



Asia Safe Abortion Partnership

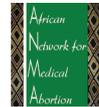


clacai

Latin American Consortium
Against Unsafe Abortion



Eastern European Alliance
For Reproductive Choice



African Network
for Medical Abortion

As part of ICMA's commitment with women's right to safe and legal abortion and convinced of the need to strengthen collaboration and share expertise and views among global stakeholders, we have invited Women on Web to join this number of our Newsletter to address one of the most promising topics in the abortion field: the hotline strategy as a mean to guarantee the right to information and to put the abortion process into women's hands.

"Hello, do you need information about safe abortion?" Hotlines on misoprostol in countries with restrictive laws

By Kinga Jelinska, Project Manager, Women on Web

Since 2008, Women on Waves and Women on Web have been supporting local groups in creating hotlines that provide information on how to do a safe abortion and how to safely self-administer misoprostol. Those hotlines run in countries where access to safe abortion services is restricted. Since 2008 local groups in Ecuador, Chile, Argentina and Peru launched the hotlines. In 2010 WoW together to a regional ICMA network, Asia Safe Abortion Partnership, worked with local groups in Pakistan.

Women on Web and Waves for several years have been running a multilingual email helpdesk. In 2010 alone WoW sent 70 000 emails to women from all around the world, advising them on how to do a medical abortion, particularly in contexts where abortion is legally restricted. Through the Women on Web website, women that need the medicines can get both mifepristone and misoprostol sent to them discretely in a courier package. However, access to the Internet in some regions remains problematic. To bridge the digital divide and compliment the online work, WoW works with partners on the ground using different strategies, like mobile phones, SMS, and word of mouth campaigns, with the goal of building awareness about misoprostol, a medicine often available locally.



The campaigns usually involve non-medical professionals. Safe abortion traditionally belongs in the spectrum of knowledge and expertise of medical professionals. Abortion with pills brings a new paradigm; the process is very similar to a spontaneous miscarriage, it is an easy procedure that can be safely done by women themselves if they have reliable instructions. The information needs to spread also outside the routine channels of doctors and mid-level health professionals and get into women's hands. Some of the groups that launched the hotlines were youth feminist groups, fighting for women's autonomy, but not necessarily working exclusively on reproductive health issues. Other partners were LGBT groups. In Latin America the groups created a regional network and it is hoped that in 2011 the activists will be able to meet on the global level with support of the ICMA.

The hotlines give detailed, practical information how to do an abortion with pills, what to expect, what are the possible complications. Unsafe abortion does not affect everyone equally. Women with financial means can always find a way to travel or find a doctor. The injuries and deaths due to unsafe abortion are overwhelming – it's as if every day a whole plane crashed, a plane filled only with women. This happens purely due to bad laws and stigma, and this tragedy is totally preventable.

Misoprostol, for many women, is the safest and certainly the cheapest option available locally. Moreover, an abortion with pills is indistinguishable from a spontaneous miscarriage, so there is no risk of prosecution for the woman to go to the doctor, if she does not mention the pills herself. This is as well a crucial piece of information given to the callers.

Furthermore, research proves that misoprostol can cut the risk of postpartum hemorrhage (the foremost cause of maternal mortality) in half. Women who will not deliver with a skilled birth attendant can self-administer misoprostol for safe birth. Misoprostol is therefore nothing less than a miracle for women's health.

The hotlines, as well as Women on Web's online help service, use the harm reduction model with the aim of diminishing the mortality from unsafe abortion. From the public health perspective awareness about available options, like misoprostol, are beneficial and life-saving for women's health.

But it were not public health scientists or activists that stimulated the use misoprostol. Since the eighties women in Latin America have been purchasing the drug and taking it, way before the protocols and recommendations were sanctioned by research. Still today there is way not enough information easily available to women in need, and some women keep on using incorrect protocols or buy false medication. In Pakistan the tablets are cheap and very accessible even without prescription, but unlike in Latin America, very few women, if any, knew about their existence. The magic pill is there, but it's just not yet used to its full potential, because of the information deficit.

In essence, the right to information is the legal rationale of the hotline projects. The right to information and the right to enjoy the benefits of scientific progress are guaranteed not only by human rights treaties ratified by governments but

most often also protected by national constitutions. The information provided by hotlines is based on the official protocols of the World Health Organization.

Despite the WHO protocols and practice, some doctors and advocates believe the pill does no magic for women. The controversy brings arguments like: it is not the optimal solution, it is not as effective as in combination with mifepristone, it can be used also for longer pregnancy termination, women can misdiagnose or lie, incomplete abortions will need further treatment and it is always better if the doctor supervises the process. It's a long list of smaller and bigger "buts" and objections. Due to this potentiality of misoprostol being used in the not utmost correct manner, some think it is better to hide the misoprostol option altogether from broader public. Should the potentiality that a few women might not obtained the most desired result get the precedence over

The hotlines are determined to get the word out there.

Hotline in Argentina: 011 156 664 7070

Hotline in Chile: 08-8918590

Hotline In Ecuador: (593) 098301317

Hotline in Peru: 01-945411951

Hotline in Pakistan:
0307 - 494 07 07 - (Urdu, Punjabi)

0315 - 917 04 08 - (Urdu, Pastho)

0315 - 947 33 99 - (Urdu, Sindhi)

For more information:
info@womenonweb.org

their most basic right to information? Even if it is often the safest possible options and it should be the woman herself to decide what is best for her?

The aura of fear hangs over popularization of information about the pills for abortion and bringing it to the community level and to the women themselves. This fear mandates that the knowledge about misoprostol should rather remain out of public view and should be over-medicalized. Concerns regarding not easily accountable outcomes, political backlashes and the governmental reactions function as an excuse for not talking loudly about misoprostol. The possibility of medication being restricted by the government can be predicted, and the conflicting agendas can be strategically challenged.

The difficulty with letting go of the control over this information, and letting it flow into public domain probably has to do with the very potential of the technology, as well as the issue of trust in women and in their autonomy. We should not protect women from any information, or protect women from themselves. It's up to individuals how they are going to use information. And they have the moral right to use it in any way they want.

The manifesto of the misoprostol hotlines is straightforward and optimistic. They document the barriers to access, but at the same time the solutions and empowerment of resourceful women that found a safe option and benefitted from it. Some of the groups use very creative way of disseminating the information - they do graffiti in the cities, they use online networks like facebook to pass on the message, they campaign at pop festivals or stamp money with the hotline numbers. For example the Lesbians and Feminists for the Depenalization of Abortion in Argentina published a book that gathers everything you want to know about abortion with pills. It was distributed with a local newspaper. And the pills on the cover have very smiley faces.

Public Opinion on abortion in Latin American countries: broad consensus for public debate on depenalization of abortion

*Claudia Dides, M. Cristina Benavente, Isabel Sáez
Programa Inclusión Social y Género, FLACSO-Chile*

The results of the opinion poll on abortion conducted by the Gender Program of the Latin American Faculty of Social Sciences, Chile (FLACSO-Chile) in Brazil, Chile, Mexico and Nicaragua in 2009, reveal that the majority of the population favour depenalization of abortion under certain critical circumstances. There is a broad consensus in the 4 countries that abortion is a serious problem in itself (82.5 per cent on average), supported by the perception that a large number of women in these countries die as a result of an abortion. Respondents also perceive (78 per cent) that women who live in poverty have a greater risk of resorting to unsafe abortions.

Consequently in Brazil, Chile, Mexico and Nicaragua, the population supports more flexibility on abortion laws in certain circumstances, such as for example when the life of the women is in danger (66 per cent on average), in cases of rape (56 per cent on average) or in case of fetal malformation (61 per cent on average). A common feature in the four countries polled is that people want more flexibility in laws penalizing abortion and ask for greater participation in the debate and the decisions related to these laws. Evidently, these societies are demanding more democratization of the debate and of decisions related to abortion, bringing it out of the exclusive sphere of the elites. Finally, one of the most relevant conclu-

sions is that it is possible to discern attitudes supporting penalization and depenalization (absolute or relative) not only across sociocultural and socioeconomic conditions that affect value scales from conservative to liberal, but also according to respondent's life experiences. Personal proximity to women who have endured difficult pregnancy circumstances (losses, unwanted pregnancies, unwanted children or abortions) influences their attitudes on abortion and indicates the presence of individual motivation, distinct from ideology or value systems, in supporting abortion under certain circumstances.

For more information: www.flacso.cl

Making mifepristone available and accessible in Latin America

*Dan Grossman, Senior Associate, Ibis Reproductive Health
Member of the Coordinating Committee, CLACAI*

Misoprostol has had a profound impact in Latin America, where the drug's availability in pharmacies has greatly improved access to a safe method of abortion. Around 40 products containing misoprostol are registered in the region, mostly for the prevention and treatment of gastric ulcers, although in a few countries misoprostol is registered for obstetric indications such as labor induction. And while this is an important advance over less safe abortion methods, is it good enough? Or should we be working to gain access to mifepristone, the gold standard medical abortion drug?

When used alone, misoprostol can be effective in up to 85-90% of cases to induce a complete abortion, meaning that at least 10-15% of women will require an aspiration procedure (such as MVA). The proportion of women who end up having an aspiration may be higher in practice, especially in settings where abortion is legally restricted and services operate clandestinely. When mifepristone is used with misoprostol in the combined regimen, the efficacy increases to 95-98%. For this reason, the combined regimen is recommended by the World Health Organization, which added both medications to its model list of essential medicines in 2005.

Mifepristone has been registered in over 45 countries worldwide, yet only one country in Latin America—Guyana—has registered it so far. However, recent legislative changes in the region may facilitate mifepristone's registration in the near future. In 2006, the Colombian Constitutional Court issued a ruling that liberalized the country's abortion law by allowing termination of pregnancy in cases of rape or incest, fetal anomalies, and when the pregnancy threatens the life or health of the woman. And in 2007, the legislature of the Federal District of Mexico City passed a law that legalized abortion up to 12 weeks' gestation, and almost immediately services were established in city-supported hospitals. In both countries efforts are underway that could lead to the registration of mifepristone.

These legislative changes may make registration of mifepristone more attractive to a pharmaceutical company because of the larger demand for the product. Certainly the perceived limited demand in countries where abortion is legally restricted discourages many companies from pursuing registration. However, it is important to note that the mifepristone regimen is also the preferred method for second-trimester induction termination, and

there is evidence supporting its use for missed abortion (or anembryonic pregnancy) and for induction in cases of fetal death. Some of these indications may be more feasible in countries with restrictive abortion laws—especially if abortion is allowed in cases of fetal malformation or threats to the woman's health, indications that are often diagnosed in the second trimester.

The pathway to registration of mifepristone may vary from country to country. In some countries, it may be possible to register the drug based on published data from other countries, while in others it may be necessary to perform a clinical trial in the country. In Mexico City, for example, Gynuity Health Projects is working with the Ministry of Health to perform an introductory study using an evidence-based mifepristone regimen in public sector facilities. One of the primary goals of the study is to generate data that could be used for registration purposes. The commitment and support on the part of the Mexico City governmental officials have been critical to obtaining the necessary approvals to perform this research.

Adding mifepristone (along with misoprostol) to the list of national essential medicines or including it in national clinical practice norms or guidelines can also be important steps toward gaining access to the combined regimen. For example, in Colombia, the national norms regarding voluntary pregnancy termination refer to the mifepristone regimen and recommend its use once the drug is registered. More work needs to be done to educate policy makers in other countries about the efficacy of the mifepristone regimen.

But what about the cost of the drug? Mifepristone is exceedingly expensive in the United States, costing almost \$100 per 200 mg tablet (only one tablet is needed per woman). And while the drug can be very inexpensive in India, few Indian manufacturers have been interested in marketing the drug in Latin America at a similar price. However, over the past few years, at least two low-cost, high-quality mifepristone products have become available that could be registered in Latin America. Concept Foundation has been working to develop and register Medabon®, a combined mifepristone-misoprostol product manufactured by Sun Pharmaceutical Industries in India. Another mifepristone product manufactured in Europe by Linepharma was recently approved in five Scandinavian countries. These products aim to have a public sector price below \$11 per tablet, and both

Concept Foundation and Linepharma are interested in working with local NGOs as well as government bodies to register these products.

Registering mifepristone in Latin America will not be easy. We can expect to confront strong anti-choice resistance, as well as a lack of knowledge, among governmental officials, including the national bodies that oversee the drug regulatory process. It will be important to be prepared with the ample evidence demonstrating mifepristone's safety, efficacy and acceptability in order to combat arguments based more on opinion than science. We might also find resistance on the part of the pharmaceutical industry, which sees a low potential for profit from mifepristone in the region. Similar challenges might be encountered trying to find a local distributor of the drug. It is heartening to see a few pharmaceutical entities interested in making this drug available at an accessible price, and in many countries it might be possible for local NGOs to act as the distributor.

Mifepristone is no longer a drug that only women in wealthy countries can access—it is now registered in many developing countries such as Cambodia, India, Nepal, South Africa, Tunisia, Vietnam and Zambia. And while there are still challenges to make this method available in the public sector in some of these countries, it is clear that important advances are being made toward bringing the most effective medical abortion regimen to the women who need it most. Such advances have not yet been seen in Latin America, and it is important that advocates, researchers and clinicians put the issue of access to mifepristone onto the safe abortion agenda in the region. It is no longer sufficient to say that the legal restrictions on abortion justify the lack of access to this drug, since abortion is legal for at least one indication in almost all countries in the region. Just like all women everywhere, Latin American women deserve to have access to the safest, most effective method to terminate their pregnancies when they decide to do so.

For more information:

Medabon®: <http://www.medabon.info/>

*Linepharma mifepristone:
email: contact@linepharma-lab.com*

*Gynuity Health Projects: www.gynuity.org
or email pubinfo@gynuity.org*

Advocacy with the mass media for gender sensitive and rights based reporting of SRHR issues

By Suchitra Dalvie, ASAP's Coordinator

The issues related to sexual and reproductive health and rights and abortion in particular is usually not dealt with by the mass media in a gender sensitive way or with a rights based approach. Often misleading or sensational information is given which can increase the perceived stigmatization of the women involved.

Journalists and reporters on the 'health beat' or 'women's issues' are rarely oriented to the social constructs or rights perspective of these issues and there is little effort for capacity building since these are usually temporary postings and often for junior staff.

In 2010, **Asia Safe Abortion Partnership (ASAP)** arranged three media sensitization workshops along with the local partners in Nepal, Vietnam and Malaysia. In Nepal it was arranged with National Media Development Center (NMDC), in coordination with Family Health Division/Ipas Nepal, Ministry of Health and Population; in Vietnam with Concept Foundation and the Centre of Research and Action for Community (REACOM) and in Malaysia it was arranged with the Reproductive Rights Advocacy Alliance of Malaysia (RRAAM).

These **media sensitization workshops** were conducted to orient journalists on the gender and rights dimensions of safe abortion issues. They were designed to address the key issues of Sexual & Reproductive Health Rights and safe abortion and to empower media persons by providing them with sufficient reference material, information and techniques for reporting on gender, Sexual & Reproductive Health Rights and abortion.

Sessions included values clarification, myths and misconceptions, law related to safe abortion in the country etc. Articles were printed in the local newspapers in both countries as a follow up to the workshop.

For the **Nepal** workshop there were 17 health reporters from -TV, radio and broadsheet dailies. There were 7 women journalists. The workshop reference materials, presentations of the expertise of the resource persons, the study data encouraged the journalists to think about bringing in-depth and follow-up stories on Sexual & Reproductive Health Rights.

All presentations were focused on gender health, health rights, safe abortion, news reporting trends, and importance and value of accurate and credible information. Technical difficulties of reporters and service providers were also discussed

and several recommendations for further improvement from both sides were drawn.

In **Vietnam**, there were 10 journalists attending this workshop from seven newspapers in Hanoi and Ha Nam and one national TV channel. The



participants were also updated about unsafe abortion and its negative consequences in the world, in Asia and in Vietnam specifically. Issues related to adolescents' abortion were deeply discussed. Medical abortion was also discussed with specific reference to young women.

A field visit was also arranged to see the clinic facilities on the last day of workshop at the Ha Nam Provincial Reproductive Health Center. At this center the journalists had chance to observe an MVA case, acting as a client for a contraceptive counseling and interviewing health providers. The observed abortion case was very friendly and following Vietnam national standards and guidelines for safe abortion service.

They also participated in a youth club activity at *Boi Cau Commune, Binh Luc District, Ha Nam*.



These visits helped the journalists to understand and develop linkages with learning from the workshop and the life experiences. These sowed many ideas for their future articles for the journalists. They experienced that the young people at the community have very poor knowledge about Sexual & Reproductive Health Rights, contraception and safe abortion and there is a need to emphasize on these issues through newspaper releases.

In **Malaysia**, there were about 20 participants from NGOs but there were only 3 press reporters and 2 were feature writers.

The pre-forum statement was published in two national papers Sun and Star. There was also a Youtube interview of Rashidah Abdullah Co-Chair of the Reproductive Rights Advocacy Alliance Malaysia (RRAAM). She spoke on the "Abandoned babies in Malaysia: Dispelling the myths" which covered unintended pregnancies and rights to accessing contraception and abortions in Malaysia on Malaysiakini.TV an online paper. She further cleared the doubts about abortion in Islam religion by stating "...in Islam, abortion is allowed up to 4 months, when the soul is regarded as entering the foetus, so it not regarded as alive, so it's not a sin,..."



Achievements of these workshops:

We learnt that mass media can play a significant role on disseminating sensitive and accurate reproductive health information and create a very supportive environment for safe abortion issues.

Health reporters clearly understood different features, aspects, social dimensions and impact of Gender and SRHR Rights, Abortion, MA and concerned Laws.

The journalists and service providers both realized that there is a need to increase the reporting capacity and knowledge on gender-health of the reporters and a commitment of the journalists for in-depth and analytical gender health news publication.

Many national newspapers covered news about the workshop and the content from the workshop in their respective local newspaper. Also news and interview with the resource persons were covered on different FM radios in Nepal and on an online newspaper in Malaysia.

Challenges and Perspectives in Advocacy for Safe Abortion

By Daniela Draghici, Eastern European Alliance for Reproductive Choice (EEARC)

Eastern Europe is a region where abortion rates remain high, despite efforts to secure contraceptive supplies and encourage use. Medical abortion drugs are registered in several EE countries; nevertheless, access to this method is very limited. Access to abortion services has been challenged in recent years because of concerns about declining birth rates, pressure from religious groups have further reduced support for abortion and contraception.

Abortion politics has also affected access to medical abortion in Central and Eastern Europe. In Latvia, the procedure proved burdensome to women, since they were required to stay in an approved facility for the duration of the procedure or up to ten days, and were subsequently subjected to ultrasound in order to confirm completion of the abortion. In Lithuania, drug approval was opposed by the Catholic Church and the Ministry of Health, and a study commissioned by the Ministry of Health concluded that Mifepristone posed a health risk to women and could potentially increase the national suicide rate. While the drug is also registered under various labels in Albania, Armenia, Azerbaijan, Belarus, Estonia, Georgia, Hungary, Latvia, the Republic of Moldova, the Russian Federation, Serbia, and Ukraine, Uzbekistan, it was previously not offered. Among the European states that have approved Mifepristone, Estonia, Latvia, Moldova, Ukraine, Albania, Romania, Serbia, and Russia have either physician-only or obstetrician-gynecologist-only provisions in their general abortion laws or national penal codes. In countries with restrictive abortion laws such as Poland, the drugs Mifepristone and Misoprostol are not registered for use as abortifacients.

Sexual and reproductive health and rights, as well as the right to reproductive choice are issues of critical importance in Central and Eastern Europe and Central Asia—crossing borders and transcending cultural differences. Women in this region are underrepresented in political and economic arenas, receive lower wages than men for equal work, shoulder a large portion of responsibility for childrearing and domestic work, and have weak legal protection from harassment or violence. All of these trends are interrelated and they all have women's right to reproductive freedom as a foundation.

While the laws may allow for women's access to abortion and contraception, the actual situation militates against any easy and universal access. Since the 1950s abortion has been legal and accessible in the 30 CEE states with the exception

of Albania and Romania, but since the collapse of communism in the 1990s abortion discussions have increasingly been framed in ideological and religious terms and this has had an impact on the accessibility of information and services. Just one example: Poland, where abortion became criminalized in 2003 and it has been so ever since.

Just one striking information from Hungary. The Parliament is planning to introduce the protection of the fetus from conception into their constitution. Hungarian activists believe the threat is really serious, as the leading Christian party that introduced the draft holds the majority and, together with another right wing party, they can really do what they want. Hungarian activists seem to be completely unprepared. They have not worked on reproductive rights for a long time as they did not see that as being necessary.

Sexual and reproductive health and rights are areas of special concern in Central and Eastern Europe and Central Asia. Women of our region face many barriers in accessing satisfactory reproductive health services and in exercising their reproductive rights to free and informed decisions concerning reproductive choice. That is due to the low priority given by governments to the issues of reproductive and sexual health and rights, as well as to the growing influence of anti-choice, conservative forces representing the so-called "traditional values". Health and legal professionals are becoming more and more conservative. While abortion may be legally acceptable, health professionals increasingly cite conscience as a reason to withhold abortion, especially medical abortion that can be controlled by women themselves.

The Eastern European Alliance for Reproductive Choice (EEARC) purports to raise awareness, sensitize providers, motivate women's groups, develop new evidence-based training curricula, and to improve access to and quality of safe abortion, including medical abortion services. EEARC has a multidisciplinary membership structure and works to collect and disseminate evidence-based information on safe abortion, including medical abortion, through country reports shared across the network. The Alliance is actively increasing its membership and promotes exchange of advocacy strategies and educational materials across the network. The Alliance is working as a catalyst to coalesce advocacy efforts to counteract restrictions recently imposed by governments and parliaments in CEE countries.

The vision of EEARC is for every woman to have

unrestricted access to safe abortion, including medical abortion, if she chooses to do so. Our goal is to help reduce maternal mortality by increasing access to safe abortion, with focus on Medical Abortion (MA). Our objective is to enhance regional advocacy capacity to raise awareness, sensitize providers, and motivate women to embrace MA. The Alliance is actively increasing its membership and promotes exchange of advocacy strategies and educational materials across the network. Through presentations at national and international conferences, members of EEARC have raised awareness about the need for better access to MA, especially to audiences of providers and women's organizers. Providers and women's organizations are the main audience in advocating for better access to MA at regional and international level.

EEARC has undertaken strategic assessments of policies regarding abortion and contraception in Romania, Moldova, Ukraine, and Russia, which have shown the real dimension of these issues among service providers, clients, decision-makers, and the community as a whole, and have broken the taboo around these issues. These have been the only tools apt to cause policy change. Such changes, though, must be sustained by both public and civil society forces in order to have effect and lasting impact. The results have been disseminated via the website and media channels, to raise awareness with the media and the population at large, and prepare the groundwork for the advocacy actions lying ahead. Country profiles have been developed and updated for the Alliance member countries and can also be found on the website.

In order to increase knowledge and attitudes of providers, EEARC has recently conducted a TOT workshop for 23 participants from the Russian speaking Eastern European region, titled "Comprehensive Care of Unwanted Pregnancies". An advocacy workshop is planned for 25 EEARC steering committee and other key members to design a multi-country advocacy strategy, using appropriate messages, including those to combat anti-choice rhetoric.

References: www.reprochoice.org

<http://www.medicalabortionconsortium.org/>

<http://www.medicalabortionconsortium.org/news/achieving-excellence-in-abortion-care--1241.html>

<http://www.astra.org.pl/>

Workshop for expanding medical abortion access in Africa

By Selma Hajri, ANMA's Coordinator

The workshop organized by the African Network on Medical Abortion was held the 24th and 25th of November in Nairobi, Kenya. Forty participants from the East African sub-region met to share, learn and discuss their experiences with medical abortion (MA). The main objectives of the meeting were to analyze the regional and international policy and legal environment; to share experiences and knowledge on MA; to examine the barriers to access to MA and how they have been addressed; and to discuss how to respond to those barriers in the region. The participants also discussed the role of ANMA and its partners in the rolling out MA in Africa.

Speakers and experts from the African countries were invited to present country-experiences, and several NGOs like ICMA, Concept Foundation, Gynuity Health Projects, Ibis Reproductive Health, Ipas and Ipas Alliance Africa, The Guttmacher Institute, and Marie Stopes International, enriched the workshop with their contributions.

The key messages of the meeting as summarized by the Chair of ANMA were as follows:

1. For policy and law: to increase engagement with regional institutions to implement existing legal /policy instruments and to incorporate MA in the public health policies and systems



2. For service delivery :

- To facilitate registration of MA drugs including misoprostol for all indications
- To use mid-level providers and pharmacists to increase access to MA in the framework of task-sharing
- To advocate for the involvement of community providers in the access to MA
- To empower women and communities by providing appropriate information and access to misoprostol
- To build the capacities of providers at different levels
- To focus on the neglected area of 2nd trimester medical abortion

3. To undertake value clarification activities at different levels to bring in attitudinal changes

4. For advocacy and information dissemination:

- To remain vigilant and monitor anti-choice movement in the face of emerging strong opposition
- To scale up evidence-based advocacy work through consolidated strategy and creative pro-choice alliance
- To provide appropriate information and harmonised messages to target diverse audiences (women, service providers, advocates, policy makers)
- To adapt existing materials where needed for MA information.

5. For networking: To foster ANMA's increased engagement with other networks and its members, and to increase contacts with governments to influence policy and practice.

ANMA's Chairperson, Getachew Bekele, closed the workshop with a take-away message

"Put women at the centre of the work, and keep in mind that medical abortion is a woman and not a provider-dependent option . It is time to avoid the talk and do the work: Walk the Talk".

MEDICAL ABORTION INFORMATION PACKAGE



Lack of knowledge about Medical Abortion is widespread, not only among women around the world but also among service providers, policymakers, pharmacists and the lay public. Informing these target groups

is a strategic objective of ICMA and the regional networks affiliates.

ICMA Information Package provides comprehensive information on Medical Abortion

to address the specific information needs of women, women's groups and organizations and other NGOs, policymakers, and health care providers, particularly those in developing countries. It includes a section containing resources, publications and contacts, model leaflets and examples of educational materials and personal histories. It also includes a section for women who need an abortion.

To access the information package go to: <http://www.medicalabortionconsortium.org>

For more information please visit: <http://www.medicalabortionconsortium.org>