



THE ABORTION GAZETTE, VOLUME 8

Post Abortion Care and Contraception



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Post Abortion Care and Contraception



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Why this Gazette?

The Asia Safe Abortion Partnership is the only safe abortion rights advocacy network in Asia. Founded in 2008 it has members from over 20 countries across South Asia, South East Asia, South West Asia and the Oceania region.

As new members and partners join the safe abortion rights' movement we realized that there are hardly any collated or curated resources that they can engage with in order to gain a deeper understanding of some of the key issues or challenges in this work.

There are search engines and journals and many websites dedicated to safe abortion rights information and even services which people can access. However, there is no dedicated space where you can get a snapshot of a core topic within safe abortion rights that can offer someone the highlights of the scope of the issue and a range of perspectives that are relevant to us as a movement.

In order to address this gap, we have launched The Abortion Gazette.

This will be an immersive repository for a reader who would like to learn more on the landscape and depth of the issue in a relatable and practical way without having to search through pages and pages on the internet and sifting through multiple sources.

It will be a short quarterly publication and will include lead articles, clinical updates, thought pieces, interviews, statistics and of course links to other key articles, videos and other relevant material. It will be published on the ASAP website as a pdf that can be downloaded and printed for use by anyone in the safe abortion rights movement. For those who would like to engage in deeper learning and a structured program, stay tuned for more updates!

EDITORIAL

Post Abortion Care is a human right

// Suchitra Dalvie, Coordinator ASAP

When I first started working on safe abortion rights issues almost three decades ago, I wondered why post abortion care was even an issue? Then as I learned more about the extent of unsafe abortions in the world I was infuriated. Women were dying and suffering for something which involved another person who never had any consequences. Not only that but they were being punished for something that is not just an ideological or moral question or even simply a public health matter.

It is life- saving emergency care in many cases and includes treatment for hemorrhage, sepsis, uterine perforation, incomplete miscarriage and complications following unsafe or spontaneous pregnancy loss. The World Health Organization classifies PAC as essential obstetric care, comparable to emergency treatment for ectopic pregnancy or postpartum hemorrhage.

Denying, delaying or criminalising it is a violation of human right to life, right to benefits of scientific progress, dignity, safety, health.

Yet across multiple countries, restrictive abortion laws have created environments where women seeking emergency post-abortion care, even for spontaneous or natural miscarriages, are interrogated, reported to police or religious authorities, detained or prosecuted. Even in cases where they are not reported to any authorities, the medical staff speak to them badly, ignore them, leave them to wait in pain, shame them and deny them timely, sensitive and quality care.

These practices persist despite international legal obligations, medical ethics and human rights standards.

While on paper almost no country explicitly criminalises post-abortion care in practice, women arriving at hospitals with complications are often treated as suspects rather than patients.

Across the globe we see stark examples where this behaviour towards women and girls seeking post abortion care creates crime scenes out of healthcare facilities, where any human being should have a right to obtain life- saving treatment.

The Philippines for example has one of the world's most restrictive abortion laws, with no legal exceptions. Multiple documented cases show that women who self-induced abortions and later sought hospital care were delayed care and left to suffer in pain and agony or were denied treatment until they confessed. They are often reported by hospital staff to the police and may even be arrested directly from hospital beds.

These practices violate medical ethics and confidentiality as well as the right to freedom from cruel, inhuman, or degrading treatment. Yet they persist because abortion is still framed as a crime and hence post abortion care seekers are treated as criminals.

In a country like Malaysia which allows abortion under limited health grounds, there is harassment from law enforcement authorities in clinics and a widespread stigma in society which prevents those who need post abortion care from reaching safe service providers.

International law does not treat this as a grey area.

Multiple bodies- including the WHO, UN Human Rights Committee, and CEDAW Committee have stated unequivocally that post-abortion care must be available regardless of abortion legality and patients must not be reported to law enforcement since criminalisation that deters emergency care violates the right to health and life

When doctors report patients, or when patients fear hospitals, states are failing their positive obligation to protect life.

Legal permission without protection is meaningless.

This is beyond the usual politics of pro-choice and abortion legality.

This demands an answer to 2 powerful questions:

- Should a woman or a pregnant person bleeding to death from a miscarriage or abortion be treated as a patient or a suspect?
- And should doctors and nurses act as healers or informants?

No other area of medicine operates this way.

We do not ask accident victims if they broke traffic laws before treating them nor do we report self-harm patients to police before stabilising them.

Only in abortion-related care do we suspend basic medical ethics!

Every major public health authority agrees: criminalisation does not prevent abortion but it only makes it more dangerous. It is the same with post abortion care.

Any legal system that forces doctors to choose between saving a life and putting a vulnerable patient in the crosshairs of the police has failed its own people instead of respecting, protecting and fulfilling their human rights. Any medical personnel or hospitals that support this behaviour are complicit.



Post Abortion Care: Transcending Harm Reduction to Rights Based Approaches

// Dr. Subatra Jayaraj, Guest Editor, Chairperson, ASAP

1 in 3 women will have an unplanned pregnancy in her lifetime. **1 in 4 women will have an abortion in their lifetime.** It is only the differences in access to abortion services that determines whether the experience will be an empowering, choice determined and safe one, versus an unsupported, coerced and unsafe process.

For centuries, women and healers have developed language and strategies to manage consequences after abortions. These management methods needed to navigate the social, political, legal and religious dimensions where each woman lived. Despite advances in medical technology and access to healthcare globally, **World Health Organization (WHO) data estimates that 10-50% of women who have an unsafe abortion need medical care.** Women who experience spontaneous abortions also may have complications that require treatment.

The term “Post Abortion Care” was described in IPAS’s 1991 strategic planning document which encouraged “the integration of post abortion care and family planning services in health care systems”. As a strategy to push back against the increasingly restrictive policies of the US government, the term was framed as breaking the cycle of repeat unwanted pregnancies and improving the overall health status of women in developing countries.

This harm reduction approach functions as a more palatable healthcare management strategy for political and funding purposes in many parts of the world. The elements of choice, rights and bodily autonomy were not outright highlighted in that iteration of post abortion care.

The original post abortion care model published by IPAS in 1994 comprised of three elements:

1. Emergency treatment services for complications of spontaneous or unsafely induced abortions
2. Post abortion family planning counselling and services; and
3. Links between emergency abortion treatment services and comprehensive reproductive healthcare.

W.H.O.’s latest Abortion Care Guidance was published in 2022 and the latest recommendations state that when medically indicated, post abortion care should always be provided and should always be confidential, even in settings where abortion is restricted.

When a termination of pregnancy has been done safely, under recommended guidelines taking all necessary precautions, potentially life-threatening complications are extremely

rare (<0.1%). These include haemorrhage, infection, uterine perforation and uterine rupture. Anaesthesia-related complications may also occur if used as sedation and pain relief.

Complications are much more common when abortions are obtained from unskilled providers, at unsafe settings, or using methods that are not recommended.

Post abortion contraception is a component of PAC. Ovulation can return as early as 8–10 days following an induced or spontaneous abortion, usually within one month. Consequently, starting contraception as soon as possible is important for those who desire to space or prevent a future pregnancy. All contraceptive options may be considered after a termination of pregnancy, but informed choice and client's wishes are the most important. In general, almost all methods can be commenced immediately following a surgical or medical abortion.

The politics surrounding PAC are complex, often tangled in broader debates about abortion legality, access to healthcare, and women's rights.

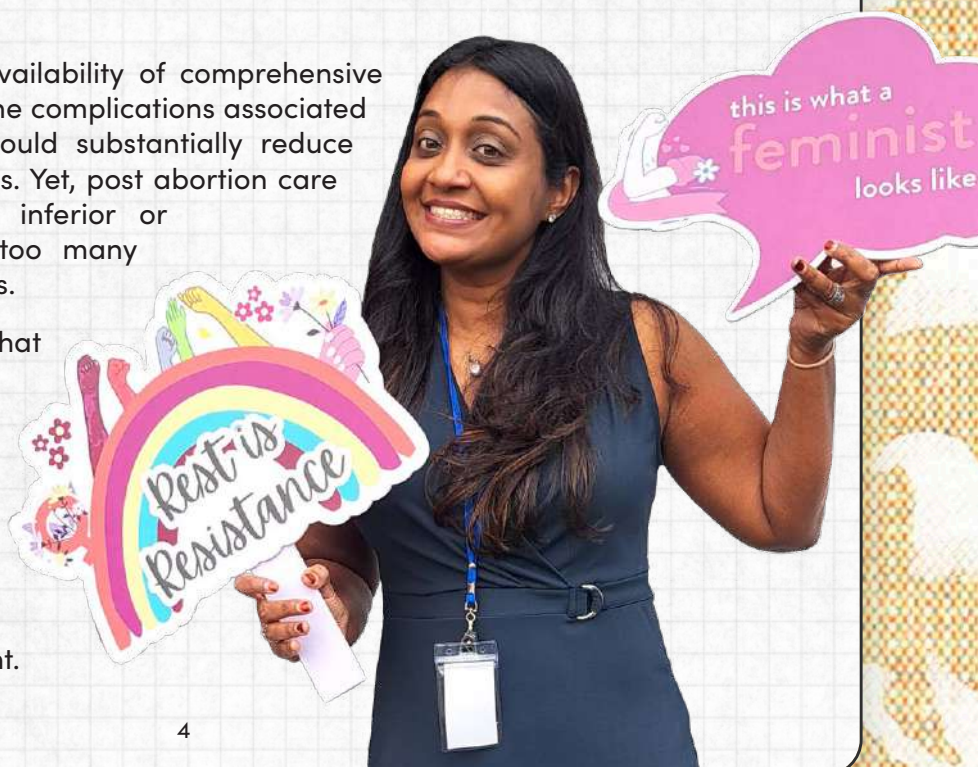
Stigma and poverty are reasons both for not accessing PAC, as well as being a repercussion of being unable to access it. Denying PAC can lead to increased poverty, debt, and income loss for women. In contrast, safe and accessible care enables women to pursue educational and employment opportunities to thrive in a more equitable society.

Effective PAC requires a comprehensive approach that addresses both the medical and psychosocial needs of individuals. Professional medical organisations such as FIGO (International Federation of Gynaecology and Obstetrics) consider post abortion care as a fundamental aspect of obstetrics and gynaecology, requiring providers to uphold ethical standards and prioritize patients' physical and psychological well-being. Clinicians and healthcare providers have an ethical obligation to provide care to all individuals in need, regardless of the circumstances of their abortion.

Reporting requirements in healthcare systems frequently are intertwined in the abortion care debate. While PAC indicators are used to track access and quality of care, they may not fully capture the complexities of treating abortion complications, particularly in contexts where abortion is illegal. Many doctors are hesitant to be honest about diagnoses, misrepresent data to navigate regulatory requirements or for the safety of clients or providers or both.

Enhancing the quality and availability of comprehensive PAC, including treatment for the complications associated with incomplete abortions would substantially reduce harms from unsafe procedures. Yet, post abortion care services remain incomplete, inferior or altogether unreachable for too many women in developing countries.

A rights-based approach that centres bodily autonomy, choice, equity and empowered decision making is essential in strengthening health systems that are bound by restrictions of traditional power structures. Every woman and pregnant person must have this as a right.



What is Post Abortion Care (PAC) ?

Exerpt from [article by Maureen R. Corbett and Katherine L. Turner for Guttmacher Institute](#)

Complications from spontaneous abortions and unsafely induced abortions pose a serious global threat to women's health and lives. An estimated 46 million induced abortions are performed annually; about 20 million are unsafe, and 95% of these take place in the developing world.

Unsafe abortion accounts for an estimated 13% of pregnancy- related deaths representing approximately 67,000 women every year.

In many other cases, unsafe abortion causes such long-term consequences as chronic pain, pelvic inflammatory disease, tubal occlusion and secondary infertility. The World Health Organization (WHO) estimates that as many as 50% of women who have an unsafe abortion need medical care; some women who experience spontaneous abortion also need treatment.

The Helms Amendment has prohibited the direct use of U.S. foreign aid for most abortion-related activities since 1973. At the 1984 International Conference on Population in Mexico City, the U.S. government further restricted population funding.

Under the "Mexico City policy," foreign nongovernmental organizations that used their own funds to perform abortion (in cases other than those in which the pregnancy threatened the woman's life or resulted from rape or incest), to provide counseling and referral for abortion, or to lobby to make abortion legal or more available could no longer receive family planning support from the U.S. Agency for International Development (USAID).

The term "postabortion care" was thus first articulated as a critical element of women's health initiatives in Ipas's 1991 strategic planning document, which encouraged "the integration of postabortion care and family planning services in health care systems" as a means of breaking the cycle of repeat unwanted pregnancy and improving the overall health status of women in the developing world.

In 1994, Ipas published the original postabortion care model, which comprised three elements: emergency treatment services for complications of spontaneous or unsafely induced abortion; postabortion family planning counseling and services; and links between emergency abortion treatment services and comprehensive reproductive health care.

Post abortion care after an Unsafe Abortion

Information adapted from resource titled '[Best practice in post-abortion care](#),' published by the Royal College of Obstetricians and Gynaecologists

⚠️ Recognising unsafe abortion

An abortion is unsafe when it is carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Indications that an abortion has been attempted by unsafe methods include:

Vaginal laceration

Cervical injury

Uterine injury, any sign of fever, significant lower abdominal pain, tenderness or abdominal distension

Uterine enlargement equivalent to a pregnancy of more than 12 weeks' duration

Products of conception visible at the cervix or in the vagina

Presence of a foreign body in the vagina or cervix

⚙️ Infection assessment

It is vital to identify those who may have an infection and to manage this urgently.

CLINICAL SIGNS OF INFECTION

- temperature above 37.5 °C
- localised or general abdominal tenderness, guarding or rebound
- unusual, unpleasant odour or pus visible in the cervical os
- uterine tenderness

SIGNS OF SEPSIS

Urgent intervention required

- hypotension
- tachycardia
- increased respiratory rate

Management of incomplete abortion

Management depends on the patient's condition, presence of infection, pregnancy duration, and skills and facilities available.

! When uterine evacuation is an emergency (i.e. the individual is shocked, bleeding heavily or has severe infection):

IF SKILLED PROVIDER AND EQUIPMENT AVAILABLE

Vacuum aspiration (MVA or EVA) should be undertaken as the uterus is emptied quicker.

IF SKILLED PROVIDER AND EQUIPMENT ARE NOT AVAILABLE

Misoprostol is the safer option. The dose depends on the pregnancy duration and on the route of administration (oral, sublingual, buccal or vaginal). If an individual is bleeding heavily then misoprostol may be less well absorbed if given vaginally than if given buccally, sublingually or orally.

If there is no suspicion of infection and uterine size is less than 14 weeks:

MEDICAL MANAGEMENT

Misoprostol 400 mcg (sublingual, buccal, or vaginal)
OR 600 mcg oral.

*In case of a missed abortion (retained non-viable fetus),
mifepristone 200 mg orally should be administered 24–48
hours before misoprostol.*

SURGICAL

Uterine evacuation with
vacuum aspiration and
antibiotic prophylaxis

If there is no suspicion of infection and uterine size is 14 weeks or larger:

14–24 WEEKS

Misoprostol 400 micrograms
administered sublingually, buccally
or vaginally every 3 hours.

OVER 24 WEEKS

The uterus is more sensitive to misoprostol as pregnancy advances, hence, use lower doses and consider increased intervals between doses, especially for people with uterine scars.

If infection is present, the uterus should be evacuated urgently

- Start broad-spectrum antibiotics immediately – intravenously if infection is severe.
- Transfer to a unit with the facilities for undertaking surgical evacuation if it cannot be done in the facility to which the individual presents.
- If the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be administered using the dose regimens above.

Prevention of post-treatment infection

PROPHYLACTIC ANTIBIOTICS BEFORE SURGICAL EVACUATION

Doxycycline 100 mg oral twice daily for 3–7 days, starting within 2 hours of the procedure.

Evidence shows a 3-day course is as effective as a 7-day course. Do not delay the procedure if antibiotics are not available.

STI SCREENING

It is best practice to conduct an STI risk assessment for everyone, and screen where appropriate (e.g. chlamydia, gonorrhoea, HIV, syphilis (if testing available)). Administer treatment doses to those with signs or symptoms of an STI. Partners also require treatment; a system for partner notification and follow-up or referral should ideally be in place.

Do not delay post-abortion care for screening.

Blood tests

Pre-care assessment does not automatically require routine blood tests.

HAEMOGLOBIN / OTHER BLOODS

Not required unless clinically indicated e.g. heavy bleeding, persistent significant bleeding, or symptomatic anaemia.

RHESUS BLOOD STATUS

May be considered if duration of pregnancy is over 12 weeks and anti-D is available.

MEASUREMENT OF HAEMOGLOBIN

Not required routinely, only where there are good clinical indications.



Post-abortion contraception

Adapted from WHO Clinical Practice Handbook for Safe Abortion, 2014

Method of post-abortion contraception	Medical eligibility criteria (MEC) category		
	First trimester	Second trimester	Immediate post-septic abortion
CHC	1	1	1
POP	1	1	1
Progestogen-only injectable	1	1	1
Progestogen-only implant	1	1	1
Cu-IUD	1	2	4
LNG-IUD	1	2	4
Condom	1	1	1
Spermicide	1	1	1
Diaphragm	1	1	1

CHC = combined hormonal contraception (pill, patch, ring, injectable).

POP = progestogen-only pill.

Progestogen-only injectable = depot medroxyprogesterone acetate or norethisterone enanthate.

Progestogen-only implant = levonorgestrel or etonogestrel.

Cu-IUD = copper-bearing IUD.

LNG-IUD = levonorgestrel-releasing IUD.

Condom = male latex condom, male polyurethane condom or female condom.

Diaphragm = diaphragm (with spermicide) or cervical cap

MEC categories for contraceptive eligibility	
1	A condition for which there is no restriction for the use of the contraceptive method.
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
4	A condition which represents an unacceptable health risk if the contraceptive method is used.

Recommendations for contraceptive use among women at high risk of HIV infection

- Women at high risk of HIV infection are eligible to use all hormonal contraceptive methods without restriction (MEC category 1), including combined hormonal contraception, progestogen-only pills, and progestogen-only injectables and implants.
- Women at high risk of HIV infection are also eligible to use Cu-IUD and LNG-IUDs without restriction (MEC category 1).

Contraception for individuals on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception that may affect efficacy of some methods of hormonal contraception. Providers should advise clients on the risk so that they can make an informed choice of method.

Caring for yourself after an abortion

Exerpt from the [Planned Parenthood Michigan website](#)

⚠ Signs and symptoms requiring urgent medical help

One should seek urgent medical attention if they experience any of the following:

-  Soaking through two or more maxi-size sanitary towels per hour, for 2 hours in a row
-  Unusual, unpleasant-smelling vaginal discharge
-  Fever or flu-like symptoms after 24 hours
-  Worsening pain, including one-sided lower abdominal pain, pain under the ribs, or pain going up to the shoulders, which may indicate an undiagnosed ectopic pregnancy

⚠ Signs that may indicate an ongoing pregnancy

One should seek medical attention if:

-  There is no bleeding, or only spotting or smearing of blood on sanitary towel or underwear, in the 24 hours after misoprostol for medical abortion
-  One still feels pregnant 1 week after the abortion

Post Abortion Care in Kenya

A Decolonial Demand for Dignity, Justice, and Care

// Silvia Okoth, Advocacy & Policy Manager at Bar Hostess Empowerment & Support Programme (BHESP) Nairobi, Kenya

Post-abortion care (PAC) in Kenya is often framed as a clinical service, treatment for complications, infection prevention, and contraceptive counseling. But this framing is incomplete. **PAC is not merely a health intervention: it is a political and human rights issue.**

It reveals whether our health systems protect women and girls, or whether they punish them for the realities of reproduction, sexuality, poverty, and inequality.

In Kenya, abortion-related care exists within a hostile ecosystem shaped by colonial-era legal legacies, religious control, patriarchy, and stigma. These forces do not only influence whether abortion is accessible, they shape whether women and girls can seek care after abortion-related complications without fear. For far too many, PAC is not delayed because care is unneeded, but because care is unsafe in another way: unsafe emotionally, socially, and institutionally.

The results can be fatal.

In a country where maternal deaths remain a public health concern, denying or delaying PAC transforms a treatable complication into a life-threatening emergency. This is why PAC must be understood as essential life-saving care, not a privilege, not a moral reward, and not something that must be earned through “good behavior.”

This reality becomes even sharper in Kenya’s arid and semi-arid lands (ASAL) counties, regions like Wajir, Marsabit, Isiolo, Mandera, and Garissa, where many communities are predominantly Muslim and where sexuality is strongly regulated by cultural and religious expectations tied to family honour and social belonging. In many contexts, sex outside marriage is taboo and pregnancy outside marriage can trigger stigma, exclusion, or violence.

For women and girls, this creates a climate where abortion-related experiences are forced into secrecy, not because they reject care, but because exposure carries consequences.

When abortion is forced into secrecy, PAC becomes harder to access.

Many women and girls delay seeking post-abortion care until complications are advanced to severe bleeding, infection, or intense pain because seeking care earlier risks being questioned, reported, humiliated, or exposed. In some facilities, instead of receiving immediate and compassionate treatment, women and girls face judgment disguised as “clinical assessment.” Questions become threats. Providers become investigators. Facilities become sites of policing.

This is the central contradiction: **PAC is supposed to save lives, yet stigma turns it into a punishment system.**

The injustice is not just interpersonal; it is structural. PAC services are unevenly distributed. Many public facilities, especially in marginalized areas, struggle with shortages of essential supplies and equipment, understaffing, lack of privacy, and weak referral systems. Women and girls can be forced to travel long distances for emergency care. They may arrive late because transport is unavailable, unaffordable, or unsafe.

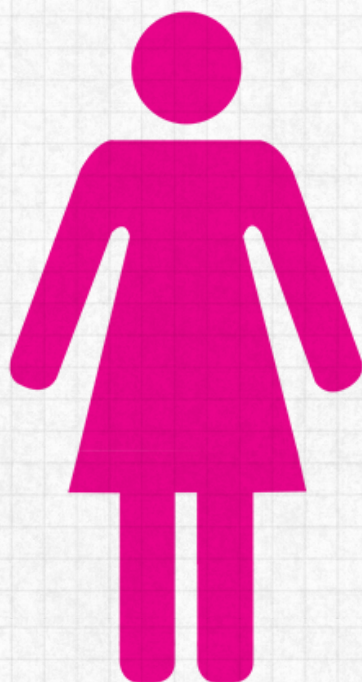
These barriers are not accidental; they are symptoms of a health system built around inequality.

A decolonial approach to PAC demands we treat women and girls as rights holders, not as suspects. It requires that PAC services be available, accessible, acceptable, and of quality everywhere, including rural and ASAL regions. It requires training and protecting healthcare providers so they can offer PAC without fear, moral panic, or institutional intimidation. It requires confidential, respectful care –including pain management, counseling, and follow-up, so that women and girls are not retraumatized while seeking treatment.

Most importantly, it requires political courage to state what should already be obvious: no one should die because they were denied post-abortion care.

PAC is not about whether society “approves” of abortion. It is about whether society values the lives of women and girls. If Kenya is serious about maternal health, dignity, and justice, then PAC must be prioritized, not as a quiet technical add-on, but as an urgent public commitment to care without stigma.

Key Findings of a National Study: Incidence and Complications of Unsafe Abortion in Kenya



465,000 induced
abortions occurred in 2012

120,000 women
received care for complications
in health facilities (“post-abortion care”)

3/4 more than three-quarters
of those complications were
moderate or severe

45% of women aged 19 and
younger who came to a health facility
for post-abortion care, experienced
severe complications

Re-locating care in Post Abortion care: The case of Pakistan

// Komal Qidwai, Aahung

Abortion continues to be criminalized in Pakistan, with the country's Penal Code only permitting it to save a woman's life or to provide "necessary treatment" before the fetal organs have developed. Yet the phrase "necessary treatment" is vague and lawyers and police officers report no known convictions under the law. Women and healthcare providers also do not cite fear of prosecution as a deterrent to seeking or providing services (Qidwai et al. 2024).

However in practice, citing the law (often inaccurately) becomes one justification for denial of services to abortion-seekers.

Against a backdrop of heavy stigma rooted in religious and cultural beliefs, an estimated six million unintended pregnancies occurred in 2023, out of which 3.8 million resulted in induced abortions, with the average abortion-seeker being a married woman with children (Sathar et al. 2025). The need is high but the provision of services is inadequate. The Pakistan Maternal Mortality Survey (2019) notes that abortion complications are the third main cause of maternal mortality in the country.

The landscape of abortion and post-abortion care services has shifted markedly over the past decade. Misoprostol is widely available and used for medication abortion as well as to treat post-abortion complications. **The complications associated with unsafe surgical procedures have dropped to negligible, which can be attributed to the uptake of misoprostol.**

However the attitudes of healthcare providers have not shifted and hence women continue to resort to self-induced abortions and then present at hospitals once bleeding has begun, seeing it as the only means to access care at facilities after being refused induced abortions by service providers.

At the same time, women are now increasingly using misoprostol to self-induce abortions as well, which could reduce post-abortion complications. Many women and advocates in the country are looking at somewhat bypassing a healthcare system which has failed women. **When we speak to abortion-seekers, care for them looks like not being shamed, degraded, humiliated, and thrown out of healthcare facilities for simply asking for a service, and being blamed for not using contraception.**

Unfortunately self-care still requires an ecosystem and a functioning public sector. As of now 20% of public facilities are still not providing services, and only 11% provide comprehensive round-the-clock care, disproportionately affecting rural and poor women (Sathar et al. 2024).

This begs the question: What does post-abortion care look like for most women?

Women are still offered procedures such as D&C and D&E even when safer alternatives exist, because these are more profitable for providers and facilities.

Only 50% of women who go to facilities for post-abortion care leave with a contraceptive method (Sathar et al. 2024). When women's preferences are not respected, methods provided during initial counseling are more likely to be discontinued. Ironically, women are then blamed by healthcare providers for not using or discontinuing contraception when they later seek abortion care.

A complete package of post-abortion services must take the term "care" seriously. The care women want is for their unique situational challenges to be acknowledged, and for respect for themselves and bodies. This requires a conceptual re-location of care beyond clinical intervention.

While it remains important to address questions of where and by whom services are being provided, we must also center women's lived experience and explore how care is delivered, and whether dignity, respect, and trust are made possible within these encounters. This will move us toward ensuring that post-abortion care is served without an extra helping of punishment.



عندما تعتقد الانسة أ أنها استنفذت كل الخيارات القانونية من
الممكن أن تستعين بمقدم خدمات اجهاض غير آمن

(Arabic Subtitles) From Unwanted Pregnancy To Safe Abortion



Asia Safe Abortion Partnership

393 subscribers

Les soins post-avortement en République Démocratique du Congo : enjeux, pratiques et défis persistants

Translation: Post abortion care in the Democratic Republic of Congo: issues, practices and persistent challenges

// By Women Future Life, DRC

En République Démocratique du Congo (RDC), la santé sexuelle et reproductive des femmes demeure un enjeu majeur de santé publique, marqué par une forte prévalence des avortements non sécurisés et des complications graves qui en découlent. Malgré des avancées juridiques notables, notamment la ratification du Protocole de Maputo, qui élargit les conditions légales de l'avortement, l'accès et la qualité des soins post-avortement (SPA) restent insuffisants face à l'ampleur du problème.

In the Democratic Republic of Congo (DRC), women's sexual and reproductive health remains a major public health issue, marked by a high prevalence of unsafe abortions and the serious complications that result from them. Despite notable legal advances, including the ratification of the Maputo Protocol, which expands the legal conditions for abortion, access to and quality of post-abortion care (SPA) remains insufficient in the face of the scale of the problem.



À Kinshasa, près de 37 900 femmes sont prises en charge chaque année pour des complications liées à l'avortement, telles que les hémorragies, infections sévères, perforations utérines ou états de choc. Parmi elles, 16 % présentent des complications graves, nécessitant des soins intensifs, tandis que 46 % souffrent de complications modérées. Dans les provinces du Nord et Sud-Kivu, au moins 1 769 personnes ont sollicité des SPA sur une période de 12 mois, majoritairement pour des interruptions incomplètes de grossesse. Les données montrent également que 27 % des patientes avaient déjà vécu au moins un avortement antérieur, révélant des situations de récurrence.

In Kinshasa, nearly 37,900 women are treated each year for abortion-related complications, such as haemorrhages, severe infections, uterine perforations or shock. Of these 16% have serious complications, requiring intensive care while 46% suffer from moderate complications. In the provinces of North and South Kivu at least 1,769 people requested PAC over a 12-month period, mostly for incomplete abortions. The data also show that 27% of patients had already experienced at least one previous abortion, revealing situations of recurrence.

Les SPA concernent principalement les femmes âgées de 20 à 29 ans (environ 50 %), suivies par celles de plus de 30 ans (35 %) et les adolescentes de 15 à 19 ans (16 %). Le taux de traitement des complications d'avortement est estimé à 14 pour 1 000 femmes âgées de 15 à 49 ans, bien que ces chiffres ne reflètent qu'une partie de la réalité nationale, de nombreuses femmes n'ayant pas accès aux soins en raison de barrières économiques, géographiques, sécuritaires et sociales.

PAC mainly concern women aged 20 to 29 (about 50%) followed by those over 30 (35%) and adolescent girls aged 15 to 19 (16%). The treatment rate for abortion complications is estimated at 14 per 1,000 women aged 15 to 49, although these figures reflect only part of the national reality, with many women not having access to care due to economic, geographical, security and social barriers.



L'accès aux SPA reste fortement inégalitaire. À Kinshasa, environ 93 % des soins sont fournis par le secteur privé ou des ONG, souvent à des coûts inaccessibles pour les femmes les plus vulnérables. Dans l'Est du pays, les conflits armés et l'insécurité aggravent la situation par la fermeture ou la perturbation des services de santé essentiels, y compris les soins maternels et post-avortement.

Access to PAC remains highly unequal. In Kinshasa, about 93% of care is provided by the private sector or NGOs, often at costs that are unaffordable for the most vulnerable women. In the east of the country, armed conflict and insecurity are exacerbating the situation by closing or disrupting essential health services, including maternal and post-abortion care.

Sur le plan clinique, le protocole national des SPA repose sur cinq composantes clés : accueil et triage sans jugement, traitement médical ou chirurgical des complications, conseil et soutien psychosocial, planification familiale post-avortement et suivi/documentation. Toutefois, dans certaines structures, des pratiques obsolètes comme le curetage par dilatation persistent, au détriment des méthodes recommandées par l'OMS telles que l'aspiration manuelle intra-utérine ou le traitement médicamenteux. De plus, la prise en charge de la douleur et le soutien psychosocial restent insuffisants.

At the clinical level, the national protocol for PAC is based on five key components: non-judgmental reception and triage, medical or surgical treatment of complications, counselling and psychosocial support, post-abortion family planning and follow-up/documentation. However, in some facilities, obsolete practices such as dilation curettage persist, to the detriment of WHO-recommended methods such as manual vacuum aspiration or drug therapy. In addition, pain management and psychosocial support remain insufficient.

Malgré ces défis, des initiatives portées par des ONG nationales et internationales, dont IPAS RDC et WOMEN FUTURE LIFE (WFL), contribuent à améliorer l'offre de services à travers la formation des prestataires, la sensibilisation communautaire et la promotion de soins centrés sur les droits des femmes.

Despite these challenges, initiatives led by national and international NGOs, including IPAS DRC and WOMEN FUTURE LIFE (WFL), are helping to improve service provision through provider training, community awareness and the promotion of women's rights-centered care.

La situation des soins post-avortement en RDC révèle l'urgence de renforcer durablement les services de santé reproductive. L'amélioration de la qualité et de l'accessibilité des SPA, l'élargissement de l'accès à la contraception moderne et l'investissement dans la formation continue des prestataires sont essentiels pour réduire les complications évitables et les décès maternels, dans un contexte humanitaire et sanitaire particulièrement fragile.

Conclusion: The situation of post-abortion care in the DRC reveals the urgent need to sustainably strengthen reproductive health services. Improving the quality and accessibility of PAC, expanding access to modern contraception, and investing in continuing education for providers are key to reducing preventable complications and maternal deaths, in a particularly fragile humanitarian and health context.

Post abortion care in Nigeria

// Favour Amaechi, Feminist advocacy writer

In Nigeria, people would argue on the right vocabulary to use when describing how women can access abortion services—whether it is just plain illegal or it is restricted.

Sections [228–230, 297, 309, 328] of the criminal code in Nigeria covers what the law in Nigeria says about abortion. There is a very blurred line between the perception that it is illegal or can be seen as restricted, since it is permitted to save a woman whose life is threatened by the pregnancy, as confirmed by a doctor, thereby stripping the autonomy from the woman and placing it in the hand of doctors, who have been known to favor their bias than save the life of a woman.

The statistics show that unsafe abortions account for anywhere from 10%–40% of maternal mortality rate in Nigeria.

In much more simpler terms, women who want to end unintended pregnancies, source for any means to DIY it themselves, over half of them use unsafe methods. Which in their defense is never their fault but the unwavering stigma society bestows on women who would dare to seek abortion.

Contrary to popular conclusions on post abortion care in Nigeria, it is legal and mandated to provide care to a woman who is in critical condition from either induced miscarriages or natural miscarriages.

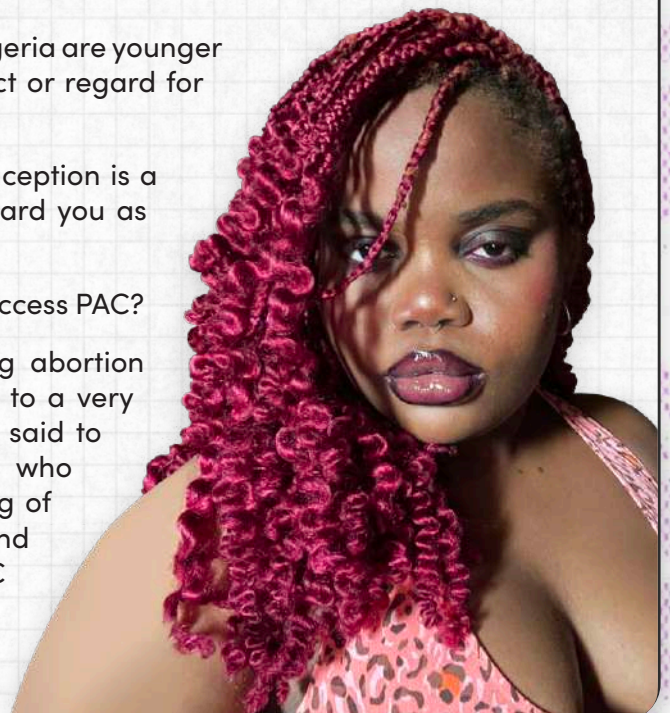
Nevertheless, for many women accessing PAC feels like a fever dream. Going through something traumatic and giving yourself up like a witch to be burnt at the stake. Understanding that trying to access PAC without the “luxury” of a husband or perceived as a respectable married woman who happened to be in a tragic situation of having a miscarriage or in the very least be able to afford privacy feels like suicide. Well at least mentally.

Over 85% of women who access abortion in Nigeria are younger than age 25 and the country holds no respect or regard for unmarried women, young/teenage girls.

Even accessing something as basic as contraception is a humiliation ritual, with medicos ready to regard you as wild and promiscuous.

Which begs the question: How does it feel to access PAC?

For the average Nigerian woman, accessing abortion should be something done in private or told to a very small handful of trusted people. This can be said to be an internalized stigma (even for women who had safe medical abortion). So when thinking of accessing PAC they have to weigh the pros and cons (that is if they are even informed that PAC is legal).



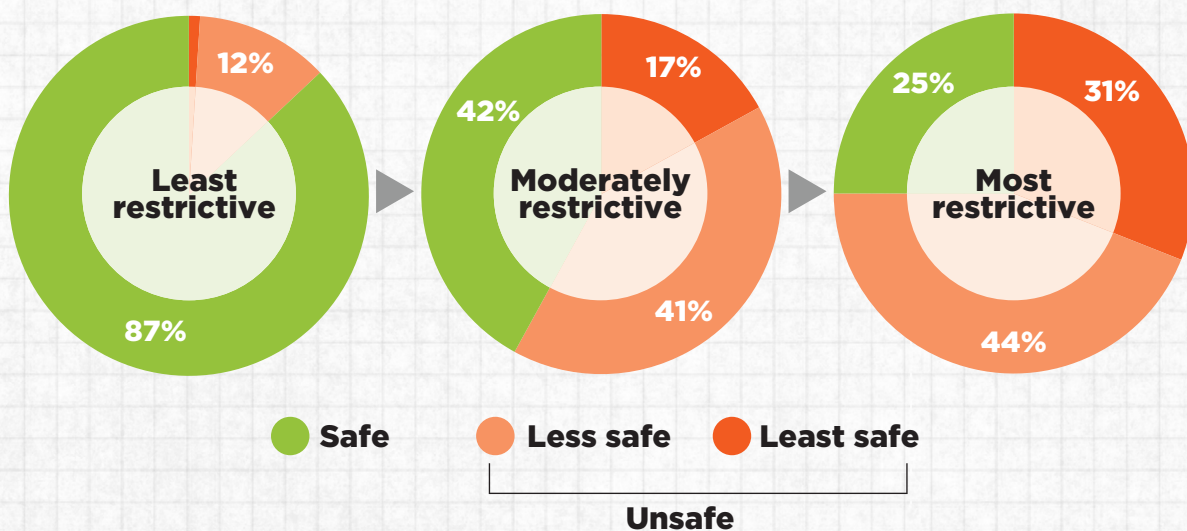
In rural areas hospitals are not necessarily at a walking distance. Eventually a lot of them are forced to seek PAC from quacks, lucky ones can get from SRHR based organizations (even though a lot of the time it has to be virtual for safety) and some are left to tend to their own wounds, holding the guilt that they deserve pain and solitude because they are sinful.

The real question is not whether PAC is accessible in Nigeria. It is whether stigma-free, empathy based, financially accessible/ free, inclusive, bias-free and properly professional post abortion care is available in Nigeria. The simple answer is NO.

The Nigerian government permitting and legalizing PAC, while our abortion law remains redundant, some will say is "medicine after death".

To ensure better post abortion care there is a need for abortion policy reform, adequately trained medical professionals not just in PAC but to be able to provide such services without judgement and at affordable cost or free.

The proportion of abortions that are unsafe is much higher in countries where laws are more restrictive



Abortion is *safe* when done by a trained person using WHO-recommended methods, *less safe* when only one of those conditions is met and *least safe* when neither is met.

Source: Guttmacher

Post abortion care in Italy

// Alessandra Brigo, Anastasia Martino, [Aborto In Pillole project](#)

Aborto in Pillole is a collective project that believes in the power of accessible information, shared action, and storytelling to change perspectives. In collaboration with other collectives and NGOs, AiP has used different formats, including workshops, videos, podcasts, and a newsletter to spread positive narratives about medication abortion and sexual and reproductive health.

Abortion in Italy is regulated by Law 194 of 1978, "Norms for the social protection of motherhood and on the voluntary termination of pregnancy." While the law legalized abortion, it framed it primarily as a measure to protect motherhood rather than recognizing abortion as a matter of self-determination. Law 194 is the result of a compromise between the positions of the feminist movement and the Radical Party, which demanded the full decriminalization of abortion, and those of the Catholic and conservative political area, which wanted the law, on the condition that they would not oppose its approval, to focus on the protection of motherhood.

In Italy, a very high percentage of healthcare personnel refuse to perform abortions or provide assistance, making abortion difficult and sometimes impossible. In 2023, for example, 57.9% of gynecologists refused to perform abortions as part of their medical procedures. High levels of conscientious objection affect not only access to abortion itself, but also the quality and continuity of care surrounding the procedure.

Medication abortion became accessible in 2009 up to the 7th week of pregnancy and only through hospital admission. In 2020, the Italian Ministry of Health approved guidelines that extended access to medication abortion up to the 9th week, compared to the previous 7 weeks. These guidelines also allowed access to this procedure in family planning clinics and via telemedicine, and introduced the possibility, upon request, of taking the second pill at home. In practice, however, only three regions have adopted the national guidelines: Lazio, Emilia-Romagna, and Sardinia, each with different levels of service provision.

Although it is still difficult to obtain an abortion in Italy, these changes have made access to the medication method easier. In 2023, the percentage of abortions carried out with pills rose to 59.4% of the total. Compared to most other European countries, access to medication abortion remains behind the recommendations of the WHO, which indicate self-management as a recommended option.

Post-abortion care within the Italian public health system is not systematically structured. Follow-up visits may be offered to verify that the abortion has been completed, but access to counselling, emotional support, and clear information about physical recovery and contraception varies widely between regions and facilities. In many cases, people are left to navigate this phase largely on their own.

Within this context, and with the aim of facilitating the experience of abortion, many groups of feminist activists have emerged over time to provide information, support, and assistance to people facing difficulties during the abortion process, including the period after the abortion itself. In Italy, accompaniment mainly consists of following and supporting people throughout their journey with and within public medical institutions, helping them access reliable information, understand what to expect during the process, and offering support during recovery and post-abortion care.

There are many feminist collectives that practice accompaniment across the country (Obiezione Respinta in Pisa, Mi Cuerpo Es Mio in Catania, 'Ccà nisciun' è FESSA! in Naples, Mujeres Libres in Bologna, LaConsultoria in Padua, Greta in Florence, Consultoria Fam in Turin). These networks often provide practical and emotional support that complements, and sometimes compensates for, the gaps in institutional services. Care related to abortion, and more broadly to the sexual and reproductive sphere, "women caring for women", has historically developed within the Italian feminist movement since the 1970s through practices of self-help and mutual aid.

The practices we are describing originate from this history; over time they have evolved according to historical, social, political, and geographical contexts, and today they play an important role in ensuring that abortion care does not end with the procedure itself, but includes support, information, and solidarity afterwards. These practices have also been made safer over time thanks to the availability of medication abortion.



Image submitted by Fòs Feminista Alliance (article on the next page)

Post abortion Counseling

A key component of the comprehensive abortion care continuum

The experience of the Fòs Feminista Alliance

Fòs Feminista is an intersectional feminist organization centered around the sexual and reproductive rights and needs of women, girls and gender-diverse people. Led and governed by the South, we work with a growing ecosystem of organizations in 35+ countries to provide access to sexual and reproductive health care and to advocate for sexual and reproductive justice.



Comprehensive abortion care includes providing information, abortion management (including induced abortion), care related to pregnancy loss or a spontaneous abortion and post-abortion care. Fòs Feminista partners provide abortion care through a variety of models according to the different country contexts: abortion on demand, abortion under certain exceptions, harm reduction and postabortion care. These, in turn, are delivered through different channels: fixed or mobile clinics, telemedicine, hotlines, community health promoters and accompaniment networks.

Key points to be included in counselling:

1. Any person that may become pregnant must be informed that ovulation may return within the first two weeks after the abortion. It can also return as soon as 8 days after a medical abortion, with the subsequent chance of pregnancy if contraception is not used.
2. Individuals interested in contraception must receive information that helps them choose the method that is most appropriate for their needs and preferences.
3. Some people may prefer talking about contraceptive options once the abortion is completed but the process should be addressed as a continuum starting with the first contact.
4. In situations consisting of a contraceptive failure, it is important to discuss whether the method was used incorrectly and how to use it correctly, or if it is appropriate to change the method.
5. After an abortion, individuals can use any contraceptive method[1]. It is important to provide detailed information regarding the characteristics of each method, including effectiveness, correct use, effects on the menstrual cycle (variation in bleeding, absence of a menstrual period), general expected effects, and warning signs.

Maximizing the opportunity for post-abortion contraception calls for creative interventions such as:

- Providing condoms and encouraging dual protection when STI/HIV prevention is necessary.
- Delivering several months of oral contraceptives at a time.
- Offering non-scalpel vasectomies for partners of heterosexual women while they are having an MVA.
- Promoting self-care methods such as self-injectables, particularly when access to services is scarce or difficult.
- In addition, providing emergency contraception for future use, in case it is needed, is always good practice.

Follow up is important and digital tools can be very helpful to revisit contraceptive choices, provide further written information and communications channels in cases of questions or doubts.

SMS or messaging follow-ups with reminders, information about side effects and opportunities to ask questions confidentially can also be a great resource if the person provides her consent to be contacted that way.

Post Abortion Care in Namibia

Life-Saving Care in a Legally Constrained System

// Tuli Kamati, MBChB, Director and founder of Reproductive Justice Namibia

Post-abortion care is not an abstract policy issue. It is something we see in our wards and clinics.

Women arrive bleeding. Some are frightened. Some are in pain. Some are grieving. Others are silent. Some pregnancies have ended spontaneously. Others have ended in ways shaped by fear, stigma, limited access, or legal restriction. Whatever the circumstances, the clinical responsibility is the same: to stabilise, to treat, and to care without judgment.

Post-abortion care (PAC) is embedded within Namibia's maternal health system and recognised in the Ministry of Health and Social Services' Comprehensive Abortion Care guidelines (MoHSS, 2022). Providers are trained to manage incomplete abortion, treat haemorrhage and infection, provide uterine evacuation when indicated, and offer contraceptive counselling before discharge. PAC is not optional– it is part of basic emergency obstetric care.

And it saves lives.

Globally, unsafe abortion remains a preventable contributor to maternal morbidity and mortality. In Southern Africa, abortion-related complications continue to appear in emergency obstetric care registers and maternal near-miss audits (Comparative Situational Analysis, 2023). Namibia is not immune to these realities. Post-abortion care reduces haemorrhage, sepsis, infertility and death. It creates an opportunity to link women to voluntary family planning and ongoing reproductive health support.

Yet this life-saving care exists within the constraints of the Abortion and Sterilization Act of 1975 , legislation inherited from Namibia's pre-independence era (Liberalise the Abortion Law in Namibia Coalition, 2023). Under this Act, termination of pregnancy is permitted only under narrow circumstances, including rape, incest or serious threat to the life or health of the woman or fetus. In practice, these provisions are procedural, restrictive and often inaccessible to many women.

This creates a difficult contradiction.

Our health system acknowledges that complications from unsafe or incomplete abortion occur and must be treated. But the same legal framework contributes



to the conditions under which women are pushed into crisis before they reach care.

Public opinion reflects a society in negotiation. Afrobarometer data show strong support among Namibians for women's autonomy in deciding when and how many children to have, and majority support for abortion when a woman's health is at risk or in cases of rape or incest (Afrobarometer, 2026). Fewer support termination "for any reason." The conversation is evolving but the law remains largely unchanged.

Meanwhile, reports of newborn abandonment and baby dumping continue to surface in national media (BBC News, 2023; The Namibian, 2025). Although legal reforms were introduced in 2019 to prevent the prosecution of mothers who safely relinquish infants, these measures address what happens after desperation has already taken root. Economic precarity, stigma, limited reproductive choice and restrictive policy intersect long before a baby is left at a hospital entrance.

Post-abortion care sits at this intersection of law, health systems, and lived experience.

As a provider trained in Namibia's PAC curriculum (MoHSS, 2022), I have seen that this work is not only technical. It requires values clarification, compassionate counselling and the ability to meet patients where they are. PAC reminds us that reproductive health care must be grounded in dignity. Every patient deserves respectful, evidence-based care, regardless of the circumstances that brought her to the facility.

But harm reduction is not the same as justice.

PAC will continue to save lives. It must be strengthened, adequately resourced, and integrated across regions. However, if Namibia is serious about reducing maternal morbidity and preventing unsafe abortion, post-abortion care cannot remain the endpoint of intervention. It must be part of a broader continuum that includes comprehensive sexuality education, accessible contraception, provider support and an honest national dialogue about the continued relevance of the 1975 Act.

Post-abortion care demonstrates that Namibia values women's lives enough to treat them when they are in crisis. The next step is ensuring that our legal and policy frameworks value women enough to prevent that crisis in the first place.

Post Abortion Care in Hong Kong

// Teen's Key Hong Kong and Ruby YS LAI

In Hong Kong, abortion was legalized in 1981 and is regulated under Section 47A of the Offences Against the Person Ordinance (Cap. 212) (the Ordinance). The law permits abortion within 24 weeks of gestation with the approval of two registered medical practitioners, on grounds such as safeguarding the woman's life, preventing severe fetal abnormalities and protecting the pregnant woman's physical or mental health.

Abortion and post-abortion care (PAC) are primarily provided through public hospitals, private hospitals and specialized clinics such as the Family Planning Association of Hong Kong (FPAHK). Governed by the Ordinance, the process ensures legal and safe terminations via surgical or medical methods.

While public services emphasize infection control and physical recovery, access to abortion services is often obstructed by **long wait times (sometimes months)** and limited slots, pushing many toward private options, which are considerably more expensive.

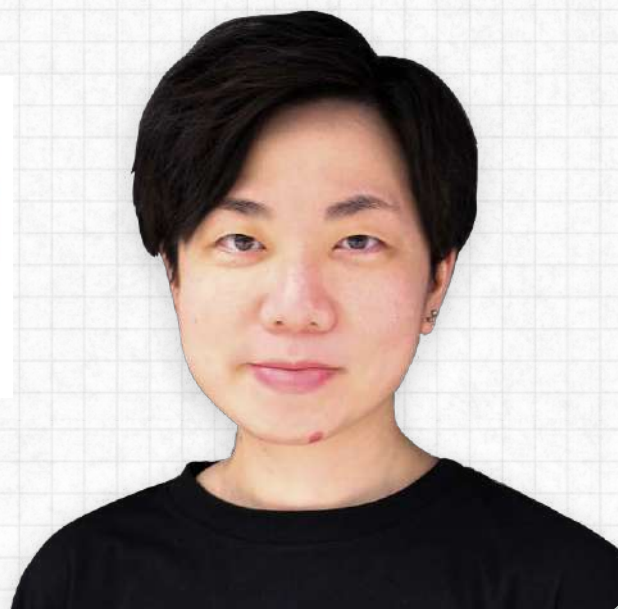
Although specialized clinics like the FPAHK offer a more affordable alternative, **they only accept cases up to 10 weeks of gestation**. Under such a system, young women and low-income groups often struggle to access timely abortion services in Hong Kong.

Following the abortion procedure, women receive immediate post-operative monitoring for vital signs and complications. A mandatory follow-up visit occurs 1 to 3 weeks later, involving ultrasound to confirm complete expulsion, blood tests, and interventions like additional misoprostol for incomplete abortion or heavy bleeding. Contraceptive counseling begins on discharge, offering options such as oral pills, injectables, or IUDs to prevent repeat unintended pregnancies. A final check at 6 to 8 weeks verifies menstrual cycle resumption and overall recovery, with advice on resuming sexual activity and daily activities.

Overall, Hong Kong's approach to PAC is largely consistent with the World Health Organization (WHO) guidelines in clinical aspects such as evidence-based treatment. However, significant gaps remain in promoting person-centered, non-judgmental, and youth-friendly post-abortion care. Many counseling services are designed primarily for miscarriage support rather than for women who have chosen abortion voluntarily, reflecting lingering societal stigma and the perception of abortion as a taboo subject. Furthermore, some counseling programs are only available to women under 26 years old, leaving older women with limited support options or forcing them to seek costly private services.

Limited public access and long wait times create inequities, often pushing women to seek private hospital care where **costs can exceed USD 3,750 or to travel to mainland China**, where follow-up care is not guaranteed.

In conclusion, while Hong Kong's PAC system aligns with global clinical standards, expanding equitable access, ensuring stigma-free counseling, and strengthening person-centered practices remain essential for achieving truly comprehensive post-abortion care.



“I wasn’t asking to be loved, I just wanted to be treated like everyone else”

The reality of post-abortion care in Togo

// By Ramatou Ouedraogo, Jonna Both and the Safe choice study team, African Population and Health Research Center; Rutgers

This article delves into the challenges and experiences associated with post-abortion care in Togo, drawing on findings from a recent ethnographic study combining participants observation and in-depth interviews in two regions in Togo.

In Togo, a significant number of women resort to unsafe procedures to terminate their pregnancies due to the legal restrictions, abortion stigma, and financial barriers. Out of the 61 girls and women we followed who had attempted an abortion, 49 experienced complications. Despite intense pain or bleeding, shivering and cold sensations many women delayed seeking care due to fear of disclosure and subsequent stigmatization (including being reported to police).

“I couldn’t even leave the room. I couldn’t stand up straight... every minute was torture. I cried alone (...). But I did not seek care because I was afraid. Afraid that they would find out I had tried to have an abortion.” – 35 years, saleswoman

Primary healthcare facilities often lack the necessary resources hence providers typically offer initial care but are frequently forced to refer patients to higher-level facilities which can cause significant additional delays and expenses.

This study and others in Africa found that some providers subject PAC patients to verbal and physical violence or delay offering them care due to their values towards abortion (Pasquier et al., 2025). Experiences like “They left me in pain until 2 a.m. without doing anything” or “The midwives really insulted me... I was very sad.” were common, especially among unmarried adolescents and young women.

The study found that the poor quality and cost of PAC had a mental, economic, and physical impact on adolescent girls and women, their relatives, and partners. As a result, some patients, who required further attention or follow up did not return: “I had pain afterwards, but I didn’t dare go back to the hospital. I was too afraid of going through that again.” (23 years, secretary)

The quality of post-abortion care in Togo is shaped by a complex interplay of factors, including inadequate healthcare infrastructure, stigmatizing provider attitudes, and socio-economic constraints. While prior efforts to enhance the quality of PAC gave positive results (Mugore et al. 2016), addressing these challenges requires a sustainable, multifaceted approach. There is a need for more structural health worker training that includes clarification for action and transformation (VCAT) for health care providers, improving healthcare infrastructure, and ensuring affordable care.

Post abortion Contraception Guidelines

Information adapted from resource titled 'Best practice in post-abortion care,' published by the Royal College of Obstetricians and Gynaecologists

Factors affecting patients' preferences

It is important not to make assumptions about a person's priorities regarding contraception. Factors that might affect preferences include:

Effectiveness of methods

Avoiding disadvantages / seeking advantages

Convenience

Future pregnancy plans

Personal and family/friends' experiences

Discreetness of method

Safety and/or side-effect concerns

Gathering information

ASK ABOUT PAST EXPERIENCE

“ Have you used contraceptive methods in the past? If so, what did you like or dislike, and why did you stop?

“ Are those factors still important to you? What is now important to you in a contraceptive method?

ASK ABOUT PAST EXPERIENCE

“ What is important to you in a contraceptive method?

? Specific questions

SPECIFIC QUESTIONS TO NARROW DOWN METHODS

- ⦿ Are there any side-effects you are particularly worried about?
- ⦿ Are you planning to have a child in the next few years?
- ⦿ What are your periods like?
- ⦿ Have you had experience taking a pill every day? How did that go for you?
- ⦿ Would you like to discuss any non-contraceptive benefits of methods?

✓ By the end of this conversation, health workers should have narrowed down two or three methods the patient is interested in, or even identified the precise method the patient wishes to start.

☰ Identifying contraindications to contraceptive methods

One should seek medical attention if:

- 1 Take a medical history. If the patient wants a combined hormonal method, take a focused family history of medical conditions that may present a contraindication to the method.
- 2 Check whether any medical conditions identified in the history make it unsafe for the patient to use their preferred method.
- 3 Check for any potential interactions between medication the patient is taking and their chosen method.

Post Abortion Contraception Methods

Information adapted from [article by Committee on Health Care for Underserved Women at the American College of Obstetricians and Gynecologists'](#)

☰ Recommendations and conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions for obstetrician–gynecologists and other clinicians to improve access to postabortion contraception

- Contraceptive counseling and methods should be made available to all patients who experience induced or spontaneous abortion, and the patient's right to decline or postpone this care should be respected.
- Recognizing the individual barriers that may exist for each patient is important to providing patient-centered care. Patients may have difficulty accessing health care for many reasons, including distance to health care facilities, work constraints, caregiving responsibilities, inadequate or no insurance, unreliable transportation, and language barriers. These challenges can affect access to interval placement or removal of long-acting reversible contraceptives (LARC), repeat visits for depot medroxyprogesterone acetate (DMPA) administration, and pharmacy visits to obtain refills of short-acting methods.
- It is important to understand the history of reproductive rights abuses, including contraceptive coercion and forced sterilization, in the United States. Recognition of one's own biases around induced and spontaneous abortion, pregnancy spacing, and cultural stereotypes is crucial to avoid coercive behaviors, such as clinician pressure for a patient to leave with a contraceptive method that day, pressure to use a specific method such as a LARC, or expression of judgment about the patient's decision to have an abortion.
- Obstetrician–gynecologists and other clinicians should remain current in their knowledge of all methods of contraception.
- Logistical barriers should be minimized to improve patient access to chosen contraceptive methods after induced and spontaneous abortion.
- Continuity of care can be improved by offering management of induced and spontaneous abortion and the full range of contraceptive methods within a practice, or by creating pathways for streamlined referral and follow-up for patients who need such care.
- **All contraceptive methods are safe and effective when provided immediately after abortion procedures and when otherwise medically appropriate for a patient.**

Key Facts

83% of women will ovulate within one month of an induced or spontaneous abortion

51% of women reported having intercourse within two weeks after an abortion

Providing a contraceptive method immediately after an induced or spontaneous abortion can help individuals achieve their desired reproductive outcomes and minimise the burden of multiple appointments.

44% of patients with spontaneous abortion have pregnancies that are unwanted or mistimed. Similar to rates in the general population of pregnant individuals.

This finding, combined with a lack of clarity about optimal pregnancy spacing after pregnancy loss; receipt of care in a variety of settings, including emergency departments; and rapid return to fertility highlight the importance of addressing contraception using a patient-centred approach.

Immediate Post abortion Contraception is Safe

- The U.S. Medical Eligibility Criteria (U.S. MEC) for Contraceptive Use lists all methods as Category 1 after first trimester abortion unless the abortion is complicated by sepsis, in which case intrauterine devices (IUDs) should not be placed.
- Patients who choose medical management of induced or spontaneous abortion can be offered most methods at the time of mifepristone administration.
- “Quick start” initiation of the implant does not interfere with mifepristone’s efficacy, which means the implant can be offered at the same visit, as can all short-acting methods including emergency contraception.
- Intrauterine device placement should be deferred until medication abortion completion is confirmed.
- Patients are often satisfied with the convenience of receiving the contraceptive method of their choice immediately after induced or spontaneous abortion.
- If available, providing free condoms and advanced emergency contraception is good practice. **Vasectomy for the male partner is always a good option if a permanent method is needed.**

Gerri Santoro and the consequences of creating barriers to safe abortions

Exerpt from [blog on The Cutprice Guignol](#)

Gerri Santoro (1935–1964) who grew up in Connecticut along with her fourteen siblings, had in 1963, left a decade-long physically abusive marriage to her husband to move home with her daughters. There, she met Clyde Dixon, a married man with whom she began an affair. She soon fell pregnant by him. But, when she discovered that her abusive husband intended to visit her and their daughters, she became fearful that he would murder her upon discovering her pregnancy by another man. She and Dixon resolved to perform an abortion.

On the night of June 8th, 1964, Santoro and Dixon checked into a motel, along with a collection of medical tools and a textbook they intended to use as guidance for their attempt to induce an abortion. During the process, Santoro began to bleed heavily and Dixon fled the scene, leaving her to die in their motel room, naked and alone. A maid discovered her the next day and her daughters were told their mother had died in a car accident.

Gerri Santoro's story is representative of so many people who lost their lives to abortion, because their ability to access a safe, medically-supervised path to end their pregnancy was denied them. What made Gerri's story stick in the public consciousness, however, was a police photograph of her corpse as it was discovered on the day she died ([please note that this image is graphic](#)): slumped forward, feet and backside covered in blood, a bloody towel stuffed between her legs.

It became a firebrand photograph for abortion rights activists in the 1970s, a stark and grim reminder of what people faced when they didn't have access to safe abortion.

Gerri Santoro, in her tragic death, represents so much about the urgent importance of providing free, accessible, and safe abortion options for all. She was left to die in a hotel room alone, because the legal blockades, as well as the societal shame and stigma, refused her the opportunity to access the care she needed. She left behind two daughters and an entire life unlived but she's not the only one.

Estimates suggest about five million years of potential life are lost to unsafe abortion every year in women of child-bearing age, due to complications and disability following the procedure.

ABSTRACT

A global review of penalties for abortion-related offences in 182 countries

// Samhita Ambast, Hazal Atay, Antonella Lavelanet, [source linked here](#)

Public health research and human rights bodies have demonstrated the risks involved with criminalising abortion services and noted a need for full decriminalisation. Despite this, abortions are criminalised in some circumstances in almost all countries in the world today. This paper uses data from the Global Abortion Policies Database (GAPD) to analyse what criminal penalties exist for those who are seeking, providing and assisting in abortions in 182 countries.

134 countries penalise abortion-seekers, 181 countries penalise abortion-providers and 159 countries penalise persons assisting in abortions. The maximum penalty is between 0 and 5 years of imprisonment in a majority of countries; however, it can be much higher in other countries. Some countries further prescribe fines, and professional sanctions for providers and those who assist. 34 countries restrict the dissemination of information about abortion.

Abortions are also predominantly regulated through the criminal law, which may compound the stigma associated with seeking, assisting with and/or providing abortions when it is criminalised.

The findings provide additional evidence of the arbitrariness and potential for stigma associated with the criminalisation of abortion and strengthen the case for decriminalisation.

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Digital Safety and Safe Abortion Rights

Guest Editor: Ayesha Bashir