Received: 10 July 2019 | Revised: 19 November 2019 | Accepted: 16 December 2019 | First published online: 13 January 2020

DOI: 10.1002/ijgo.13092

SPECIAL ARTICLE

Obstetrics

Advocating safe abortion: outcomes of a multi-country needs assessment on the potential role of national societies of obstetrics and gynecology

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Funding Information

Anonymous; KIT Knowledge Investment Fund (KIF)

The copyright line for this article was changed on 17 January 2020 after original online publication.

Abstract

In 2019 the International Federation of Gynecology and Obstetrics (FIGO) embarked on an initiative that aims to strengthen the capacity of 10 national societies of obstetrics and gynecology (ObGyn) in advocacy for safe abortion. In 2018 needs assessments that entailed a desk study, interviews, and stakeholder workshops were conducted in Benin, Cameroon, Côte d'Ivoire, Kenya, Mali, Mozambique, Panama, Peru, Uganda, and Zambia. The general aim of the needs assessments was to gain a deeper understanding of the contextual situation and identify the needs of ObGyn societies in relation to safe abortion advocacy. This paper provides a cross-country analysis of the outcomes of the needs assessments and reflects on the capabilities, barriers, and opportunities to strengthen this role of ObGyn societies. Common barriers, such as unavailability of services, lack of technical guidance, unawareness and ambiguity about the legal framework, provider attitudes, and abortion stigma, pose challenges for ObGyn societies to work constructively on safe abortion advocacy. However, ObGyn societies have a strong position due to their strategic networks and technical credibility and can be a facilitator in healthcare providers' advocacy role. Five strategies were developed to strengthen the capacity of ObGyn societies in safe abortion advocacy.

KEYWORDS

FIGO initiative; Medical societies; National societies of obstetrics and gynecology; Prevention; Safe abortion; Safe abortion advocacy

1 | INTRODUCTION

As a follow-up to the "prevention of unsafe abortion initiative," running since 2007,[1–5] the International Federation of Gynecology and Obstetrics (FIGO) in 2019 embarked on a 3-year initiative that aims to strengthen the capacity of 10 national societies of obstetrics and gynecology (hereafter called ObGyn societies) in advocacy for safe abortion. As a first phase of the initiative, a needs assessment was set out in 2018 to gain a deeper understanding of the current contextual situation in each of the implementation countries and identify the

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main needs of the ObGyn societies in relation to safe abortion advocacy. The aim of this paper is to report to FIGO members and other readers on the cross-country analysis of legal, political, sociocultural, and professional contexts that ObGyn societies work in and to reflect on the capabilities, barriers, opportunities, and identified strategies to strengthen their role in safe abortion advocacy.

The global incidence of unsafe abortion remains unacceptably high. Between 2010 and 2014 there was an estimated number of 25 million unsafe abortions per year, representing 45% of all abortions.[6,7] While there is no association found between the legal status of abortion and total abortion rates,[7] in restrictive settings 75% of the abortions are unsafe, compared with 12.5% in countries without restrictions.[6] Unsafe abortion is one of the major contributors to maternal mortality and morbidity, especially in regions where access to safe services is limited.[8–10] This is despite a decline in unintended pregnancies. Studies show that a reduction of unintended pregnancies in the developing regions does not coincide with a reduction in abortion rates, indicating that besides a need for contraceptive services, the need for safe abortion care remains.[11] In the past two decades, international human rights bodies and United Nations (UN) expert committees have characterized unsafe abortion or lack of access to safe abortion as a human rights issue concerning violations to girls and women's rights to health; privacy; non-discrimination; and freedom of cruel, inhuman, and degrading treatment.[12,13]

Abortion has become medically more feasible and safer with the increased availability and use of misoprostol and mifepristone.[14] While this has increased access to safe abortion inside and out of the medical system, barriers to access remain high due to abortion stigma, legal restrictions, political unawareness, the socioeconomic status of women, and unavailability of services. Advocacy in health can serve a number of goals (e.g. protection/prevention or empowerment) and operate at multiple levels (e.g. individuals, community, society, political).[15] Safe abortion advocacy should serve to legitimize safe abortion as a basic component of women's reproductive health and rights by enhancing the supply of accessible quality services, and increasing the demand of women and society for safe and respectful care.[16] Advocacy strategies for safe abortion that seem to work are context specific, but often based on deep and well-informed understanding of abortion, a public health approach synthesized with the articulation of human rights, and the strategic involvement of multiple stakeholders.[16–18] This includes the involvement of healthcare providers and healthcare institutions. While their primary role is to offer healthcare services, these actors are in a unique position to become advocates for women's sexual and reproductive health and rights, including access to safe abortion care.[19,20] Various organizations, such as FIGO and IPAS, have facilitated this role of healthcare providers as advocates.

2 | MATERIALS AND METHODS

FIGO, in consultation with its member ObGyn societies, selected 10 countries for the needs assessment and future initiative: Benin, Cameroon, Côte d'Ivoire, Kenya, Mali, Mozambique, Panama, Peru, Uganda, and Zambia. Selection was done based on the following criteria: 1) experience with the country in the previous "prevention of unsafe abortion initiative;" 2) geographical area of interest for the funding agency; 3) need and potential for change; and 4) willingness to participate. The assessment in each country was carried out by a couple of international and national independent researchers, in collaboration with the ObGyn societies. Thematic areas were defined based on a literature review and outlined in a needs assessment framework (Supplementary Table S1). It included factors affecting safe abortion, such as legal and political framework, abortion stigma, health system, accessibility and quality of services, as well as elements influencing the advocacy role of the ObGyn society, including attitudes and organizational strengths and weaknesses. The cross-country analysis of the potential role of ObGyn societies in safe abortion advocacy was conducted by the team of international researchers and based on data from 10 needs assessment country reports, for which an additional matrix along the themes of the needs assessment framework was developed. Where needed the primary extensive notes were reviewed to fill gaps. The results of this overall analysis were presented and validated by representatives from the ObGyn societies during a finalization and planning workshop in London.

The qualitative country assessments, performed in 2018, involved a desk study, key informant interviews (KIIs), and 2-day stakeholder workshops to validate preliminary study findings, conduct stakeholder mappings, and draft country action plans for the future initiative. The needs assessment framework with specific objectives and research questions was used for the design of data collection tools and analysis of data. An ethical waiver was obtained on January 22, 2018, from the Research Ethics Committee of KIT Royal Tropical Institute on the consideration that the needs assessment related to semi-structured interviews with professionals that cover information related to the professional duties of the respondents and information in the public domain. In all countries a key member of the ObGyn society checked and concluded that the waiver was applicable for a needs assessment in their specific country. All notes and recordings were given a code to ensure confidentiality. Data could only be re-identified by the researchers, who kept this information in a secure place.

Data collection was consistent across the 10 countries, using a similar desk review tool, interview topic guides, and workshop outline. The desk study entailed a review of peer-reviewed literature, national data on abortion, and gray literature. For the KIIs and stakeholder workshop, participants were purposively selected to ensure a high variety of knowledgeable informants. These included board and general members of the ObGyn society, members of other professional bodies (nurses/midwives, clinical officers), policy officers, and, based on the context of the country, additional relevant stakeholders, such as representatives from legal and religious institutions, multilateral or non-governmental organizations (NGOs), including civil society and women's rights organizations. Interviewees were recruited by the national researcher based on knowledge of the field and by

the abortion focal point and/or president of the ObGyn society based on their mapping of key stakeholders. Written consent was obtained and, where permitted, interviews were recorded in addition to extensive note-taking. Between February and May 2018, a total of 127 key informants (10–15 per country) were interviewed about their relation to safe abortion care and the role of the ObGyn societies. The stakeholder workshops brought together 18–33 stakeholders in each country to discuss the topic (total 246).

A thematic framework analysis[21] was applied, where the extensive interview and workshop notes were categorized along thematic areas and used for the development of a report for each country. Country reports (accessible through the FIGO website[22]) were written by a pair of national and international researchers in English, French, or Spanish, and peer-reviewed for quality assurance by senior experts in qualitative research and key members in the ObGyn society. The reports were translated into English, or the local language where needed, and checked for accuracy by the bilingual international researchers.

3 | RESULTS

Of the 127 KIIs in 10 countries, 41 respondents were interviewed in their role as ObGyn society member, 12 as representatives from other professional bodies, 21 as policy officers, 38 as representatives from NGOs and multilateral organizations, with 15 others (Table 1). The number of ObGyn society members interviewed was in fact higher than 41 as some of the respondents in the latter four groups were also gynecologists, but not primarily interviewed in their role as ObGyn society members. In all countries both male and female respondents were interviewed. The cross-country results are presented following the thematic areas of the framework (Supplementary Table S1) and identify commonalities and differences between countries.

3.1 | (Gaps in) existing evidence

Data from the desk review and interviews highlighted that most countries had estimations on the incidence of abortion and on complications of unsafe procedures, mostly based on hospital data of post-abortion care in large central hospitals. However, accurate nationwide data on both safe and unsafe abortion were limited. In all countries, respondents discussed the fact that even abortions performed within the legal framework were underreported and/or falsified due to fear of stigma, accusations when registering cases, or limited knowledge about how the registration system works.

> *In the clinic it [abortion] is not displayed as a service offered, given that the law remains prohibitive. In terms of documentation, the final diagnosis may be recorded as pre-eclampsia or incomplete abortion (representative of other professional body, male, Kenya).*

Panama was the only country that had a national register, as all legally permitted therapeutic abortions need to be approved by the National Multidisciplinary Commission of Therapeutic Abortion. The gaps in data on incidence of abortion were perceived as a barrier to have an evidence-based debate and influence policy and change.

> *They [policy makers] keep asking for evidence of national statistics, regarding the impact of unsafe abortion. But most of what has been done so far is limited to hospitals, so we need to do more (NGO representative, female, Zambia).*

3.2 | Legal and political context

The countries assessed had diverse legal frameworks. Except Mozambique, where abortion is legal on request, the countries had either semi-liberalized or restrictive legal frameworks (Table 2).

TABLE 1 Type of respondents for KIIs per country.

	Ben	Cam	CI	Ken	Mal	Moz	Pan	Per	Ugan	Zam	Total
Obstetricians and gynecologists in training (ObGyn society members)	3	6	5	3	3	7	7	2	3	2	41
Representatives of other medical associations (nurses/midwives, clinical officers, medical council[a])	1	1	1	3	1	2	1	1		1	12
Policy officers[a]	1	2	1	2	3	1	3	2	5	1	21
Representatives of NGOs and multilateral organizations[a]	4	5	4	4	2	2	2	9	2	4	38
Others (representatives from universities/research institutes[a], legal organizations and religious institutions[a]; journalist; traditional healer)	1			2	1	3	1	1	4	2	15
Total	10	14	11	14	10	15	14	15	14	10	**127**

Abbreviations: Ben, Benin; Cam, Cameroon; CI, Côte d'Ivoire; Ken, Kenya; KIIs, key informant interviews; Mal, Mali; Moz, Mozambique; NGOs, non-governmental organizations; Pan, Panama; Per, Peru; Ugan, Uganda; Zam, Zambia.

[a]Among respondents that were interviewed in their role as (representatives of) medical councils, policy officers, NGOs, multilateral organizations, researchers and religious institutes were also ObGyn society members.

TABLE 2 Legal frameworks in the assessed countries.

Fully liberalized (on request)	Semi-liberalized (to protect women's health)	Restrictive (only in case of risk of mother's life and/or incest/rape/ fetal malformation)
Mozambique	Zambia Kenya Benin Peru Cameroon	Côte d'Ivoire Uganda Mali Panama

More liberalized legal frameworks did not necessarily mean improved access to safe abortion care. In most countries, respondents mentioned that additional legal requirements in the form of diverse required consents, established timelines, or procedures to obtain permission formed barriers to access. In addition, at the time of study, the law did not always align with additional legal documents such as the penal code or a judicial decree. This leaves space for an ambiguous interpretation of the legal framework.

> *Without an implementing decree the law is not complete. The decree gives the details of the implementation. The decree describes who intervenes and it allows to know where one can put their feet or not (policy maker, male, Mali).*

In most countries, respondents expressed that lack of awareness and misinformation about the existing legal frameworks among healthcare providers and the general population hampered service provision and demand. National technical guidelines usually facilitate the implementation of legal frameworks but specific abortion guidelines were only available in half of the countries (Benin, Mali, Mozambique, Peru, and Zambia). In addition, where guidelines were available, they were often not updated, well disseminated, or used in practice. This leaves health professionals unaware of rights, obligations, and medical guidance. The willingness and efforts of policy makers to provide technical guidelines and facilitate implementation depended on the current powers, meaning the level of operation at ministries can change per political term.

> *…But the current environment is hostile. The new team in the ministry decided to reverse our reproductive health policy (gynecologist, male, Uganda).*

In some countries opposing actors were powerful, with the capacity to mobilize public opposition, while pro safe abortion actors were not always outspoken or unified. Respondents in Benin, Zambia, Kenya, Uganda, Panama, and Peru mentioned that international political developments also influenced local politics. The reinstatement of the global gag rule for example had not only enforced the fear of losing United States funding, but also strengthened the opposing actors.

3.3 | Abortion stigma

Stigma around abortion is a global phenomenon and was mentioned to be present in all countries at the individual, community, organizational, and political level, including among healthcare providers:

> *In addition, I am afraid that the society will stigmatize me and that I will lose my prestige and lose the customers (gynecologist, male, Mali).*

Stigma was sometimes described as a stronger barrier to safe abortion care than the legal and political context. The social construction of stigma varied across countries, though it was generally based on social and gender perceptions, underscored by cultural and religious norms. The stigma was not only related to abortion, but also to sexual and reproductive health in general, including sexuality education, unintended pregnancy, family planning, and adolescent sexual health.

> *Society, politics and religious leaders could oppose the advocacy process because sex is still a taboo subject. Reactions raised by the adoption of the law on marriage confirm that it will be necessary to manage this advocacy process tactfully (NGO representative, female, Côte d'Ivoire).*

Some direct consequences of the abortion stigma included double standards among healthcare providers, who may perform a safe abortion when a woman is in need, but speak publicly against the practice. Healthcare providers in all countries apart from Mozambique and Zambia shared that this was fueled by legal restrictions as they felt unprotected by the law. The lingering high sensitivity of the topic generally resulted in a profound reluctance to champion advocacy for access to safe abortion services.

> *…Nobody has the courage first to carry the flag …in the current political context they are afraid to be stigmatized… (NGO representative, female, Mali).*

The sensitivity also affected the terminology. In some countries, there was a preference among ObGyn society members for more sensitive terminology than "safe abortion," such as "Comprehensive Abortion Care (CAC)" or "preventing unsafe abortion."

> *We are still cautious to talk about 'safe abortion'. We do not want to push it, we do not want to lose what we have (gynecologist, male, Zambia).*

3.4 | Service delivery environment

Respondents in all countries confirmed that the availability of safe abortion services was limited and centralized around capital cities. Abortion services were often provided by private clinics and NGOs. In the public sector, provision of safe abortion was limited

and hence, according to key stakeholders, it is difficult to hold facilities accountable for the services that should be provided according to the law. It often remains unclear who provides the services and a good referral network was generally lacking, especially in the rural areas.

> *Which providers? If they are there, the problem is that it's all underground and it is difficult even to know what they use and if they have the right gadgets […]*
>
> *they don't want to admit that they do it, so it's difficult to know or ask […] And I think that's where we have a problem, that it is done in secrecy (researcher, female, Uganda).*

Post-abortion care was more readily available in most urban areas, but often severely limited in rural areas.

The most performed method was manual vacuum aspiration, while respondents in all countries mentioned that medical abortion is increasingly practiced. Misoprostol was available in all countries, though the registration for its use in abortion care varied, while mifepristone was often unavailable. In 2018 mifepristone was approved in half of the countries (Cameroon, Kenya, Mozambique, Uganda, and Zambia).

Other reported gaps in service delivery included lack of trained and willing providers, limited dissemination of guidelines, and scarce commodities. Negative attitudes of health workers to abortion were mentioned as a common barrier in all countries.

> *It also occurs that in the processes the doctors try to convince you to not do it [abort]. There should be more confidentiality (gynecologist, male, Panama).*

Workshop participants in at least half of the countries discussed that official or unofficial fees for services limited access. These barriers to access safe services often lead to unsafe practices with consequences of maternal morbidity and mortality.

> *I remember a 16 year old girl requesting for abortion. I tried to tell her to keep the pregnancy. When she left she said I did not help her. Later I was called to the emergency ward, it was the same girl […] she survived but lost the uterus. I wonder what the quality of her life is*
> *(gynecologist, female, Uganda).*

3.5 | Professional attitudes towards abortion

ObGyn societies are, by definition, a heterogeneous group of medical professionals. Consequently, within the societies there was a diverse range of opinions on abortion. In some countries, positions were highly divided and a number of vocal opponents of safe abortion seemed unlikely to change position. However, discussions within workshops illustrated that opinions were often more nuanced and dynamic. A gynecologist from Cameroon saw the need of women as a common ground:

> *I think from a clinical point of view, human ethics, professional conscience, I do not align myself one hundred percent for this position [liberalized abortion]. But I wish that one day the legal environment of my country could allow young girls to stop doing unsafe abortions at all*
> *(gynecologist, male, Cameroon).*

Apart from the ObGyn societies in Peru and Mozambique, hardly any of the societies had a clear, public, and well-disseminated institutional standpoint on safe abortion. Potential partners highlighted this lack of clarity as a barrier to work with ObGyn societies.

Within all societies, there was an on-going need for further discussion on how to balance personal values and beliefs with professional obligations. In general, there was limited knowledge of the international declaration on conscientious objection.[23] Respondents confirmed that providers often feel the right to exempt themselves from abortion care or counsel the patient not to abort, but are not aware of or do not acknowledge the ethical obligation to refer when a patient is in need of services, or provide timely care when referral is not an option but delay would jeopardize a patient's health.

> *Many times hospitals and groups collectively make use of conscientious objection. There is no specific legislation on conscientious objection (NGO representative, male, Peru)*

3.6 | Organizational strengths and weaknesses

While unique society-specific strengths such as organizational and scientific capacities were identified in each country, some general strengths in relation to safe abortion advocacy were identified across countries. All ObGyn societies had a wide network of partners and strong relations with their respective Ministry of Health. They had credibility as technical experts, including on safe abortion.

> *We have partners with whom we have good relations, for example the society of midwives and the paediatricians [….] framework agreements with two NGOs that do community activities and other institutional partners, they call on us when they need the expertise of SOGOC [….] We have a framework agreement with the Ministry of Health, it would normally be for decision making that we are being called […] (gynecologist, male, Cameroon).*

Most societies had members with strong research capacities and all societies hosted individuals who are extensively engaged as advisors on safe abortion, for example in the development of national guidelines. However, due to the lack of a clear and public society position, other advocacy activities were often done on an individual basis rather than from the society as an institution.

As a general weakness it was recognized that society members, including those in leading positions, who often work for the society on a voluntary basis, had high workloads in their clinical jobs. Most societies had limited technical support staff in the form of a secretariat,

financial department, or communication expert. This is a genuine stumbling block to advancing advocacy initiatives and leads to irregular and insufficient communication to members, contributing to a limited capacity to broker knowledge.

3.7 | Advocacy efforts and opportunities of ObGyn societies

All assessed societies took part in the previous “prevention of unsafe abortions” initiative.[3–5] The explicit focus on advocacy for safe abortion was an approach that is not immediately comfortable to all. Participants in workshops and interviews highlighted that advocacy should include: broader recognition of the need for safe abortion; enhancement of the availability of services, trained providers, and commodities; the development, implementation, and dissemination of national guidelines; the engagement of young people, and traditional and religious leaders; and awareness-raising about the law among healthcare providers, policy makers, and the public.

Advocacy opportunities on safe abortion are diverse across countries as they depend on various factors, namely: (1) existent legal frameworks, (2) the stage of public debate and discourse around abortion, and (3) the role and strength of multiple key stakeholders for safe abortion.

In legally restricted countries, advocacy could focus on liberalization of the law. However, liberalizing the law was not the main aim of all ObGyn societies, especially in countries that already have a liberalized or semi-liberalized framework.

> *We could come up with a position where we acknowledge the facts and the national laws and policies that are there. My personal discomfort is the push from certain parties to change the law. We as an association have not been comfortable with that (gynecologist, female, Zambia).*

The stage of debate and discourse around abortion not only limits the scope for advocacy, but also opportunities in identifying the strategic angles (including terminologies) from which safe abortion can be positioned and consolidated within the public debate.

Coordination and collaboration with existing initiatives and key partners can be strengthened. As the ObGyn societies were mentioned to be well-respected actors in all countries, they can easily build on existing initiatives by strengthening their own institutional positioning on safe abortion.

> *I wish for collaboration with gynecologists as they are better placed. If we have their support, it will be very easy to have legalization […] We want to hear them (NGO representative, female, Benin).*

4 | DISCUSSION AND CONCLUSION

This needs assessment explored the potential role of 10 national societies of obstetrics and gynecology in safe abortion advocacy. It identified possible barriers and opportunities for advocacy for ObGyn societies and their partners, explored the contexts the societies work in, and showed how the socio-political environment and deeply rooted stigma pose challenges on them to work constructively on safe abortion advocacy. At the same time, the needs assessment confirmed that ObGyn societies have a strong position due to their strategic networks and technical credibility and can be a facilitator in healthcare providers’ advocacy role for safe abortion.

The study faced several limitations. It aimed to include a wide range of stakeholders and while there was a feeling that saturation of data was achieved in each country, the voices opposed to or indifferent to abortion were heard relatively infrequently. In some countries they responded to interview invitations, in others it was difficult to get them involved in the needs assessment. Due to the set-up of the assessment, interviews and stakeholder workshops were not transcribed verbatim. This limitation was mitigated by having extensive notes and recordings as back-up that were used to fill gaps. All consultants that worked on the data analysis were involved in data collection as well. Therefore, the data analysis was enriched with their direct experiences and observations.

The needs assessment confirmed that, while a majority of the assessed societies work in a restrictive legal and political environment, the reasons why women have limited access to safe abortion care are more complex and rooted in sociocultural norms and gender inequalities. Unavailability of services, lack of technical guidance, unawareness and ambiguity about the possibilities the existing legal framework may provide, and absence of accurate data all coincide and contribute to poor women's health and rights and maternal mortality as a result of unsafe abortion. Abortion stigma remains a common and crosscutting issue and is present at all levels from individual to community and national level. The various views and barriers to constructively discuss abortion among their members affects the potential role of ObGyn societies in safe abortion advocacy, as they often struggle to raise an institutional voice on abortion. This phenomenon is not new, given the historical experience and empirical evidence as described by Holcombe.[24] It is rare for medical societies, by nature collectives of autonomous professionals, to be at the forefront of policy reform to politically sensitive issues, unless professional autonomy or income is at stake. While the right to autonomous decisions such as conscientious objection should be secondary to the provider's duty to treat and prevent harm, in practice professional autonomy has often overruled scientific evidence and (inter)national ethical statements on abortion and women's rights.[24–27] However, several ObGyn societies in other countries have successfully deployed their role as advocates to publicly support abortion reform. In Ethiopia the ObGyn society actively supported the 2005 liberalization of abortion[24] and more recently this happened in Uruguay[28] and Ireland.[29] In the United Kingdom, the Royal College of Obstetricians and Gynaecologists (RCOG) has recently established an abortion task force, advocating the decriminalization of abortion and bringing abortion services back into the public health sector.[30,31] Factors that facilitated reform in these countries were organizational commitments to reduce maternal mortality and a vocal public health sector, in addition to an active

civil society movement, favorable public opinion, and the right political momentum.[18,24,28,32] This implies that, to become stronger advocates for safe abortion, ObGyn societies will have to deepen their internal reflections and discussions, as well as strengthen their interplay with civil society, other medical bodies, and the political environment. Only when ObGyn societies are clear on their own position in relation to safe abortion and its contribution to maternal health, can they facilitate this interplay with partners to improve safe abortion advocacy. As also outlined from this needs assessment, policy and legal reform alone does not remove all barriers to safe abortion. Therefore, it is necessary to work beyond national legislations and policies, tackle abortion stigma, operate at the subnational level, and acknowledge the contexts that will determine which strategies will be successful.[17,33] Abortion advocacy requires substantial organizational investments, time that clinicians in scarce environments often do not have, implying a need to make people and time available to drive the change.

The global burden of unsafe abortion calls for strategic initiatives to improve women's access to safe abortion care. Based on the needs assessment the authors, in collaboration with the ObGyn societies, identified the potential role of the societies operationalized in five overall strategic objectives that should strengthen capacity in safe abortion advocacy and contribute to increased access to safe services. With support from FIGO, the societies will work towards:

1. Strengthened society management, organizational capacity, and internal and external communication on abortion.
2. A strengthened network with likeminded stakeholders to advocate for safe abortion and within the reproductive health system to improve access for Comprehensive Abortion Care (CAC).
3. Increased awareness and acceptance of safe and legal abortion among health workers, policy makers, and the general population.
4. Improved communication and sensitization about the national legal frameworks on safe abortion and advocate for improved guiding principles.
5. Advocacy with government and multilateral agencies for better generation and use of evidence on abortion in the country.

Societies may have different priorities, depending on their internal and contextual factors. The pathways taken will be country- and society-specific and associated activities are outlined in individual country action plans. By achieving these objectives, national societies of obstetrics and gynecology, in collaboration with their locally identified partners, will be in a strong position to advance women's rights and contribute to a reduction in maternal mortality and morbidity due to increased access to safe abortion care.

AUTHOR CONTRIBUTIONS

Under the technical lead of KK, the authors IV, LJ, BT, SB, and KK designed the study, contributed to data collection in 10 countries, and conducted the cross-sectional analysis that is presented in this article, AK was involved in peer-review and quality assurance. JT gave input at all stages and validation for cross-sectional analysis as technical advisor from FIGO. IV led the manuscript writing with equal co-writing from LJ, BT, SB, and KK. All authors approved the final draft for publication. National research consultants and national societies of obstetrics and gynecology were given the opportunity to peer review the article before submission.

ACKNOWLEDGMENTS

For an extensive list with names, please see Supplementary Annex S1. The authors wish to thank the national consultants in all 10 countries that contributed to the data collection and analysis of country-specific studies. In addition, they want to show special gratitude to the focal points for safe abortion and presidents of national societies of obstetrics and gynecology that participated in this needs assessment, as well as their society members and affiliated partners that contributed to interviews and workshops. The needs assessment was carried out on FIGO's request and funded by an anonymous donor. This article was written and published with funding of the Knowledge Investment Fund (KIF) of KIT Royal Tropical Institute.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Table S1. Needs assessment framework.

Annex S1. Acknowledgments.