and provider–client contacts through the use of telemedicine and self-management approaches, when applicable, ensuring access to a trained provider if needed.
- Adjust forecasting for commodities and supplies to meet the anticipated increase in need for medical methods of abortion, (WHO, 29).

Of note is particular consideration given to the use of telemedicine and self-management of abortion, as well as a call to reduce barriers that could delay care.
There are examples of contexts where this advice was ignored and examples of outliers who heeded the recommendations for public health. Before that however, it will be useful to consider the specific ways that Covid-19 impacted on abortion services.
Notably, a number of Pan-African NGOs have come together within the last decade to develop information services and practices that seek to end the high mortality rates linked to unsafe abortion in the African continent and many of the contexts where abortion is largely illegal but post-abortion care is not, they have found ways of introducing these methods as integral parts of the 'port-abortion care' that make great strides in harm reduction (see Tanzania in country summary). That this work has already had some time to bed in before the outbreak of Covid-19 is important, as these are the strategies which have continued to prove most useful in keeping abortion seekers safe during a pandemic, even when physical clinics can no longer stay open. (Moseson et al.)

Section C - Covid-specific blockages

Many of the global lockdown policies routinely used a homogenised approach to populations ignoring a range of community and demographically specific needs such as class, gender, ethnicity and disability, which can only have increased already present discriminations within healthcare systems (Nandagiri, Coast and Strong).

> "... the COVID-19 response is posing threats not only to comprehensive abortion care in the traditional sense, but also to many of the effective workarounds that people have developed in response to legal restrictions and other access challenges." (Senderowicz and Higgins,147).

Many abortion seekers living in contexts with highly restrictive abortion laws have to use a combination of other methods to circumnavigate the blocks in access. These usually include; travel to nearby countries or states where the provision is easier to access, ordering pills via telephone hotlines and online telemedicine services, and dangerous self-managed options. The issue since the pandemic and its global nature, has meant that those methods previously accessed as safety valves countering state obstruction, became closed completely or severely compromised, (Saenz and Coote-Muñoz). This has included: Polish women needing to travel to Germany, Mexican, Australian and American women travelling long distances interstate, Irish and Northern Irish women travelling to England, and Maltese women trying to get to Spain. In sexual health clinics in

large landmass countries such as Kenya, have often been forced to shut - especially where abortion is not exceptionalised in the local lockdown restrictions.

> "Marie Stopes Kenya, which normally operates 20 centres and 15 mobile outreach teams, has been forced to temporarily suspend its outreach programs because of Kenya's curfew and restrictions on movements and group gatherings." (Wadekar)

There are similar concerns across Asia, the recent IPPF report on "Safe abortion services amid COVID19" estimates that normally about 4.6 million women in the region are treated for unsafe abortion due to complications each year. The continued levels of logistically restricted access from Covid-19 may result in an additional 49 million unmet contraceptive needs as well as an additional 15 million unintended pregnancies over the course of a year, (IPPF).

Although many of the barriers to abortion access already existed before Covid-19 due to pre-existing legal restrictions, as well as the supplementary abortion-travel routes being closed off once the pandemic spread across the world, further barriers were erected:

1. Postal services were disrupted due to staff shortages.
2. Drug shortages occurred following the grounding of air traffic in India and China, where a majority of the world's production of misoprostol was based, was now inaccessible, (Senderowicz and Higgins, 2020). This was particularly worrying as the medication is affordable and widely used as the global standard response to local restrictions by abortion NGOs and activists.
3. Many countries redirected clinical and staffing resources to cope with Covid-19 cases, leaving sexual and reproductive health services under-resourced or closed, (Sanchez, Rodriguez and Gralki).

The UN had warned of the likely impacts for women and girls, including restrictions to sexual and reproductive healthcare as well as an increase in intimate partner violence, as it had seen the same unfold during the Zika and Ebola outbreaks, (United Nations Population Fund, 2). This was addressed, at least in part, by the funding of specialist emergency sexual and reproductive health training to over 233,952 health workers in the Asia and Pacific region in 2020. The purpose of the funding also included actively working to strengthen the global supply chains of contraceptives and abortion medication. For instance in Bhutan, free hotlines and mobile services were developed to continue the availability of contraception as telemedicine and in Viet Nam, "a telehealth intervention is being piloted to ensure the continuity of SRH services, including maternal and family planning services, for ethnic minorities and migrant workers" (United Nations Population Fund, 4)

Global abortion developments have continued, sometimes because of and often despite of the crisis. Notably not all countries went into the pandemic from the same starting point either legislatively or in terms of the functionality of their public health systems. The global south is home to both the toughest criminalisation of abortion and the largest incidence of death due to unsafe abortion.

> "The African continent has the highest proportion of less and least safe abortions of any region in the world."(Moseson et al.)

Telemedicine to the rescue

To consider the many speedy interventions and policy changes that have happened for abortion provision since Covid-19 is to acknowledge the boon provided to areas of healthcare that may have remained impeded by ambivalent bureaucracy for years to come otherwise (Bateson et al., 242). Almost as soon as the crisis had confirmed its grip on Europe, the European Parliament voted to deal with the pandemic and its consequences, including measures to ensure the necessary access to contraceptive and abortion care (Caruana-Finkel, 2). As outlined below these measures did not impact in contexts like Northern Ireland, Poland and Malta, where state powers refused to act in the interests of abortion seekers, and travel to other jurisdictions became increasingly difficult during the pandemic.

For decades, the knowledge of the use of misoprostol, (which began in Brazil as an off-label use) to end early pregnancy has expanded exponentially with the help of feminist activists and their global solidarity and knowledge sharing (Assis and Larrea, 1; Bloomer, Pierson, et al. 88). NGOs such as Women on Web, Socorristas en Red in Argentina, Women Help Women, Samsara in Indonesia and MAMA in Africa have stepped in to provide the abortion care that is needed when states forbid it. It could be argued that the work of international NGOs and on-the-ground activists in a multitude of contexts, paved the way for the current telemedicine protocols such as those released by WHO for use during Covid-19:

> "The history of women self-managing abortion with pills creates a paradigm shift for realizing the full potential of medical abortion, regardless of the legal restrictions of any country and the availability of a clinician." (Jelinska and Yanow, 87).

Although writing before the outbreak of Covid-19 Jelinska and Yanow understand more than most, through their roles in Women Help Women, that what abortion seekers need in a crisis isn't laws or guidance, it's practical help, including abortion inducing pills, that are safe, easy to self-administer and easy to access. There were very few examples of telemedicine embedded into official state health services and regulations worldwide until the outbreak of the pandemic. Not only do abortion seekers prefer to not have to travel for healthcare during a pandemic, there is clear evidence that many people also value the sense of control, the privacy and the relative comfort of one's own home that telemedicine can offer (Assis and Larrea, 2).

Some countries where telemedicine was launched or extended include: the Republic of Ireland, Scotland, England & Wales, South Africa:

> "... patients mostly love the increased access and convenience of telehealth visits; for the patients we do see in clinic, we generally have so much more time to spend with them now without being rushed; some clinicians have been able to expand their practice to now offer medication abortion to meet the need." (Clinician, cited in Upadhyay, Schroeder and Roberts, 2020)

Assis and Larrea, (3) propose an approach to abortion care which they deem is radical, where the needs of abortion seekers are paramount and over-medicalisation is averted. Their proposals explicitly embrace the activist modes of support that Covid-19 safe abortion care has been based on; these include

- Eliminating barriers such as prescription requirements and over-regulated requirements for distribution and administration of pills.
- Allow information on self-managed abortion with pills to be available online and without censorship.
- Improve and instigate localised production of abortion medication in order to ensure equitable access across the globe by setting affordable prices where state healthcare does not provide free of charge.
- Values training for providers to decrease the likelihood of encountering stigmatised care.
- Ensure training on MVA and 2nd trimester abortions is given so there are options for people unable to avail of EMA.

Assis and Larrea, (3) take great pains to underline that over-medicalisation of EMA can create unnecessary barriers to care and that state health systems need to play catch-up with women and activists on the ground who understand the empowering nature of allowing people to safely self-manage their own abortions. Some countries have begun to understand the many benefits of this approach, not least the cost-effectiveness of self-managed telemedical care.

Providers such as MSI have worked hard to circumnavigate countries' internal travel restrictions even beyond telemedicine. In Burkina Faso and Madagascar for example, EMA has been delivered by motorbike and MSI minibus with special government dispensation, to avoid women having to leave their homes (MSI).

Sadly however, there are still many contexts where any crisis can be exploited to further restrict the options of abortion seekers.

Opportunities for passing bucks instead of laws

Despite the WHO guidance and public health messages on abortion, despite the clear and unequivocal statements on access to reproductive health as a right from UN CEDAW, there are still too many contexts where access to abortion was restricted further using the COVID-19 pandemic as an excuse.

Some USA states went further than ignoring WHO advice in the beginning and instead of enshrining abortion healthcare as vital during the pandemic, declared it as a nonessential service. Although many of these state-level induced restrictions were overturned as the crisis deepened, the initial blocks took a hefty toll on both clients and healthcare providers alike. (Roberts, Schroeder and Joffe)

Indeed, as recently as January 12, 2021 the Supreme Court ruled to block the almost all abortion providers from sending medication by post even in the COVID-19 pandemic, in favour of the Trump administration. This not only increases the risk of health workers contracting Covid-19, but also arguably increases the overall public health risk for a faster spread of the virus (Ramaswamy et al.). Whether President Biden will choose to roll back the FDA classification to circumnavigate this restriction remains to be seen:

> "Reproductive rights advocates expect Biden to quickly overturn Trump-era rules, like banning federal funds for foreign and national health organizations that promote and provide abortion and giving employers more freedom to deny free contraceptive

coverage for their workers" (Atkins).

In contexts where governments have attempted to exploit the pandemic to effectively deny access to abortion at clinics, such as the US, it has been claimed that the need to redeploy staff and resources is the main barrier. This has resulted in at least 11 USA states issuing statements that abortion was being suspended to assist in frontline care, in a country where abortion deserts are common, and interstate travel was restricted (Romanis and Parsons, 480).

Some have posited that disallowing legal telemedicine for abortion actually impacts health systems more than legalising telemedicine provision, due to a greater number of people needing medical intervention after inducing their own abortions with a variety of unsafe methods, and unwanted pregnancy, childbirth and neonatal care always need significant resources. Blocking telemedicine, especially during a pandemic has the end result of blocking abortion for too many, likely to be those already experiencing multiple social disadvantages (Romanis and Parsons, 484).

In Europe the countries that most closely mimicked this 'non-essential' approach were Germany, Austria, Croatia and Romania, with also Malta and Gibraltar failing to budge on their pre-existing restrictions and Poland causing a civil uprising with its attempts to push back already gouged-out rights. (Caruana-Finkel, 2)

In an example of a glaring failure to understand the issue of abortion even nominally, the Slovakian Government advised its citizens that it did not 'recommend' accessing abortion care at this time. The failure to understand the time sensitive nature of abortion is what governments in Slovakia and beyond have allowed to put women and pregnant people at great risk (Romanis and Parsons, 483).

Low- and middle-income countries overall have the most restrictive abortion laws, therefore death and injury from unsafe abortions are extremely common in these largely global south contexts. In response to this phenomenon, the Bangladeshi government sanctioned "menstrual regulation" a process to remove the uterine lining using surgical or medical methods whether the woman is pregnant or not, which therefore allowed people to seek help legally through primary care services, this creative legal strategy is one that could lead as example in the pandemic and beyond, to other countries where the results of unsafe abortion are high maternal death rates and disability from injury (Zhou, Blaylock and Harris, 8).

Alongside the policy blocks what remains unknown is the impact that Covid-19 will have on the resourcing of SRH services, as well as the impact it will have on people no longer able to support another pregnancy or child (MSI).

Having provided an overview of the global trends of the impact of COVID-19 on abortion, we now move to look at specific countries.

Section D - A country summary

To begin the global round up, what follows is a list of jurisdictions where abortion is forbidden by law in all circumstances: Andorra, Dominican Republic, El Salvador, Gabon, Guinea-Bissau, Haiti, Holy See, Madagascar, Malta, Nicaragua, Palau, Philippines, Republic of Congo, San Marino, Senegal, and Suriname (Lavelanet et al.).

Inclusion in the list below points to any change, progressive or regressive since the development of Covid-19. An attempt has been made to include anywhere where Covid-19 converged with or kickstarted a change in service provision or legislation. As this is still an ongoing global pandemic, not all country information is widely available, and this is not an exhaustive list.

1. **Afghanistan** "reported that Post Abortion Care (PAC) clients are worst affected and reduced by 80% whereas there was a dip of 58% in uptake of contraceptive services." (IPPF, 1)
2. **Argentina** legalised abortion in a landmark moment for women's rights in January 2021. In so doing — Argentina became one of only a handful of South American nations to legalise the process, following a long-fought campaign. Resistance is beautiful! Images of mass pro-choice celebrations in Argentina were beamed across the globe, the streets heaving with people adorned with green scarves — breath-taking scenes reminding us how vital reproductive choice it: it quite literally is a matter of life or death. Whilst Argentina has no official data on abortions, it is estimated that more than 400 women died in 2019 from unsafe abortion. (Berry).
3. **Australia** New South Wales joined the rest of Australian states in decriminalizing abortion, permitting abortion on request up to 22 weeks, (Centre for Reproductive Rights)
4. **Bangladesh** abortion Pill Mife/miso packs in India and Bangladesh ensured self-medication became safer and more intuitive for women, expanding its access to local pharmacies, and often replacing hormonal contraception (Zhou, Blaylock and Harris, 2020). Yet FPA Bangladesh noted a 26% reduction in the Menstrual Regulation (early medical abortion) services since the pandemic. They also recorded the end of workplace intervention due to the pandemic lockdown which meant at least 25,000 women from the garment factories failed to access contraceptive and safe abortion services (IPPF).
5. **Bhutan** unfortunately most abortion seekers are forced to rely on treatment in neighbouring India, which has become inaccessible due to the Covid-19 restrictions, data is yet to emerge of the impact of closed borders with India on sexual and reproductive health and maternal death rates, (IPPF).
6. **Ethiopia** was able to implement liberal provision which integrated medical abortion services into their local healthcare system by utilising the skills of mid-level healthcare staff and using existing national guidelines. However, unlike the example of Nepal (below), rather than innovating, services are still underserving in Ethiopia – only 20.5% of providers have been given the necessary abortion training, and a majority (71.6%) were not comfortable to be in a facility providing abortions, never mind accessing training for themselves, due to social and religious stigma. It's clear that a supportive government is vital to the generation and implementation of new policies, but wider sociocultural influences such as religion and gendered beliefs about social roles, can impede progress, Covid-19 happened during this transitional period and has stalled progression in service provision (Zhou, Blaylock and Harris, 6).

7. **Ghana** NGO MSI noticed an unprecedented increase (300%) in contact in Ghana once lockdown measures provided safer ways, such as social media messaging to talk to providers discreetly, which they believe indicates an obvious need for greater provision of multiple ways to contact services which aren't face to face (MSI).
8. **Honduras** moved to reinforce a total abortion ban, as part of the proposed reform of the constitution (Article 67) on the "Absolute and Eternal Prohibition of Abortion" (Berry).
9. **Iceland** now has one of Europe's most liberal abortion laws, permitting abortion on request up to 22 weeks (Centre for Reproductive Rights). The country's legislators also made an interesting ruling on stigmatising language, "that *þungunarrof* (interruption of pregnancy) should henceforth be used instead of *fóstureyðing* (abortion, or literally "fetus extermination"), stating that the word *fóstureyðing* "has been considered a charged word.""(Ćirić)
10. **India** abortion Pill Mife/miso packs in India and Bangladesh ensured self-medication became safer and more intuitive for women, expanding its access to local pharmacies, and often replacing hormonal contraception (Zhou, Blaylock and Harris, 2020). There is evidence to show that many abortion seekers from Bhutan, Sri Lanka & Maldives need to travel to India to access abortion services (IPPF) and this has been greatly impacted by Covid-19. In contrast to non-pandemic years, India has seen 1.3 million less women which they have calculated could result in an increase of 1 million unsafe abortions, an additional 650,000 unintended pregnancies and 2,600 maternal deaths. (MSI).
11. **Jamaica** a bill by Juliet Cuthbert-Flynn of the Jamaica Labour Party, aims to decriminalise abortion by repealing sections of the law and replacing it with a new act which would allow for abortion in the case of rape or incest. Parliament this month hears final submissions from the public, then the Prime Minister's office will decide next steps. Such action fails to acknowledge that unsafe abortions were the third leading cause of maternal mortality among women in Jamaica. (Berry)
12. **Kenya the Kenyan** High Court rules that the withdrawal of 2012 standards and guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion in Kenya is illegal, holding abortion lawful on both physical and mental health grounds. (Centre for Reproductive Rights)
13. **Malta** abortion is illegal in all circumstances in Malta, however, there has been continued movement towards change since 2018. It is a staunchly Catholic island nation with the attending stigmas on abortion, sexuality and the resulting stigma is widespread. (Caruana-Finkel, 2). 'An estimated 300-400 Maltese women travel abroad every year to get an abortion, usually to the UK. But pandemic travel restrictions have made this option far less viable.' (Smith-Galer)
14. **Nepal** has implemented proactive measures to introduce medical abortion services by regional healthcare system by implementing national guidelines and task-shifting provision to nurses and lay staff (Zhou, Blaylock and Harris, 4). Nepal is now an exemplar of innovation in the region for abortion healthcare. However, "FPA Nepal reported decline of around 53% in abortion, 55% post abortion and 47% FP services." (IPPF)
15. **Nigeria** found it difficult to provide medical abortions due to the high costs of drugs and tighter restrictions, but clinics were well-equipped to provide surgical treatments for incomplete abortions in accordance with their laws. (Zhou, Blaylock and Harris, 7)
16. **New Zealand** decriminalised abortion in March 2020. Up til then, it was punishable with a 14-year prison term. (Berry)
17. **Northern Ireland** unlike its near neighbours Great Britain and Ireland, telemedicine has not been permitted, (Bracke) despite the Northern Ireland Health Minister having the power to do so since April 2020. Rather he has been unwilling to enact provision, despite

pressure from health professionals, activists and the UK government. The in-clinic provision of medical abortion up to 10 weeks has seen an unprecedented number of abortions being provided within the jurisdiction, however despite the law allowing for abortion in almost all circumstances and beyond 24 weeks with serous foetal anomaly or risk to life, a significant proportion of women and pregnant people remain forced to travel by air or sea to access. The current provision is largely viewed as a temporary measure for the pandemic, and none of the expected commissioning of services has been implemented despite the legal duty to do so. (Connor and Alliance for Choice)

18. **Poland** has witnessed further attacks on already highly restricted access, with the judgment of the Constitutional Tribunal on abortion seeking to shut down almost all access. In addition, public protestors and protestor organisers are being targeted for prosecution, with organisers of protests facing up to eight years in prison. (Michalski)
19. **Russia** President Putin has put pressure on the Russian Government to advance efforts in 'abortion prevention' by dissuading women from having abortions. (International Campaign for Women's Right to Safe Abortion)
20. **Sierra Leone** which "according to the WHO, has the worst maternal mortality ratio in the world (1,360 deaths for every 100,000 live births) in the world, with unsafe abortions contributing to 10% of these deaths, has stalled on introducing a new safe abortions law. This is despite it being tabled in Parliament on several occasions. Instead, the law remains set within the Offences Against the Person Act, 1861, criminalises abortion and, therefore, forces women to rely on unqualified practitioners who carry out clandestine abortions in unsupervised and unsafe conditions (AdvocAid). Marie Stopes International estimate that 33,272 unsafe abortions and 708 maternal deaths were prevented in 2019. However, the partial-lockdown restrictions that have been in place since March 2020 mean that more families cannot leave their homes, and that women's domestic and caring responsibilities have become overwhelming whilst any travel has been much more closely watched and restricted. With a high probability of being caught if they try to access proper services, it is commonly accepted that there is a heightened risk during the pandemic of death or injury resulting from unsafe abortions. (Srivatsa, 5) In order to prevent the spike in teenage pregnancies and maternal deaths seen during the Ebola crises, NGOs such as MSI worked in partnership with Youth Programmes and local government to increase awareness around contraception and access to post abortion care services (MSI).
21. **South Africa** moved to declare SRH as essential including telemedicine, this was approved by government in a policy amendment in April 2020. (Stevens) Expensive medication cost has also been a blockage to widespread abortion pills provision. (Zhou, Blaylock and Harris, 6)
22. **South Korea's** constitutional court ordered the country's decades-old abortion ban to be lifted in a landmark ruling in 2019. In 2020, the South Korean government announced new draft legislation that would permit abortion up to 14 weeks and, in some circumstances, up to 24 weeks, but fell short of full decriminalisation (Berry).

23. **Tanzania** has been subject to a pilot a harm-reduction model set within a public health centre in Dar es Salaam, whereby those identified with a need for early medical abortion but without grounds recognised by law, were given information on the harms of herbal or other self-managed methods and information on using misoprostol for safer outcomes. A follow-up appointment a number of weeks later allowed for screening for complications, and the follow up examinations revealed that 98% of those who were given this harm reduction information had safely used misoprostol (Moseson et al.). This type of preventative information method has demonstrated significant reduction in deaths of abortion seekers. Marie Stopes is one of the main clinical providers of post-abortion care in Tanzania, their clinics have remained open during the pandemic however with changes to accommodate social distancing measures (MSI Tanzania).
24. **Thailand** is moving closer to legalising early abortion. The House of Representatives has approved the final reading of the bill that would allow abortion up to 12 weeks (Berry).
25. **Uganda** in a highly innovative initiative, led by MSI, set out to circumnavigate strict travel restrictions, "the MSI team set up a pilot project, in partnership with UNFPA, to deliver healthcare products using the SafeBoda ride-hailing mobile app. Women can now order contraception and have them delivered to their door by motorcycles, known as boda bodas" (MSI).

Section E - Conclusion

As identified in this overview the approaches within countries in dealing with abortion in recent times have varied considerably. There has been widespread frustration with governments whose stasis or opportunism effectively rolled back real access to abortion for hundreds of thousands of women and pregnant people globally. They have always been and still are structural manifestations of state violence against women and people who can get pregnant.

> "...the violence of injustice and inequity. Distinct from direct or interpersonal violence, it focuses attention on often unnoticed systems—legal, political, economic and sociocultural institutions—that shape an individual's experiences, health and wellbeing."(Nandagiri, Coast and Strong)

Abortion is established as a controversial element of reproductive healthcare globally, yet we had begun to see a movement towards increased liberalisation and more widespread cultural acceptance in many countries prior to the outbreak. As this global overview has shown, the legal framing of abortion in each country, or sometimes federal state, has had a huge impact on whether it has been able to deliver swift change to mitigate the potential harm Covid-19 had on those unable to access abortions. As ever, along with the legal framework, it is widely evidenced that logistical barriers which already affected the marginalised to the greatest degree, have been greatly exacerbated by this crisis, and for many contexts, effectively criminalising poverty.

Abortion travel should never be necessary, forcing those in need of abortions to make substantial journeys on top of the usual logistics involved with healthcare access, has been deemed a grave injustice by CEDAW, (OHCHR CEDAW) and is opposition to the public health recommendations by the WHO, (World Health Organization). Both bodies have shown swift and courageous leadership in their clear and concise recommendations as to how to address abortion during Covid-19, yet it is familiar to any abortion rights advocate that their recommendations often fall upon deaf, unwilling ears when it comes to government and healthcare institutions delivering on provision.

The success of telemedicine for delivery of abortion healthcare, especially during a pandemic cannot be overstated, neither can the role of the thousands of abortion activists who paved the way for the protocols of this provision to even be possible. When Moreau et al. reviewed the situation across all of Europe they concluded,

> "We believe that these advances, mostly conceived as temporary responses to a health crisis, could serve as catalyst towards 'liberalising' abortion provision and that they should become the standard of care…In addition, these remote care options should be included in public health plans to guarantee equity in abortion access. (Moreau et al., 5)

Despite this we know that the playing field for abortion was never even to begin with, until abortion is understood as life-saving essential healthcare across the world and without legal restrictions, we will continue to see each crisis be stacked against everyone that needs safe and legal abortion healthcare.

Section F - References

Abel, Kerry. “Abortion by Telemedicine: The Case for Home Use Has Been Made.” *Abortion Rights*, 14 Jan. 2021, abortionrights.org.uk/abortion-by-telemedicine-the-case-for-home-use-has-been-made/.

Aiken, ARA, et al. “Experiences and Characteristics of Women Seeking and Completing At-Home Medical Termination of Pregnancy through Online Telemedicine in Ireland and Northern Ireland: A Population-Based Analysis.” *BJOG: An International Journal of Obstetrics & Gynaecology*, vol. 124, no. 8, Oct. 2016, pp. 1208–15, doi:10.1111/1471-0528.14401.

Assis, Mariana Prandini, and Sara Larrea. “Why Self-Managed Abortion Is so Much More than a Provisional Solution for Times of Pandemic.” *Sexual and Reproductive Health Matters*, vol. 28, no. 1, Jan. 2020, p. 1779633, doi:10.1080/26410397.2020.1779633.

Atkins, Chloe. “Biden Readies Sweeping Rollback of Trump-Era Abortion Crackdown.” *NBC News*, 18 Jan. 2021, www.nbcnews.com/politics/white-house/biden-readies-sweeping-rollback-trump-era-abortion-crackdown-n1254552.

Bateson, Deborah J., et al. “The Impact of COVID-19 on Contraception and Abortion Care Policy and Practice: Experiences from Selected Countries.” *BMJ Sexual & Reproductive Health*, vol. 46, no. 4, Oct. 2020, pp. 241–43, doi:10.1136/bmjsrh-2020-200709.

Baum, Sarah E., et al. “‘It’s Not a Seven-Headed Beast’: Abortion Experience among Women That Received Support from Helplines for Medication Abortion in Restrictive Settings.” *Health Care for Women International*, Nov. 2020, pp. 1–19, doi:10.1080/07399332.2020.1823981.

Berry, Alisa. “International Repro-Round-Up: The Good, Bad & the Ugly.” *Abortion Rights*, 21 Jan. 2021, abortionrights.org.uk/international-repro-round-up-the-good-bad-the-ugly/?mc_cid=e7f35d4904&mc_eid=1be875dcf1.

Bloomer, Fiona, et al. *A TRADE UNION SURVEY NORTH & SOUTH of IRELAND Acknowledgements*. , Oct. 2017, www.unison-ni.org.uk/sites/default/files/TU%20Abortion%20Report%20Oct9_Final_Final_Edit.pdf.

Bloomer, Fiona, et al. *Reimagining Global Abortion Politics: A Social Justice Perspective*. Policy Press, 2020.

BPAS. “| BPAS.” *Www.bpas.org*, 11 Sept. 2020, www.bpas.org/about-our-charity/press-office/press-releases/comment-on-dhsc-abortion-statistics-telemedical-abortion-service-results-in-significant-drop-in-gestation-at-which-women-can-access-care-protecting-their-health-during-the-pandemic/.

Bracke, Sophie. “Current Abortion Provision in Northern Ireland.” *BMJ Sexual & Reproductive Health Blog*, 13 Jan. 2021, blogs.bmj.com/bmjsrh/2021/01/13/current-abortion-provision-in-northern-ireland/.

British Pregnancy Advisory Service. “Comment on DHSC Abortion Statistics: Telemedical Abortion Service Results in Significant Drop in Gestation at Which Women Can Access

Care – Protecting Their Health during the Pandemic." *Www.bpas.org*, 11 Sept. 2020, www.bpas.org/about-our-charity/press-office/press-releases/comment-on-dhsc-abortion-statistics-telemedical-abortion-service-results-in-significant-drop-in-gestation-at-which-women-can-access-care-protecting-their-health-during-the-pandemic/.

Caruana-Finkel, Liza. "Abortion in the Time of COVID-19: Perspectives from Malta." *Sexual and Reproductive Health Matters*, vol. 28, no. 1, June 2020, pp. 1–4, doi:10.1080/26410397.2020.1780679.

Caruana-Finkel "Barriers to Efficient Reproductive Healthcare in Malta: The Ectopic Pregnancy Case." *Abortion Rights*, 14 Jan. 2021, abortionrights.org.uk/barriers-to-efficient-reproductive-healthcare-in-malta-the-ectopic-pregnancy-case/.

Centre for Reproductive Rights. "The World's Abortion Laws | Center for Reproductive Rights." *Reproductiverights.org*, 2019, reproductiverights.org/worldabortionlaws.

Ćirić, Jelena. "Abortion Bill Passed in Icelandic Parliament." *Iceland Review*, 14 May 2019, www.icelandreview.com/news/abortion-bill-passed-in-icelandic-parliament/.

Connor, Naomi, and Alliance for Choice. "Department of Health NI Figures on Abortion." *Alliance for Choice*, 1 2021, www.alliance4choice.com/news/2021/1/department-of-health-ni-figures-on-abortion.

Crossman, Ashley. "Durkheim's 'Division of Labor' and Evaluation of Social Change." *ThoughtCo*, 2019, www.thoughtco.com/mechanical-solidarity-3026761.

Dutch, Rosie. "The Colonial Legacy of the Offences against the Person Act 1861." *CFFP*, 9 Mar. 2020, centreforfeministforeignpolicy.org/journal/2020/3/9/the-globalisation-of-punitive-abortion-laws-the-colonial-legacy-of-the-offences-against-the-person-act-1861-ygeff.

International Campaign for Women's Right to Safe Abortion. "RUSSIA - Putin Orders Government to Improve 'Abortion Prevention' Efforts." *International Campaign for Women's Right to Safe Abortion (SAWR)*, 4 Nov. 2020, www.safeabortionwomensright.org/news/russia-putin-orders-government-to-improve-abortion-prevention-efforts/.

IPPF. "IPPF SARO COVID19 Response-3: Safe Abortion Services amid COVID19 - Agile, Adaptive & Innovative Response from South Asia (May 2020) - Bangladesh." *ReliefWeb*, United Nations Office for the Coordination of Humanitarian Affairs (OCHA)., 27 May 2020, reliefweb.int/report/bangladesh/ippf-saro-covid19-response-3-safe-abortion-services-amid-covid19-agile-adaptive.

Jelinska, Kinga, and Susan Yanow. "Putting Abortion Pills into Women's Hands: Realizing the Full Potential of Medical Abortion." *Contraception*, vol. 97, no. 2, Feb. 2018, pp. 86–89, doi:10.1016/j.contraception.2017.05.019.

Kassebaum, N. J., et al. "Global, Regional, and National Levels and Causes of Maternal Mortality during 1990-2013." *Obstetric Anesthesia Digest*, vol. 35, no. 4, Dec. 2015, pp. 196–97, doi:10.1097/01.aoa.0000472714.57328.86.

Khunti, Kamlesh, et al. “Covid-19 and Ethnic Minorities: An Urgent Agenda for Overdue Action.” *BMJ*, June 2020, p. m2503, doi:10.1136/bmj.m2503.

Kirk, Siobhan. “Current Abortion Provision in Northern Ireland.” *BMJ Sexual & Reproductive Health Blog*, Jan. 2021, blogs.bmj.com/bmjsrh/2021/01/13/current-abortion-provision-in-northern-ireland/.

Kirk et al. “Introduction of the National Health Service Early Medical Abortion Service in Northern Ireland – an Emergency Response to the COVID-19 Pandemic.” *BMJ Sexual & Reproductive Health*, Jan. 2021, p. bmjsrh-2020-200920, doi:10.1136/bmjsrh-2020-200920.

Lavelanet, Antonella F., et al. “Global Abortion Policies Database: A Descriptive Analysis of the Legal Categories of Lawful Abortion.” *BMC International Health and Human Rights*, vol. 18, no. 1, Dec. 2018, doi:10.1186/s12914-018-0183-1.

Macquarrie, Colleen, et al. *Crossing Troubled Waters : Abortion in Ireland, Northern Ireland, and Prince Edward Island*. Island Studies Press At University Of Prince Edward Island, 2018.

Michalski, Patryk. “The Prosecutor’s Office Wants to Pursue the Organizers of the Abortion Protests. Up to 8 Years in Prison.” *Rmf24.Pl*, 29 Nov. 2020, www.rmf24.pl/raporty/raport-strajk-kobiet/news-nawet-8-lat-wiezienia-prokuratura-chce-scigac-organizatorow-,nId,4822741.

Moreau, Caroline, et al. “Abortion Regulation in Europe in the Era of COVID-19: A Spectrum of Policy Responses.” *BMJ Sexual & Reproductive Health*, vol. Online First Edition, Oct. 2020, doi:10.1136/bmjsrh-2020-200724.

Moseson, Heidi, et al. “Contextualizing Medication Abortion in Seven African Nations: A Literature Review.” *Health Care for Women International*, vol. 40, no. 7-9, June 2019, pp. 950–80, doi:10.1080/07399332.2019.1608207.

MSI. *RESILIENCE, ADAPTATION and ACTION: MSI’S RESPONSE to COVID-19*. Marie Stopes International 2020, 2020.

MSI Tanzania. “A Message from Marie Stopes Tanzania on COVID-19 Coronavirus.” *Www.mariestopes.or.tz*, 2020, www.mariestopes.or.tz/covid-19/.

Nandagiri, Rishita, et al. “Abortion in the Time of COVID-19: A Study in Structural Violence.” *LSE COVID-19*, 17 Dec. 2020, blogs.lse.ac.uk/covid19/2020/12/17/abortion-in-the-time-of-covid-19-a-study-in-structural-violence/.

OHCHR CEDAW. “Guidance Note on CEDAW and COVID-19.” *United Nations Human Rights*, © OHCHR 1996-2020, tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CEDAW/STA/9156&Lang=en. Accessed 18 Jan. 2021.

Plan International. “Living under Lockdown: Girls and COVID-19.” *Plan International*, 30 Apr. 2020, plan-international.org/publications/living-under-lockdown.

Pokhrel, Sabina. “How COVID-19 Is Threatening Girls’ Sexual and Reproductive Health and Rights.” *Plan International*, plan-international.org/sexual-health/how-covid-19-threatens-girls-women. Accessed 15 Jan. 2021.

Ramaswamy, Amrutha, et al. “Medication Abortion and Telemedicine: Innovations and Barriers during the COVID-19 Emergency.” *KFF*, 8 June 2020, www.kff.org/policy-watch/medication-abortion-telemedicine-innovations-and-barriers-during-the-covid-19-emergency/.

Raymond, Elizabeth G., et al. “Commentary: No-Test Medication Abortion: A Sample Protocol for Increasing Access during a Pandemic and Beyond.” *Contraception*, vol. 101, no. 6, June 2020, pp. 361–66, doi:10.1016/j.contraception.2020.04.005.

Roberts, Sarah C. M., et al. “COVID -19 and Independent Abortion Providers: Findings from a Rapid-Response Survey.” *Perspectives on Sexual and Reproductive Health*, Dec. 2020, doi:10.1363/psrh.12163.

Romanis, Elizabeth Chloe, and Jordan A. Parsons. “Legal and Policy Responses to the Delivery of Abortion Care during COVID-19.” *International Journal of Gynecology & Obstetrics*, vol. 151, no. 3, Oct. 2020, pp. 479–86, doi:10.1002/ijgo.13377.

Saenz, Gabriela, and Natalia Coote-Muñoz. “Abortion in the Time of COVID-19.” *Council on Foreign Relations 100*, 25 June 2020, www.cfr.org/blog/abortion-time-covid-19.

Sanchez, Erica, et al. “Coronavirus Pandemic Is Making Existing Gender Inequalities Worse.” *Global Citizen*, 25 Mar. 2020, www.globalcitizen.org/en/content/how-covid-19-coronavirus-affects-women-girls/.

Senderowicz, Leigh, and Jenny Higgins. “Reproductive Autonomy Is Nonnegotiable, Even in the Time of COVID-19.” *International Perspectives on Sexual and Reproductive Health*, vol. 46, no. , 2020, pp. 147–51, doi:10.1363/intsexrephea.46.2020.0147.

Smith-Galer, Sophia. “Covid: Locked-down Women Turn to Pills amid Malta Abortion Ban.” *BBC News*, 9 Jan. 2021, www.bbc.co.uk/news/world-europe-55579339.

Srivatsa, Sripriya Iyengar. “Action on Covid-19 and Gender: A Policy Review from Sierra Leone.” *Https://Www.alignplatform.org*, Advancing Learning and Innovation on Gender Norms, July 2020, www.alignplatform.org/sites/default/files/2020-07/sierra-leone-brief.pdf.

Stevens, Marion. “South Africa: A Space of Many Contradictions – and Now Covid-19.” *International Campaign for Women’s Right to Safe Abortion (SAWR)*, 1 May 2020, www.safeabortionwomensright.org/south-africa-a-space-of-many-contradictions-and-now-covid-19/.

UN Human Rights. “Guidance Note on CEDAW and COVID-19 - OHCHR.” *Ohchr.org*, 2021, www.ohchr.org/Documents/HRBodies/CEDAW/Statements/CEDAW_Guidance_note_COVID-19.docx.

United Nations Population Fund. “As Pandemic Rages, Women and Girls Face Intensified Risks.” *Www.unfpa.org*, 19 Mar. 2020, www.unfpa.org/news/pandemic-rages-women-and-girls-face-intensified-risks.

Upadhyay, Ushma D., et al. “Adoption of No-Test and Telehealth Medication Abortion Care among Independent Abortion Providers in Response to COVID-19.” *Contraception: X*, vol. 2, 2020, p. 100049, doi:10.1016/j.conx.2020.100049.

Wadekar, Neha. “The Coronavirus Is Cutting off Africa’s Abortion Access.” *Foreign Policy*, 4 May 2020, foreignpolicy.com/2020/05/04/coronavirus-africa-abortion-access/.

World Health Organization. *Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context. Interim Guidance*. World Health Organization 2020, 1 June 2020.

Zhou, Jacy, et al. “Systematic Review of Early Abortion Services in Low- and Middle-Income Country Primary Care: Potential for Reverse Innovation and Application in the UK Context.” *Globalization and Health*, vol. 16, no. 1, Sept. 2020, doi:10.1186/s12992-020-00613-z.