THE SAFE ABORTION WATCHDOG 2020

original writing, artwork and short films about safe abortion from young people around the world

youth coalition

working internationally for sexual and reproductive rights

Cover Illustration: Yinkore (22, Nigeria)

LETTER FROM THE EDITOR

I am very pleased to launch the Youth Coalition Safe Abortion Watchdog 2020 on International Safe Abortion Day to join the global movement for safe abortion on September 28th 2020. All through September, the Youth Coalition has been running a digital advocacy campaign to spotlight the state of abortion rights all over the world using the tools of digital media. This has included starting conversations on #AbortionAroundTheWorld, how COVID-19 has affected the global access to abortion services, writing about abortion ethically and sensitively, being trans inclusive in the abortion rights discourse, and of course, self-managed abortions – the theme of International Safe Abortion Day 2020.

COVID-19 brought sharply in focus what some abortion advocates have been saying for years – that increasing access to self-managed abortions is crucial in the fight for reproductive justice. As COVID-19 disrupted supply chains and widened the already considerable gaps in abortion and contraception access, telemedical abortions emerged as the saving grace. In our Safe Abortion campaign at Youth Coalition, we hosted several conversations with experts to shed the misinformation and myths surrounding self-managed abortions. One of these conversations is even documented as a video here!

With this Watchdog, we wanted to encapsulate this current moment that young activists across the world have been thrown into by this pandemic. We are living through a time of despair – tightened restrictions, increased surveillance and exacerbated inequalities; but also through a time of grit and resilience – of finding unlikely solutions and continuing to loudly champion the access to safe abortion as a fundamental human right. We were humbled by the volume of submissions we received from young people all over the world, and saddened at not being able to publish them all.

In the following pages, you will find articles, painting, poetry and films by young people from seventeen different countries – from Mauritius to Nicaragua to Philippines to Venezuela! You will find analytical pieces about the abortion access in different parts of the world after COVID-19, evocative illustrations celebrating womanhood, denouncing stigma and standing up fiercely for abortion access, deeply personal accounts of having abortions, of being an healthcare provider in a country with restrictive access, of leaving behind a conservative upbringing that denounced abortions as evil, and so much more.

These pages contain a snapshot of youth activists' unceasing advocacy efforts to fight for reproductive justice and access to safe abortions in these unprecedented times of crisis. Of course, even the act of creating these pieces of art and writing is an act of resistance in itself! After all, we live in a world that still hushes loudly and averts its eyes at the mention of the word 'abortion'.

I hope you enjoy reading this.

In love, rage and solidarity,

Asmita Ghosh
Youth Coalition for Sexual and Reproductive Rights

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1. UNTITLED

AARUSHI KHANNA, 29, INDIA

Together, we create new self-definitions that can validate our resistance, our intersectional realities and pave the way for reproductive justice.

Follow Aarushi on Twitter.

2. ABORTION LAW AND POLICIES IN NIGERIA

OLUWAPELUMI ALESINLOYE-KING, 23, NIGERIA

According to the Guttmacher Institute, Nigeria has one of the highest maternal mortality ratios in the world; with unsafe abortions being a major contributor. In spite of restrictive abortion laws in Nigeria, abortions are still very common.

Nigeria is a highly "religious and moral" country that does not allow for the free expression of reproductive rights. Sexuality education is avoided like a plague and the use of contraception is only reserved for married women. It is believed that talking about sexuality education will encourage promiscuity.

Many young women who have little or no knowledge of pregnancy and contraception, end up getting pregnant and seek out the fastest, most secretive, and easiest way to terminate their pregnancies.

The quacks that offer dangerous and unsafe abortions range from auxiliary nurses, fake doctors, local medicine vendors to traditional birth attendants.

According to the World Health Organization, *"Unsafe abortion is a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills and/or in an environment that does not conform to minimal medical standards."*

Some methods of unsafe abortions include the insertion of sharp objects into the vagina, drinking herbal concoctions, a combination of drugs in large doses; such as painkillers and antibiotics, drinking dangerous chemicals; such as bleach and dye. According to WHO, the results of unsafe abortions

range from infertility, injury, loss of blood, uterine perforation, incomplete abortion, infections, death.

In order to drastically reduce deaths arising from unsafe abortion cases in Nigeria, organizations such as Safe2choose work actively to provide safe abortions for women who need it. But despite all efforts at this, the word “abortion” is still met with stiff opposition, from many religious organizations and lawmakers (especially of the older generation).

An example of this opposition is the raid by the Nigerian Police on the Marie Stopes Clinic in Lagos. On the 21st of May 2019, officers of the Nigerian Police force raided the reproductive health clinic on the basis of allegedly providing “abortion and birth control” services for women. This issue was highly condemned by many individuals and women’s rights organizations, who were saddened by the constant infringement on women’s sexual and reproductive health rights.

Sexual and reproductive health rights include free unrestricted access to sexual and reproductive health care and information, as well as autonomy in sexual and reproductive decision-making—are human rights; they are universal, indivisible, and undeniable. Until Nigerian abortion laws are reformed to respect fundamental human rights, many women will keep dying in their numbers from complications arising from unsafe abortions. In short, the question of women’s rights is nothing else than a matter of human rights.

"Until Nigerian abortion laws are reformed to respect fundamental human rights, many women will keep dying from complications arising from unsafe abortions."

At HowToUseAbortionPill, we explain how medical abortion works, what you need to know in advance, how it is done safely, and what to expect next. You can read all this information on our website. Our chatbot is also available 24/7 to answer all your medical abortion-related questions.

Follow Oluwapelumi on Facebook, Twitter and LinkedIn.

3. SAFE ABORTION FOR ALL: A POEM

RUKUMANI TRIPATHI, 27, NEPAL

I was a teen,
Probably sixteen,
Then one day I saw a boy
We hung out together, we did enjoy.
I was in love
And thought of us as a pair of doves
Never did I know what is right
Never did we ever have a fight.
With everything new
As fresh as dew
I loved him even more
We shared our heart, we shared our soul.
We had sex as we were deeply in love
But then after a month my period stopped.

I was worried
I was scared
I was in high school and I was not prepared
I was very scared when I checked
Oh my god, I was pregnant!
I didn’t know what to do
I didn’t know who to contact
I told my boyfriend

And since then our relationship ended.
No wonder I cried all night and smiled all day
I had to show the world that I am perfectly well.
One day I heard an advertisement
Safe abortion for all

I went there and took counselling before I fall.
Thank god I was just 8 weeks pregnant
And they told me that I could abort it with my own consent.
I was relieved because I had given up hope,
To live any more.
If there wasn't an abortion service at that time
I would have probably ended my life.
It made me realize I should be careful and I should be conscious
This incident taught me that I should be cautious.
I have ambition
I have dreams
Safe abortion for all is a human right
Because birth should bring joy, not fright.
I will plan a baby when I am ready
With the promise to myself I will be capable for that day.

Follow Rukumani on Facebook.

4. ABORTION IN THE LGBTQIA+ COMMUNITY: IDENTIFYING GAPS IN OUR MOVEMENTS

CARLOS ACOSTA, 26, COLOMBIA

Abortion rights have largely been discussed worldwide and while progress has been made in many countries, the narrative of abortion services keeps leaving certain vulnerable groups aside – transgender men, non-binary people, lesbian women, and other members of the LGBTQ+ spectrum.

Are these rights different?

We can start the discussion with the most explicit difference. When talking about LGBTQ+ rights, there is little to no mention about abortion. Over the years countries like Argentina have had progressive moves in accepting marriage and even procreation for same sex couples, but somehow abortion still seems to be out of the picture.(1) This erasure becomes an ethical question when we observe that the high rates of violence towards this population could easily result in unwanted pregnancies. One cannot help but wonder at the gap between abortion rights and the LGBTQ+ movement, considering that both movements are built on the foundation of bodily autonomy being a fundamental right.

Let us look at how LGBTQ+ and abortion discourses are built. Much of the conversation around LGBTQ+ rights revolves around bodily autonomy, marriage, violence and adoption. These are, in fact, sexual and reproductive rights – however, abortion is left out. When looking to the abortion movement, these have a natural focus on women and girls, who are the most highly impacted by the lack of access to safe abortion. However, the abortion discourse often leaves out many individuals on the gender spectrum that have female-assigned reproductive systems. Abortion is still a "she" or "women's" topic and leaves out non-binary and transmasculine people, trans men, and other people who do not identify as women.

This doesn't necessarily mean that we have everything upside down. We just need to draw attention to the fact that we must support abortion rights for everyone by amplifying our efforts to diversify who we think needs abortion and access to contraceptive services. In 2013, Chen et.al evidence that LGBTQ+ individuals suffer equal or more intimate partner violence compared to non-LGBTQ+ households.(2) If we were to take this fact, shouldn't

we evaluate the consequences of intimate partner violence and correlate those facts to the potential need of abortion services to this population?

I believe that unity and cross-sectoral conversations amongst different movement can help us address these gaps.

"One cannot help but wonder at the gap between abortion rights and the LGBTQ+ movement, considering that both movements are built on the foundation of bodily autonomy."

Another aspect of why abortion services are important for diverse communities is because there is a long history of treatment and care divergencies towards the LGBTQ+ community.

Abortion services in most countries come from the study of obstetrics and gynecology. This area of medicine (study of specific organs and reproduction) has long been directed towards cis-gender people and their patterns of reproduction. There are few scientific focuses on different types of reproduction patterns that lesbian women, transgender men, and other individuals in the community might have, leaving the needs of these populations unattended. Common practices are still centred towards cis-women bodies and a larger attention on medical education could ameliorate this situation. (3)

Prevention should also be different. We must attempt to mould comprehensive sexuality education (CSE) in accordance to current needs of the population. Tailoring sexual education towards diversity is a key factor in preventing unwanted pregnancies in LGBTQ+ youth, and also providing information about abortion to diverse youth. The typical talk about cucumbers and bananas doesn't fit many individuals in the community and it is scientifically outdated. There should not only be education about physical relationships but also interpersonal ones and how to foster respect and tolerance for each other. With this we also prevent violence and other violations of human rights.

In conclusion

Abortion advocacy should be a joint effort coming from diverse NGO, governmental, and civil society sectors. Working collectively allows our conversation to be intersectional. However, our actions should follow the same trend. Engaging with the community helps to tailor our interventions to a more focused population. This will help us see a better and much larger impact. Hopefully, as a ripple effect, we can also see our projects convert into meaningful reduction of harm and an increase in health benefits for millions of people. This 28th of September, stop for a moment to think how you can include more people in your beliefs surrounding abortion.

What direction do we follow? The short answer would be: the one where we leave no one behind.

Follow Carlos on Instagram and LinkedIn.

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5. PRO-CHOICE ACTIVISM IS MY COMMUNITY CARE

LAURA O' CONNOR, 20, CANADA

I grew up in a highly homogeneous Catholic community in Southeastern Ontario, going to church every Sunday, saying the rosary with my family on a daily basis, and attending longstanding Catholic schools for the entirety of my primary and high school years. While I obviously love and care for my family and early childhood friends, I can't deny that our paths diverged quite early in my life and have continued to go in polar opposite directions. For those of us who grew up in these environments, unlearning certain values can not only be difficult, it can be extremely painful. One of the key principles of the Catholic dogma that was taught to me was the "value of the life of the unborn," and the so-called commitment that each of us have in protecting and defending these "lives." Phrases such as "the unborn are the most innocent" and highly anti-Semitic Holocaust comparisons were regularly heard throughout my childhood and teenage years.

"When I started to question the things that I was being told about what someone can and cannot do with their bodies, I felt alone, and like I was turning my back on my community."

Because of this, when I started to question the things that I was being told about what someone can and cannot do with their bodies, I felt alone, and like I was turning my back on my community. What I was being told about abortion, the life of a foetus, and to what extent the state could interfere in one's bodily autonomy didn't make sense to me as I heard more about modern feminist movements and pro-choice activism. While I still couldn't tell you why, the more I questioned what I was being taught about abortion, the more abortion became the issue I cared about the most. After moving away for university, I delved head-first into the reproductive justice community in Ottawa. When I entered this world, I felt euphoric that I was finding community and making a new identity for myself; but I also felt isolated from my hometown community and family, and afraid to share my views and how I was choosing to spend my time in Ottawa. Unlearning the anti-choice views about abortion that I had been taught to believe was liberating and terrifying at the same time.

That being said, I gradually began leaning on my pro-choice activist community more and more, and felt my strongest links shifting from my hometown towards Ottawa. The reproductive justice community is relatively small, despite how impactful it is. Moreover, the majority of pro-choice activist groups and organizations operate from a grassroots framework, meaning that horizontal relationships and open dialogue are encouraged and fairly normalized.

Being in this new environment was wildly different from the highly exclusive and hierarchical church structure I grew up in, and the idea that I could freely share my views, hardships and high points was foreign to me. In addition, I felt shame that I had grown up in an environment that taught me ideas that caused so much harm to the reproductive justice movement. However, as my repro community strengthened and I saw the sacrifices my peers were making for me, in addition to the graciousness of my fellow community members for the work I had done, I began to unlearn the shame I had grown up to feel. Once I began putting my trust into my community, the repro justice world became my source of community-care, and where I began to truly become the woman I am today. While I once felt isolated, being able to lean on my activist community was the key to feeling supported and together.

In celebration of International Safe Abortion Day,

I thought sharing this little part of my pro-choice activist journey could help commemorate this day. The community behind this movement, behind Safe Abortion Day, have been formative in shaping who I am, provided me with community when I most need it, and continue to be my primary form of community care. Not only this, but I am confident that there are many people who are like me – who grew up in a difficult environment that didn't accept their political activism and had to unlearn the self-stigma around abortion and shame of growing up in an anti-choice environment. For myself and people like me, there could not be enough thanks given to the reproductive justice community.

Follow Laura on Twitter and Instagram.

6. #REFORM53: ABORTION BY CHOICE

NANDINI TANYA LALLMON, 29, MAURITIUS

Watch on Youtube.

In many countries, the law says that abortion is not allowed. However, in practice, people still perform the act but with the use of crude tools, which endangers their lives. Young girls and women should be given access to their sexual and reproductive health and rights. Through the #Reform53 anti-discriminatory laws campaign, the Commonwealth Youth Gender and Equality Network is lobbying to ensure provisions in the law for abortion by choice.

Follow Nandini on Facebook, Twitter and Instagram.
Follow Commonwealth Youth Gender and Equality Network on Facebook, Twitter and Instagram.

7. GLOBAL GAG KILLS WOMEN

JORDAN STEVENSON, 22, USA

Oil painting on sandpaper, digitally edited.

This piece serves as a message to United States lawmakers who claim that they care about women but refuse to repeal the Global Gag Rule; in addition to this hypocrisy, it is important to note that the Global Gag Rule does indeed kill more than just women, but boys, girls, men, and nonbinary folks as well.

Follow Jordan on Instagram and Twitter.

8. THE GLOBAL GAG RULE & THE FIGHT FOR ABORTION RIGHTS GLOBALLY

CHANDREYI GUHARAY, 28, NICARAGUA/NETHERLANDS

On January 23, 2017, in his fourth day in office, President Trump signed an executive order to reinstate the Mexico City Policy, also known as 'Global Gag Rule' (GGR). In short, the policy forbids foreign NGOs from receiving US bilateral health funding if they provide information, referrals, advocacy for access to safe abortion or services for legal abortion in their country — *even when using their own non-US funds.* Due to these restrictions, the GGR 'gags' health providers, counsellors, advocates and NGOs that provide abortion services.

The latest GGR, renamed as 'Protecting Life in Global Health Assistance Policy' (PLGHA), is an expanded version of the previous iterations. This time the Trump administration has gone further by placing unprecedented and radical restrictions that apply not only to family planning funding but also to all US global health assistance. This includes assistance towards HIV, tuberculosis, malaria, Zika and water, sanitation, and hygiene, among other programs. While preceding versions of the GGR solely affected family planning funding — averaging at $600 million annually— the PLGHA is estimated to affect between $8.5 to $10.00 billion per year, an amount 15 times bigger.

The effects of this dangerous anti-abortion policy are far-reaching and they disproportionately impact women, girls and vulnerable populations — such as adolescents, LGBTQI+ people and sex workers — in the Global South. The GGR puts ideology before evidence and rather than protecting life, it endangers the right to health, well-being and bodily autonomy.

In fact, there is no evidence supporting the effectiveness of the GGR in decreasing abortion rates. Instead, the limited, but relevant studies reviewing the policy's impact suggest that the GGR goes contrary to its stated purpose: by reducing access to contraception and family planning services it then increases the number of unintended pregnancies and (unsafe) abortions. As a result, the policy also has negative impacts on maternal, newborn, and child health. Besides, the GGR has an imperialistic nature, by exporting the US domestic ideological divide to the Global South, where women's lives are risked for the political gain of conservative and anti-abortion politicians and groups.

"The GGR goes contrary to its stated purpose: by reducing access to contraception and family planning services it then increases the number of unintended pregnancies and (unsafe) abortions."

Against the adversity and hostile environment that the GGR has created around access to safe abortion, multiple actors are devising creative and innovative ways to mitigate the policy's harmful impact. The SheDecides movement emerged in 2017 as an invigorating response to the current GGR. SheDecides has been supported by several country governments and has established itself as an international movement that aims to raise awareness and unlock resources for contraception and abortion services for women and girls in the Global South. In 2019, the Global Health, Empowerment and Rights Act (Global HER Act) was introduced in the US Congress. If passed, this bill would repeal the GGR and prevent its future reinstatement.

Other various organizations — such as PAI, Marie Stopes International and International Planned Parenthood Federation — have been fighting against the GGR since it was first instated by President Reagan in 1984, and are providing evidence of how

this harmful policy is endangering the health and human rights of people around the world. It is yet to be seen, however, whether these well-hearted efforts will be enough to mitigate the damage and the social, economic, ethical and human costs caused by the current GGR.

The Global Gag Rule is a direct attack on global abortion rights and on the access to other essential life-saving health care, putting the lives of millions in danger, particularly the most marginalized. In these trying times, we must stand in solidarity and support with organizations and movements who are standing up against the GGR; we must educate and raise awareness about the harmful impacts of this policy, and, most importantly, we must keep fighting back regressive actors who threaten progress.

Abortion is *essential healthcare*; abortion is a *human right*. This should be the norm rather than the exception, for every person, in every corner of the world.

Follow Chandreyi on Twitter and Instagram.

9. "NOT SLUTS, NOR SAINTS. JUST WOMEN."

YINKORE, 22, NIGERIA

Follow Yinkore on Instagram and on her website.

10. CAN ABORTION BE POSTPONED IN COVID-19? ABSOLUTELY NOT.

ARSHPREET KAUR, 28, INDIA

One of the most stringent lockdowns in the world in response to COVID-19 outbreak had an unforeseen consequence – disruption of family planning services in India. It has grimly impacted the lives of women due to lack of access to contraceptives and abortion services. Hence, there's been a surge in unintended pregnancies, unsafe abortions and maternal mortality.

A recent study conducted by Marie Stopes International revealed that 1.3 million women in India alone - out of two million women globally - missed out on sexual and reproductive health (SRH) services between January and June. According to data released by UNFPA, prolonged lockdown over six months could keep 47 million women in low and middle-income countries from accessing and using modern contraceptives.

Even though the Government of India listed safe abortion as an essential service during the nationwide lockdown, pregnant people still found it difficult to access this medical service. As public health centres were converted to COVID-19 care centres and ASHA workers (or Accredited Social Health Activists who distribute contraceptives at community level) were diverted towards coronavirus containment work, it restricted the availability of SRH services. Many private health centres were also not operational due to lack of personal protective equipment and mandatory COVID-19 testing facilities. Medical supplies had also been hit due to limitations on inter-state travel and temporary shutdown of factories manufacturing family planning products.

Clinics/hospitals are not always located in one's neighbourhood. Consequently, many women were unable to visit them due to suspension of transportation. Amidst the pandemic-led lockdown, they were concerned of being exposed to the virus. Plus, they also feared the inquiry by police regarding the purpose of their visit. The attitude towards abortion in India has been: "We are facing a pandemic and you want to avail abortion?!" The woman seeking an abortion does not look seriously ill. Therefore, it is hard to explain to people why a normal and healthy looking woman needs medical assistance.

A girl who lives in my neighbourhood discovered her pregnancy just after the lockdown was announced. The 23-year-old wanted an abortion immediately. She could not talk about it due to the stigma surrounding abortion. With clinics closed and whole city at standstill, she bought an abortion pill without consulting a doctor (as per Indian law, prescription of pills is required by a licensed medical professional in India). Bleeding for hours and in extreme pain, she called a gynaecologist who talked her through termination.

Though lockdown restrictions are now easing, experts predict a spike in demand for abortion – especially second-trimester abortions. A recent report by Foundation for Reproductive Health Services India indicated that there could be an additional 834,042 unsafe abortions and 1,743 maternal deaths thanks to COVID-19. A delay in availing medical intervention can lead to more surgical abortions instead of medical ones. Also, pregnancies over 20 weeks are not legally permitted to be terminated as per India's abortion law.

The attitude towards abortion in India has been: "We are facing a pandemic and you want to avail abortion?!"

The additional measures to be taken by medical facilities to prevent coronavirus are also expected to increase the cost of abortion services which would affect marginalised/vulnerable women the most. They would be forced to seek unsafe methods. It is clear, then, that the need for abortion does not stop even when the world seems to come to a halt. Postponing abortion services will exacerbate reproductive health and rights of women. The countries that neglect healthcare of women would have to bear the heaviest of burdens for a long term.

Follow Arshpreet on Twitter and Instagram.

11. ABORTION STIGMA DITI MISTRY, 28, INDIA

This illustration depicts the true story of an unmarried young girl from a marginalised socio-economic community in India and her struggles with accessing abortion services without family support.

Premarital sex is widely discouraged in our society, and pregnancy among unmarried women is so extremely stigmatized that it is perceived to ruin a family's reputation. In most cases, young women have to face violence from their family members.

Also, health service providers, with their conservative nature, discriminate against unmarried women and don't allow them to access services without their parents. These experiences result in young people spending cash to access underground unsafe abortion services and miss out on following healthy practices for post-abortion care.

Follow Diti Mistry's organisation Beyond Eye on their website, Facebook, Twitter and Instagram.

12. COVID-19: ANOTHER BARRIER TO SAFE ABORTIONS IN COLOMBIA

CATALINA CALLE DURÁN, 24, COLOMBIA

March 2nd, 2020 – 14 years after the last decision by the Colombian Constitutional Court that legalised abortion on three specific grounds *(if the health - mental or physical - of the pregnant person is in danger, if the foetus presents a malformation that makes it incompatible with life or if the pregnancy is the product of rape or incest),* the Court ruled that nothing changes. The debate started last year, when the Court received two lawsuits requesting a complete ban on abortions, arguing that life starts from gestation. Taking advantage of the possibility of changing the abortion laws of the country, and following the guidelines of international health and human rights organizations, Magistrate Alejandro Linares sought to decriminalize abortion in the first 12 weeks of gestation.

The Court concluded that it was not legally feasible to re-analyse the abortion laws of the country – meaning that abortion in Colombia stayed conditional, as it has been since 2006. The Court itself has identified 14 barriers when accessing legal abortion services, including delays in bureaucratic procedures, ignorance & legal non-compliance from health providers, and economic & cultural barriers.

The conditionality and the obstacles to access safe abortions might be the reason for the low number of these procedures performed legally in the country. According to Profamilia, an SRH provisioner in the country, there are less than 17,000 legal abortions a year. On the other hand, according to the Guttmacher Institute, there are around 400,000 clandestine abortions a year. Unsafe abortion procedures, one of the leading causes of maternal mortality, are accountable for 1 in 8 global maternal deaths. The data from the Health Ministry shows that, in Colombia, an average of six women a month die from a complication from illegal abortions.

The same day that the Court announced its decision, the country increased from moderate to high risk of the Coronavirus entering the country. Colombia still had zero cases but the LAC region already had a few. Even at that early stage, international organizations like International Planned Parenthood Federation (IPPF) had foreseen that this pandemic was going to put millions of additional women at risk of sexual violence, lack of access to contraception, and unintended pregnancy. Currently, in Colombia, State and private entities have already documented

that, in the pandemic, gender violence has exploded.

An increase in interpersonal violence can increase unwanted pregnancies – especially with, as international organizations that partnered with local sexual and reproductive health organizations, like IPPF and Médecins Sans Frontières have reported, a shortage of contraceptives in the LAC region. In early April, IPPF published a survey with collected evidence of how COVID-19 has affected the delivery of sexual and reproductive health (SRH) services. In the report, data showed that Colombia was among the most affected countries by the closures of clinics and/or community-based service outlets, reporting more than 100 closures at the start of the pandemic.

On April 24th, the Ministry of Health issued a statement clarifying that SRH services, including legal abortions, had to continue to be accessible for everyone. At the same time, the government-mandated social distancing and lack of PPE pushed legal abortion clinics, like Orientame, to move towards telemedicine, adding a barrier to access legal abortion services in Colombia.

"An increase in interpersonal violence can increase unwanted pregnancies – especially with the shortage of contraceptives in the LAC region."

As of December 2019, Colombia's Ministry of Information Technologies and Communications reported that nearly half the country lacks mobile internet access. People from lower-income groups in rural parts of the country encounter additional obstacles when accessing safe abortion services. IPPF Director-General stated that if governments do not address the increase in barriers to access safe abortion, contraceptives, and other SRH services "the consequences for women and girls will be catastrophic; resulting in loss of health, autonomy, and life."

Follow Catalina on Instagram, Twitter and LinkedIn.

13. EXORCISM DEEPSHIKHA SHARMA, 22, INDIA

A Faith inverse with the declaration of evil
Two pink lines announce the possession
Amidst plastic, porcelain, tears, and urine
I ready my corrupted soul to be chastised
My body to be burnt
Legs spread apart on the altar
Pitchforks in the hand of the priest
A necessary evil for the cosmic good
Does not pardon my masculine curiosity

By the pricking of my thumbs, a warning by the gut
Lunar incantations for the "good", the society in a rut:

"A loose woman" they say, "but it needs to be done"

"Blood split by the thorn
Needs to be wiped

Rotten fruits from the Devil's rose
Need to plucked
Consorts of the type
Need to be chastised
Wombs of ringless women
Need to be purified"

As my shackles rattle, and my body contorts
I forget verbal stings about Devils and consort

Pain blinds my sight
Screams numb my throat
The soul holds unto my body
Unwilling to part
Ball of flesh, clot of blood
Haunts the marrow in my bone
As the sludge from the exorcism
Slips into the cauldron
Sight returns and jaw slackens,
I beg for the manacles to be taken

The grass rustles underneath my feet,
The pain has set me free
Angst and guilt
Are healed by the bruises in my thighs
Stones are thrown, pitchforks wave
But nothing wicked comes my way
Nothing I couldn't nurture and grow
Nothing I couldn't provide for

Because I was right to choose about the when and where.

14. MY BODY, MY CHOICE

KARREN BARCITA, 22, PHILIPPINES

15. SEXUAL AND REPRODUCTIVE RIGHTS IN UGANDA IN THE GLOBAL GAG ERA

ATEGEKA FRANK, 30, UGANDA

In January 2017, the Global Gag Rule (GGR) was signed into law through an Executive Order by U.S. President Donald Trump. The GGR aims to block U.S. federal funding for non-governmental organizations (NGOs) and groups that provide abortion counseling, make referrals, and/or advocate to decriminalize abortion or expand abortion services as a method of family planning. This policy requires non-American NGOs to certify that they will not "perform or actively promote abortion as a method of family planning" with any of their funding (including non-U.S funds) as a condition for

receiving U.S global health assistance.

Unlike previous versions, the current version of the policy applies to recipients of family planning funding and recipients of all global health assistance under U.S. government departments or agencies. This means that: "For the first time ever, organizations that provide counseling, referrals, or services or advocate for safe abortion with their own funding will be banned from all global health funding from the U.S. government." The ban thus directly impacts funding for international health programs including HIV/AIDS, maternal and child health, malaria, family planning, and global health security. In earlier versions of the GGR, PEPFAR, one of the biggest funders for HIV/AIDs programs in many countries including Uganda, was excluded, but in the 2017 version, it was "gagged" since it is under the Department of State in the President's Cabinet.

Implications of GGR on Sexual and Reproductive Health and Rights (SRHR) in Uganda

In Uganda, the restrictive legal environment on abortion and the limited national health budget does not guarantee SRH service delivery, and abortion remains highly stigmatized. Like in many other countries in the world, despite the legal restrictions, abortions occur in Uganda anyway, often in environments and with methods that put women and girls at higher risk. In fact, according to Uganda's New Vision, 1500 women die annually due to unsafe abortions, more than 93,000 women were hospitalized for complications from unsafe abortion in Uganda in 2013, and more than 10% of the country's maternal deaths were due to unsafe abortion. Rather than curbing abortion, the GGR will inevitably increase these numbers.

In the 2013–2014 Uganda Health Accounts National Health Expenditure, it was reported that 41% of Uganda's current health expenditure is financed by development partners, primarily bilateral donors. Of the funding provided through health financing by development partners, 49% of funds go to preventive care. This is the scope of the impact of the GGR in Uganda — an entire 20% of the health sector's preventative care will be lost.

The report further indicates that the government of Uganda depends on $6.7 million (USD) in donor funding for sexual and reproductive health (SRH) supplies. According to the Ministry of Health, there remains an estimated gap of $9 million (USD) for family planning commodities overall. Through outside funding, many NGOs have been trying to close this funding gap for SRH. The statement of the current GGR has delivered a huge blow to these efforts, causing many organizations to scale back services or even close offices. For example, Uganda Health Marketing Group (UHMG) accounts for 80% of SRH supplies in Uganda and is funded by the USAID project AFFORD. Because the SRH services provided by UHMG through their 256 clinics countrywide are "gagged" by the GGR, those accessing SRH commodities there will not be counseled on options related to abortion, even where abortion is legal.

This is the scope of the impact of the GGR in Uganda — an entire 20% of the health sector's preventative care will be lost.

The Ugandan government's project offering breast and cervical cancer screenings and promoting the use of Sayana Press, a new brand of injectable contraceptives, has been halted. The GGR is also likely to further hinder advocacy efforts for progressive health policies such as the sexuality education policy that would ultimately curb maternal deaths caused by unsafe abortions in Uganda. Furthermore, the policy is already adversely affecting Uganda's commitments of providing access to family planning in line with the government's National Family Planning Action Plan and Family Planning 2020 Commitments because of reduced or lost funding to NGOs that were the leading SRH service providers. Ultimately, the GGR is a major setback to Universal Health Coverage by 2030, as most Ugandans will have to either pay for SRH services from private service providers or go without services if they cannot afford to do so.

The Way Forward

Rural Aid Foundation, the organization I co-lead with my fellow Global Health Corps alumna Caroline Achola, has been partnering with the Alert Fund for Youth to raise awareness about the GGR and its implications on access to SRH services for young people in Uganda.

We have already conducted a project inception meeting with civil society and community organizations as well as adolescent girls and young women, and have begun documenting their health challenges as a result of the Global Gag Rule. Using a community-led approach, we supported them in developing and presenting a petition to protect young Ugandan's access to sexual reproductive health services and rights. The petition was presented to the Vice-Chairperson of the Parliamentary Health Committee requesting that the Ugandan government:

- Close the funding gap for reproductive health services for youths in Uganda by allocating alternative local funding.
- Conduct an impact assessment on the implications of GGR on access to reproductive health service provision in Uganda and present a summary paper to the full Parliament.

The Vice-Chairperson on the Health Committee of Parliament made a commitment to present the petition to the health committee and also present it on the floor.

The GGR poses a threat to sexual reproductive health service delivery and this will likely hinder the realization of Universal Health Coverage by 2030. States must understand the implications and make informed decisions for SRHR policy change and financing to protect young people and other vulnerable populations to ensure no one is left behind.

DOCUMENTARY ON IMPACT OF GLOBAL GAG RULE IN UGANDA BY FRANK ATEGEKA AND RURAL AID FOUNDATION

Follow Frank's organisation, the Rural Aid Foundation Uganda on Facebook and Twitter.

16. THE SOUND OF IT BREAKING

TAVLEEN SINGH, 22, INDIA

Follow Tavleen on Instagram.

Sometimes, in the dead of the night, I can still hear it in the silence.

My phone beeps a little and lights up with your name. I wonder what it is. A link to a song? A question about a pending assignment? A joke?
With half opened eyes I load the image, oblivious to how this would change the course of our lives. Slowly, I see the two lines on the white test stick. Before I can reply, you shoot me a screenshot. It is with the 'boy you have been talking to'.
We refused to label him because we did not want to take him too seriously.
He has 'left you on blue ticks', a universal millennial acknowledgement of not taking you seriously either.

Sometimes, in the dead of the night, I can still hear it in the silence.
We sit on your bathroom floor and Google tips, because it is all we know. Somehow, you are calmer than I am.
I am looking up possibilities of false positives, bated breath for some hope. You are telling me that we need to look up medicines that could help. A few quick searches later, we delete the histories on our phone. No one can ever know.

Sometimes, in the dead of the night, I can still hear it in the silence.
Your mother drops the plate of curd rice she is carrying into the kitchen. She prepared it because she wanted to cheer up her darling daughter, wondering what had caused you to cry since morning, but not daring to probe. It splatters across the floor, and I know now that even three years later when I visit, there would still be stains on the tiles. She is shaking. This is not her daughter. But before the rest of the house can hear the noise, the simultaneous breaking of hearts and trust concealed by a clattering plate, she must protect the baby. Her baby. She tells you to not tell anyone and that she will 'take care of it'.

Sometimes, in the dead of the night, I can still hear it in the silence.
You don't remind her, she doesn't say a word. Two weeks later, you are feeling sick every morning and your family starts joking about how your mother had these signs when she was about to have you. A tear escapes your eye at this parallel. She must 'take care' of things sooner. A friend makes a prescription, black clothing is bought and a trip is made to the local pharmacy. She gives you the pills and as your family gets worried about your deteriorating health, she comes up with more excuses.

Sometimes, in the dead of the night, I can still hear you whispering in pain.
Your cries get louder as the pain gets more unbearable. You are clutching your stomach, but you tell me it is your heart you want to hold. You ask me, if the pills hurt to make you realize that you would always carry the burden of this death? You ask me if the weight of a secret could crush you? Wrong names have been given at the doctors, school teachers have been allowed to gossip about what is happening. They can't come up with anything that is worse than the truth, your mother has said. You wonder what it would be like, if you could just scream it. Tell someone. Anyone. About the painful medication, the refusal to let the doctor know, the glances from your mother. But most of all, the guilt in the relief of somehow, still getting over with it.

And so, in the broad daylight, I hear you.
You don't have to be sorry, for picking yourself. You don't have to be sorry, because they did not stand up for you. You don't have to be sorry, because your body was never considered your own. You don't have to be sorry you tell me, and it might be a small start, but I hear you.

17. THE FRUSTRATION OF BEING A DOCTOR IN HONDURAS

MARIANELA MARTINEZ
BUEZO, 26, HONDURAS

I work as a primary healthcare physician at a public clinic at La Paz, Honduras. Everyday, I have consultations related to sexual and reproductive health – usually prenatal care and providing birth control. In these last 10 months, I've seen 4 patients who got pregnant after sexual violence. One of them was only 12 when she gave birth.

The story of this girl is the one that has ripped me apart the most. An older man raped her when she was just 11 years old and she got pregnant. Abortion is completely illegal in Honduras, and she gave birth to a son. She lived with her son at an orphanage, under the custody of the government of Honduras.

The conditions at this place were unbearable for her and she decided to escape with her son and go back to her former house. I met her when she visited the clinic with her one-year old son looking for medical assistance. She was terrified to go to a doctor as she believed she would be sent back to the orphanage. She was illiterate, her child was malnourished and she was living with family members who believed that her abuser was her "husband".

"In these last 10 months, I've seen 4 patients who got pregnant by sexual violence . One of them was only 12 when she gave birth."

During the consultation, she received a phone call. I asked her who it was, and she told me it was her son's father. This rapist had the nerve to contact this young child when he is serving time in jail for raping and impregnating her. I reported this several times to the police and Child Protective Services, but they did nothing. This is not an isolated case – we have hundreds like this all over Honduras.

The Honduran system has failed these girls. They have no immediate access to healthcare after sexual violence, and at La Paz, there is not a single psychologist in the public system. These girls live in a country where the public health system does not have a protocol to assist survivors of sexual violence. They are mistreated and revictimized by the system, every single time they mention their abuse.

In 2009, Conservative groups pushed a motion at the Congress to prohibit the sale and distribution of the emergency contraceptive pill (ECP) as they wrongly believe it causes abortions. The ban of the ECP is yet another obstacle for survivors.

Every year, more than 900 girls between 10 and 14 years old get pregnant after sexual abuse in Honduras. In 2017, 2664 girls under 18 years were evaluated by forensics after sexual abuse – that's at least seven girls sexually assaulted *every day*.

Honduras is one of the few countries in the world where abortion is illegal and criminalized under any circumstance. Honduran law describes abortion as "the death of a human being in any moment of the pregnancy or during birth", and though this definition is not based on scientific facts, women can be sentenced to prison from 3 to 6 years for this "crime".

Each year, between 50,000 and 80,000 self-induced abortions are performed in Honduras. It's been repeatedly proven that restrictive abortion laws and penalization don't stop unsafe abortions. Impunity is also a huge problem, as rapists and abusers are rarely held accountable by the Honduran justice system.

Working as a public healthcare provider in my country has made me see first-hand the huge gaps in our country's healthcare and justice system. Honduras is a conservative country with a distorted notion of morality. Access to emergency contraception and safe abortion and receiving qualified medical, legal and psychological attention are not allowed in a country that forces an 11-year-old child to give birth, condemning her to be controlled by her rapist for the rest of her life.

Follow Marianela on Twitter.

18. THE DECISION IS MINE KARIN ECKERLING, 27, ISRAEL

Watch the animated short film on Youtube.

Pregnancy termination is something everyone has heard about, but do you really know what it entails? In Israel, completing an abortion without permission is considered a crime for which one may serve up to five years in prison. The diagnosis, treatment and process are outdated, judgmental and humiliating based on patriarchal, political and religious normative values. The shame that accompanies the process leads women to lose their freedom to choose what happens to their bodies during this futile and hurtful evaluation. My final project for my degree in visual communication at University delved into the abortion experience through my own personal story. My goal is to share my story support other girls and boys with their own abortion experience.

Follow Karin on Instagram and Facebook.

19. ADOLESCENT GIRLS AND YOUNG WOMEN'S ACCESS TO ABORTION IN AFRICA

KERIGO ODADA, 28, KENYA/SOUTH AFRICA

The right to safe abortion is not a single right. It is a composition of rights that includes the right to health, the right to equality and non-discrimination, the right to self-determination, dignity, privacy, the right to be free from cruel and inhumane treatment, amongst others. Nonetheless, the right to access safe abortion services still faces a lot of opposition in many jurisdictions in Sub-Saharan Africa (SSA) whose laws and policies have their roots in Western Customary law that was influenced heavily by religion. Access to safe abortion services, as was stated in African Commission on Human and People's Rights General Comment 2 on Article 14, and United Nations Committee on Economic, Social and Cultural Rights, General Comment 22, is an important human right that every individual, capable of getting pregnant, should be able to access without any form of discrimination or unnecessary barriers.

Accessing safe abortion services is, unfortunately, a challenge that disproportionately affects adolescent girls and young women in SSA.

Accessing safe abortion services is, unfortunately, a challenge that disproportionately affects adolescent girls and young women (AGYW) in SSA. Members of this social group are socially positioned to experience intersecting forms of oppression due to gender, age, class, education status, parity, marital status et al. Therefore, it is imperative that AGYW deemed mature enough to comprehend and internalise issues such as sex and its consequences, and be allowed to have access to confidential SRH services including abortion. States and other duty bearers must strike a balance between protecting adolescents from abuse, and recognising their sexual and bodily autonomy and evolving capacities.

With one-quarter of unsafe abortions occurring amongst adolescents aged 15-19 in Africa, which is the highest rate globally, unsafe abortion is no longer just a human rights concern, but also a serious public health issue in SSA. Restrictive laws and delayed access to abortion services have created an environment where AGYW are unable to access much-needed health care services which oftentimes results in adverse health outcomes. According to the World Health Organization, unsafe abortion is 'a procedure of pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both'. Consequently, states, in fulfilment of their obligations under the various human rights instruments that safeguard rights that are violated when access to safe abortion services is not guaranteed, must take all appropriate measure to remedy the status quo.

In SSA, unsafe-abortion has been identified as one of the leading causes of maternal mortality and morbidity. It accounts for 520 deaths per 100 000 live births, and this is caused by structural and legal barriers, and societal stigmatisation of abortion, which, ultimately prevent AGYW from accessing timely safe abortion services. The Maputo Protocol calls upon governments to 'authorise medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health or life of the pregnant woman or life of the foetus'. Further, the International Conference on Population and Development Programme of Action, and the Beijing Declaration and Platform for Action, both of which revolutionised Sexual and Reproductive Health and Rights, call upon states to change how laws, policies, and social programmes approach adolescent sexuality and their attendant health needs. Nevertheless, in as much as this is the case, 3 out of 4 abortions that occur in Africa are still unsafe.

States have a duty to ensure all AGYW have access to quality services to manage abortion and the complications arising from unsafe abortion. They must create an enabling environment for AGYW in Sub-Saharan Africa to access abortion and post-abortion care services as and when they need so. Members of this social group, in many parts of Africa, have limited access to sexual and reproductive health information and services and are therefore at a heightened risk of unintended pregnancies due to sexual exploitation and abuse, and the negative outcomes of early sexual debut. At the moment, AGYW make up the bulk of those who experience problems resulting from unsafe abortion, although this a health right recognised in regional and international human rights instruments.

Additionally, another significant barrier that adolescents also face in accessing safe abortion services is the service providers. Medical service providers may, due to personal beliefs, social-cultural norms of a society, or ignorance, deny abortion services to adolescents due to their age, irrespective of whether the law permits it or not.

When health systems refuse or neglect to provide health services that only women and girls need, they are guilty of discrimination. Therefore, structural and legal barriers that many members of this social group face while navigating health systems on their own must be eliminated because they violate the right to equality.

In conclusion, this article posits that laws that prohibit abortion or restrict access to safe abortion services must be repealed, and where abortion is allowed like in South Africa, more awareness must be raised. States must ensure 'domestic abortion laws and practice are transparent and accountable so that any abortion rights that the state confers can be meaningfully realised by all persons seeking an abortion'. Other factors include stigma, refusal to provide service by health care workers, financial barriers, requirements for consent et cetera must also be eliminated because unsafe abortion is preventable.

Follow Kerigo on Twitter and LinkedIn.

20. A LETTER OF GRATITUDE TO NON-JUDGMENTAL ABORTION PROVIDERS

ANONYMOUS, 25, INDIA

December 2019-January 2020

"Fun's over, kids", Dr. Kumar* said and laughed out loud!

This was the first time he was speaking to my partner and me. In no time, we realised that he was not only the kindest but also the funniest doctor I had ever come across. This morning appointment with him had resulted in us laughing out loud for the first time in the nine hours of knowing that I was pregnant.

Ever since the abortion, I have been looking forward to seeing him and thanking everyone at the hospital for being so kind to me in a difficult time in my life. I remember the smallest and the biggest moments where Dr. Kumar and his team ensured I was at ease throughout. There was a moment when Dr. Kumar showed me the hands that the foetus had started developing. There was a brief pause, followed by his words, "Hey, it's not a big deal. Don't think much of it!"

Later when I was waiting for my surgery, the nurses started chatting with me. During those days, I had been feeling utterly terrible about myself. After months of therapy, we realized that I had been going through depression. This was even before I had even gotten to know that I was pregnant. So when the nurses spoke to me, I was still in a place where I did not think very highly of myself. However, just when I was drowning in my thoughts, one of them said, *"Aapki awaaz kitni pyaari hai* (You have such a lovely voice)." And all of a sudden it felt as though someone had pulled me out of the void of my self-deprecating thoughts. At that very moment, I felt good about myself. I began to remember the feeling – almost like cycling after a long time.

Through my abortion journey, my brother, partner, friend, therapist, doctors and staff at Manna Hospital* were all there for me and made sure that I didn't feel guilty for choosing myself. They supported me out and out. Initially, I didn't expect any warmth from the hospital staff; I expected to face judgement as a 25-year-old unmarried pregnant woman. But the empathy I received was so filling and warm. Therefore, this letter with the Tsunamika doll is dedicated to everybody at Manna Hospital who stood strongly by me and continue to stand strongly by every woman in their toughest times. With strength and kindness.

To everybody who stands by us.
Thank you.

**names changed to protect author's anonymity*

21. UNTITLED ANDREA PAOLO HERNANDEZ, 24, VENEZUELA

when I say death is inside me
I'm really saying my flesh is just a raw wound
I say veneration to the silenced pain
I say acid vomit gulps conquering my throat by knock out
I say it hurts it hurts *it hurts*
when I say dead inside
I say I wish it was possible
not to ooze fire
to come back to my own eyes
put on some shoes
walk a straight line

when I say death is inside me
I mean I am inside death
I mean I wish I didn't know the sound
of organs melting away

Follow Andrea on Twitter and Instagram.

22. COVID-19 AND ITS IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN PAKISTAN

NEHA KHAN, 25, PAKISTAN

The Novel Corona Virus 2019 (COVID-19) outbreak in Wuhan, a province of China, led to the spread of infectious virus across the world and afflicted around 213 countries and territories. In no time, numbers of corona cases surged in Pakistan, for sharing porous borders with the two highly affected states of China and Iran. Till date, the confirmed number of COVID cases in Pakistan are 309,015 with 6,444 causalities.

In Pakistan, access and provision of safe abortion services is already stigmatized, which quadrupled during COVID – like most countries. A huge number of COVID cases put an inordinate strain on the already fragile healthcare system.

The burden on the healthcare system resulted in social unrest – shortage of personal protective equipment (PPEs) instigated protests among healthcare workers nationwide. Several incidents of violence against healthcare providers (HCPs) were reported. Moreover there were no proper SOPs defined by Government for the protection of healthcare workers, which led to the spontaneous spread of infection in health facilities and causalities of HCPs.

As a result of the high numbers of Corona cases, an emergency was declared nationally in all hospitals – only emergency obstetric care was functional; where the influx of patients recorded was significantly reduced due to fear of spread, which ultimately lessened the approachability of women in need of Sexual Reproductive Health (SRH) services, including Postabortion care (PAC). The number of COVID positive pregnant women also increased alarmingly, resulting in the spread of virus among the gynaecologists. Furthermore, the closure of maternity wards of big hospitals like Pakistan Institute of Medical Sciences (PIMS) and Lady Reading Hospital (LRH), aggravated the situation.

During COVID, emergency PAC services were available only at tertiary care facilities, but were compromised due to focus on COVID. Providers have come forward with such emergency cases; where women/girls have taken abortion pills on their own and were brought to the facility in a serious situation.

Hence, the lockdown has completely restricted SRH services which has increased the risk of women/girls entering the cycle of unsafe abortions. Additionally, due to nationwide closure of Population Welfare Department, provision of family planning and counselling services halted and this will enormously contribute to the number of unwanted pregnancies, predicted to be reaching to 7 million in the middle and low-income countries during the pandemic.

In Pakistan, access and provision of safe abortion services is already stigmatized, which quadrupled during COVID

In Pakistan, during COVID-19, the entire focus is on treating Covid-positive patients and containing the virus, which reflects gaps in the existing approach towards SRH and family planning. NGOs and INGOs such as Family Planning Association of Pakistan (FPAP), Ipas and UNFPA working on SRHR have adopted new approaches to increase the access of women/girls to SRH services in emergency situations.

Rounds of Virtual Meetings have been held among the CSOs, NGOs, INGOs and the Ministry of National and Provincial Health Services, to review the SRHR situation and refine and ease the service provision . As a result of these efforts, Ministry of National Health Services Regulations & Coordination (MoNHSR&C) has issued guidelines on "Continuation of Sexual, Reproductive and Maternal Health Services during COVID-19", which emphasizes on the availability of SRH supplies and critical services as per Minimum Initial Service Package (MISP), telemedicine approaches for abortion care and contraception, self-care practices and interventions for medical management of abortions and pregnancies respectively. The guidance has given significant emphasis on comprehensive abortion care and contraception as an essential service available 24/7 at Health facilities. MoNHSR&C has also endorsed the guidelines of Pakistan Alliance for Postabortion Care (PAPAC) calling out national level public/private facilities which are providing SRH care to remain open and continue providing the outpatient services/counselling during pandemic.

The world is still struggling with the pandemic. However, cases are relatively decreasing in Pakistan. The World Health Organization (WHO) has advised states to take all necessary preventive measures while moving towards normalization. The government of Pakistan has started the gradual opening of offices and markets with stringent implementation of standard operating procedures for post-lockdown opening.

Follow Neha on Facebook, Instagram and LinkedIn.

23. ADDRESSING THE OBSTACLE OF SAFE ABORTION IN NEPAL DURING COVID-19

LIRISHA TULADHAR, 20, NEPAL

COVID-19 has given rise to a systemic crisis for health access and delivery for countries around the world. Sexual and reproductive health services, an integral necessity, has been hugely impacted as well. The lockdown arising from the pandemic has exacerbated inequalities, especially for marginalized groups such as young women, young migrants and refugees, youth living in rural areas, young persons with disabilities, and young people of different sexual orientations. Accessing sexual and reproductive health services is a major challenge for people living in developing countries like Nepal.

Abortion in Nepal was legalized in 2002, under the National Safe Abortion Policy, which provided its services through a number of certified, government, non-government, and private health facilities. Along with policy implementation, Nepal's government also initiated the provision of safe abortion all over the country including medical abortion services.

Access to safe abortion is an essential service, the denial of which may lead to pregnant people reaching gestational thresholds, seeking unsafe methods and putting their health and lives at risk. Therefore, it is crucial for the provision of safe abortion to be ensured at the right time and need.

Despite having one of the most liberal abortion laws, in Nepal, an estimated 60% of all abortions that were performed in 2014 were unsafe. Even before the pandemic, Nepal saw many barriers in providing access to safe abortion services and care, and COVID-19 has amplified the problem even more.

According to IPPF, the South Asia region, including Nepal, is found to have the largest numbers of closure of mobile clinics and community-based care outlets due to the pandemic lockdowns. It is important to find alternatives to address the problem of reduced access to safe abortion.

Marie Stopes Nepal has been working to combat this gulf with a mobile helpline called *"Meri Saathi"* (My Friend). It provides free and confidential counseling for issues like contraception, safe abortion, safe sex, pregnancy, menstruation, masturbation, etc. Similarly, Ipas is also working to ensure continued access to abortion services via digital tools.

The efforts from these organizations to provide the safe abortion services however, cannot be the only solution. It is vital for Nepal's telemedical health services to improve their reach. Promoting telemedical abortions enables women to self-manage their abortion in an environment that is safe from COVID-19, confidential and relatively cheaper.

Millions of the women self-manage their abortions every year, with the use of medical abortion pills recommended by WHO. It includes intake of Mifepristone and Misoprostol in the correct dosage without even needing to visit the clinics. Policymakers, government and health facilities must increase the potential of telemedicine in Nepal.

The government should also provide support to organizations like Marie Stopes, UNFPA, PSI etc. which have been working extensively to ensure safe access to sexual and reproductive health services amidst this pandemic.

Follow Lirisha on Facebook and Instagram.

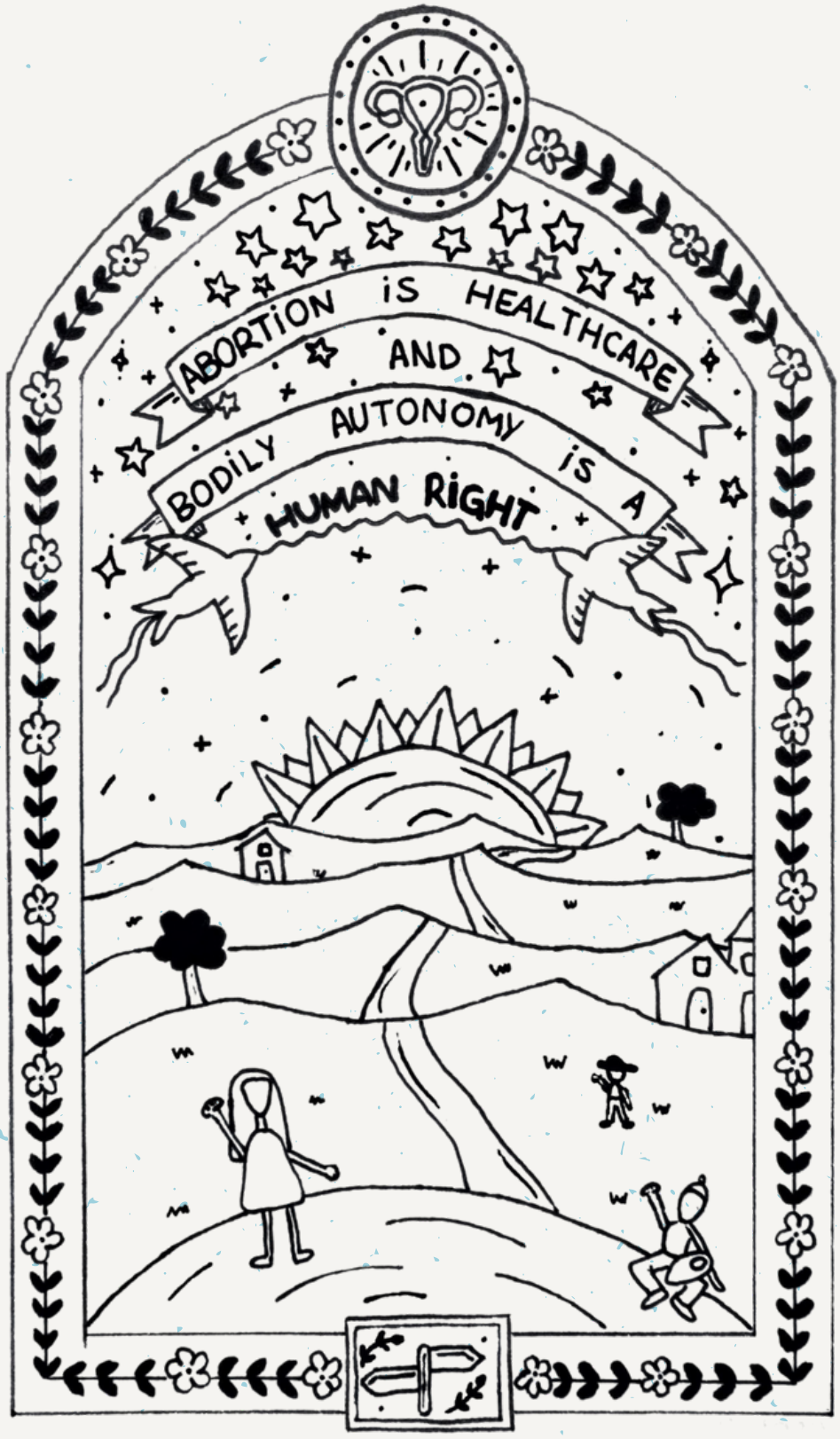
24. SELF-MANAGED ABORTIONS: AN INTERVIEW WITH WOMEN ON WEB

YOUTH COALITION FOR SEXUAL AND REPRODUCTIVE RIGHTS

Women on Web, started in 2005, was the first ever organisation to provide telemedical counselling and abortion services to pregnant people living in restrictive settings. This year, the theme for Interntional Safe Abortion Day is self-managed abortions, and their work is finally being mainstreamed and recognised as a crucial weapon in the toolkit for reproductive justice. Catch Hazal Atay, a member of Youth Coalition and Women on Web, in conversation with her colleague Victoria Satchwell from Women in Web, as they discuss the technical aspects of self-managed abortions, their experiences of being activists in this space and the impact of COVID-19.

25. BODILY AUTONOMY IS A HUMAN RIGHT

BEATRIZ ROTOLI, 26, BRAZIL/ITALY



26. ACCESS TO ABORTION IN CRISIS AND HUMANITARIAN SETTINGS

CHELANGAT S. SHEMA, 25, KENYA

Approximately 26 million women and girls of reproductive age are in need of humanitarian assistance around the world. Women and girls in crisis settings face tremendous obstacles to meeting their sexual and reproductive needs, even when it is incredibly crucial. In as much as this is a fundamental right, humanitarian laws, policies, and protocols are yet to be meaningfully interpreted and adapted to respond to their specific needs, including their sexual and reproductive health and rights.

In particular, safe abortion services are routinely omitted from sexual and reproductive health services in humanitarian settings for a variety of reasons, including an improper deference to national law, the disproportionate influence of restrictive funding policies like the Global Gag Rule, and the failure to treat abortion as medical care.

Sexual and reproductive health is often invisible, compared with the need for food, water, shelter and vaccines. The prevalence of gender-based violence against women and girls is well documented in humanitarian settings. Sexual violence is often used as a weapon of war, targeting civilian women and children. In these crisis settings, women face significant hardships trying to prevent pregnancy, and end unwanted pregnancies. The nature of life in those setting make access to this right extremely difficult. Women living in those conditions suffer greatly because they are out of options. Addressing this need is an essential towards meeting their right to health as prescribed by Article 14 of Maputo Protocol, which guarantees respect and promotion of women's right to health, including sexual and reproductive health (SRH) among other laws.

Among the challenges that hamper the realization of this right in humanitarian settings is the fact that there is a lack of adequate funding towards facilitating this right in conflict areas. Conflict-affected settings receive 57% less funding for reproductive health care than countries without significant conflict. Comprehensive sexual and reproductive health care, including safe abortion and contraception, is neglected in emergency settings in large part because of misperceptions. These myths are the result of misinformation, stigma and a lack of commitment to the basic human rights of women. The myths result in organisations, the donor community and practitioners incorrectly assuming that: there is no demand for safe abortion care, the delivery of abortion is too complicated in fragile settings, donors will not fund abortion care in fragile settings and/or abortion is illegal.

Conflict-affected settings receive 57% less funding for reproductive health care than countries without significant conflict.

The mistaken belief held by decision-makers that abortion is illegal must be countered. 93% of the world's population lives in a country where abortion is permitted under one or more circumstance. For instance in Kenya, abortion permitted only if, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other law.

Finally, we know safe abortion care reduces unsafe abortions and ultimately saves lives in any context. We also know that sexual violence against women in humanitarian settings is not only a risk during crisis, but continues during protracted emergencies, when women are supposed to be safe from coercion and assault. Governments, as duty bearers, have an obligation to ensure sexual and reproductive health facilities, information, education, goods and services, are available, accessible, acceptable and of good quality, particularly for adolescents, women in humanitarian settings.

Thank you for reading, sharing and contributing to the 2020 Watchdog on Safe Abortion.

Editing, compilation and design by Asmita Ghosh.

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