



## International Consortium for Medical Abortion

*Promoting access to medical abortion in  
the context of safe abortion worldwide...*

# Conference report

## ***Expanding Access to Medical Abortion: Building on two decades of Experience***

Third International Conference

*Hosted by ICMA in collaboration with*



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### ICMA Staff:

ICMA Coordinator: Rodica Comendant, Moldova;  
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## Expanding Access to Medical Abortion: Building on Two Decades of Experience

On March 2, 2010 over 150 clinicians, public health officials and advocates from 60 countries around the world came together for the third international conference on medical abortion sponsored by the International Consortium on Medical Abortion (ICMA). The three-day conference facilitated the sharing of experiences, research findings and strategies across national borders to improve access to medical abortion.

The third international conference built on the previous two ICMA conferences. The first conference, convened in Johannesburg in 2004, introduced medical abortion to a global audience. The second conference, held in London in 2007, focused on medical abortion in the second trimester of pregnancy.

This conference celebrated the increased diffusion of medical abortion around the world and identified the barriers that still prevent too many

women from accessing medical abortion. While recognizing that each country has unique challenges, the conference had five specific objectives for international exchange:

- To share information on the current situation of access to medical abortion with an emphasis on lessons learned and challenges in expanding access
- To examine strategies that have successfully improved access
- To examine barriers to access and how they have been addressed
- To discuss issues causing controversy within the medical abortion community
- To discuss future strategies on expanding access to medical abortion.

The conference addressed these objectives with an agenda that reviewed the current status of medical abortion internationally and highlighted key issues in advancing access to medical abortion, including strategies for making medical abortion more accessible, overcoming political opposition, and the debate over how much supervision women need when using medications to end a pregnancy. The situations in several specific countries with unique successes in introducing medical abortion or overcoming barriers were presented to illustrate innovative approaches and strategies. The conference included caucuses of participants from five world regions, and concluded with a discussion of future priorities and the identification of strategies for working on the local, regional and global levels to increase women's access to medical abortion in the context of safe abortion care.

The Conference presentations are displaced on ICMA web site: [www.medicalabortionconsortium.org](http://www.medicalabortionconsortium.org)

## The Current Status of Medical Abortion

The setting for the conference was an appropriate one, as Portugal is one of the most recent countries to change their abortion laws, legalizing abortion in 2007. Duarte Vilar, the Director of the Family Planning Association of Portugal, opened the conference with a description of the mobilization for changing the Portuguese abortion law and the subsequent successful introduction of medical abortion in the public health sector. His remarks outlined themes that resonated throughout the conference, including how to give women a choice of methods, how to ensure service delivery throughout the country, and how to overcome political opposition.

To give an overview of the field, Marge Berer (ICMA Chair) and Nathalie Kapp from the World Health Organization (WHO) reviewed the changes in abortion methods over the last decades and areas for future research. In the 1960s and 70s, abortion techniques included dilation and curettage (D & C), hysterotomy, and intra- and extra-amniotic injections. All of these methods carried a relatively high risk of complications. Current abortion techniques, including manual and electric vacuum aspiration, dilation and evacuation (D & E) and medical abortion are significantly safer and more effective than older methods, and ongoing research continues to identify optimum practices and medical regimens.

Since 1988, mifepristone has been registered in 44 countries, and access to medical abortion with mifepristone/misoprostol continues to expand. The



World Health Organization (WHO) has added mifepristone and misoprostol to the essential medicines list. Millions of women have safely used the mifepristone/misoprostol regimen for abortion around the world. Misoprostol and mifepristone are now manufactured and distributed by more companies worldwide. However, the overmedicalization of the procedure (including requirements for ultrasound, limits to who can provide it, and restrictions on where and how women use the medicines), the barriers to registration in many countries, and the costs are issues that advocates must continue to address to increase access to the method. In countries without mifepristone, legal restrictions and lack of information about how to use misoprostol are significant barriers.

Additional research is needed to identify the optimum doses of mifepristone and misoprostol, and of misoprostol alone, and on intervals and routes of administration. If research can support increased regimen flexibility, including various routes of administration and home use, and an increased use of midlevel providers, women's access to medical abortion will increase. Other areas for future research include comparison of pain control methods, flexibility in follow up protocols, the efficacy of mifepristone/misoprostol after 63 days, and the impact of choice on women's experience.

“It was fantastic to have so many countries participating.”

“Learned issues: power of partnerships, alliances, coalitions.”

### Progress in Expanding Access to Medical Abortion

- Misoprostol and mifepristone have been included in the WHO list of essential medicines
- Mifepristone has been approved in 44 countries
- Information about medical abortion is more available to women across borders
- Nepal, Ethiopia, Columbia, Mexico City, Switzerland, Portugal and Spain have either legalized abortion or expanded the grounds on which an abortion is considered legal
- Low-cost mifepristone and misoprostol products, including combined products, have become more available
- Several new provision models, including social marketing of misoprostol and education of pharmacists, have been piloted
- Safe internet provision of medical abortion has become a reality



✧ The quotes represent the opinions of the conference participants from the evaluation forms

## Strategies for Providing Medical Abortion Pills to Women

*Does empowering women to use medical abortion on their own absolve the health systems of their responsibility to provide women's health services?*

*- Bela Ganatra, Ipas India*

In less legally restricted settings, changes in service delivery can increase access. Dr. Danielle Hassoun of France shared the challenge of moving medical abortion from hospital provision by obstetric/gynecology specialists to the provision of medical abortion by general practitioners in clinics. Elizabeth Talmont discussed the provision of medical abortion by midlevel providers in several states in the USA and how this has increased the number of sites where medical abortion is available.



Misoprostol is available in many pharmacies in countries where abortion is legally restricted and pharmacists are primary sources of health information in many settings. Traci Baird of Ipas described work in Kenya to educate pharmacists on the use of misoprostol for safe abortion. Challenges include the negative attitudes of some pharmacists to abortion, their fears of prosecution, and the large number of small unregistered pharmacies. However, there has been some success in increasing pharmacy provision of misoprostol there. Eric Abraham of Egypt described a social marketing campaign with pharmacists and doctors to promote misoprostol distribution without a prescription. It was noted that projects to expand pharmacy distribution of misoprostol has resulted in a backlash in Egypt, Brazil and the Philippines, where the governments have restricted misoprostol availability to hospitals.

In addition to pharmacies, the Internet is a resource for women seeking the medicines needed for medical abortion. Kinga Jelinska described Women on Web, an Internet service that provides mifepristone and misoprostol, information and support to women in countries with no access to safe abortion services. Women report high satisfaction with the service; however, relatively few women know about or can access Women on Web.

“Topic that I found most valuable: The medical's perspective about support and counseling, use and advantage of counseling in MA.”

## Establishing How Much Medical Supervision Women Need to Use Medical Abortion Safely and Effectively in Early Pregnancy

*The statistics on unsafe abortion are the visible tip of an unknown mountain of women safely using medical abortion on their own that we can't measure.*

*Victor Lara, PSI Nepal*

The over-medicalization of abortion can restrict access, yet the question remains of how much involvement of medical professionals is needed to ensure the safety and efficacy of medical abortion. Galina Maistruk outlined the very good outcomes obtained in the Ukraine where medical abortion is provided by obstetric/gynecology specialists in a hospital setting. Other speakers highlight-

“We need to creatively develop vision at global level, messages – at local level.”



ed that the reality of the scarcity of clinicians in settings with more legal access, and the wide availability of the medicines in countries with more restrictive laws, drives the question of the potential of women to use the medicines with far less medical supervision. Requirements for effective and safe use of the medicines by women include access to quality medicines, a way to safely get the medicines, and information about how to use the medicines correctly and how to handle complications. Dhaval Patel of Marie Stopes International (MSI) described services at 21 MSI clinics that offer medical abortion with limited or no supervision. Ann Furedi from the British Pregnancy Advisory Service (bpas) reminded the audience that women are very motivated to use the medicines properly, can follow instructions if given clearly and are able to cope with the process of cramping and bleeding. Victor Lara of Nepal outlined the lack of data on the millions of women who take medicines to provoke an abortion on their own each year, outside of the health care system. The successful model of Women on Web delivering medicines and providing virtual support was noted.

“Women are clever enough to take the drugs themselves..✱”

The issue of how much clinical supervision is needed depends on the political and legal context, and on the expectations and needs of the woman herself. Adolescents or women with anemia may need more clinical guidance. In many countries, women expect that the service will be medicalized, and this must be taken into account when thinking about the need for medical supervision. Sharad Iyengar of India raised the critical issue of how to hold governments accountable for providing resources for sexual and reproductive health care, even when methods such as medical abortion may require less state investment to ensure safety.

“I got different strategies ideas on how to advocate for MA. ✱”

## Nepal

*In 2002 Nepal legalized abortion up to 12 weeks of pregnancy and as late as 18 weeks in cases of rape or incest. Before 2002, 50% of all maternal deaths were due to*

*complications from unsafe abortion. The current maternal mortality rate is 281 per 100,000 births, an enormous improvement in women's health. Medical abortion has been integrated across multiple sites in the public health system, and is*

*used in 13% of second trimester abortions. Nepal is an inspiring example of how abortion access can lower maternal morbidity and mortality rates in a low resource country.*

## Informing Women about Medical Abortion

*Only by listening do we learn how to talk*  
*Christina Villarreal, Oriéntame, Colombia*

The challenge of educating women about the safe use of medicines for abortion is a global one. Bela Ganatra of India highlighted the importance of clarifying what we mean when we attempt to address “women’s perspectives” – feminist activists who have not had a medical abortion and want to hold health systems accountable for providing care, women who used medicines on their own, and women who had a medical abortion under the guidance of a clinic or physician all have unique perspectives on this issue.

There is a clear difference between counseling and information. However, creating a context in which women can hear information is critically important. Women considering medical abortion are often anxious, fearful, and feeling isolated. Reassurance and patience are important first steps before trying to convey information. Most women do not need psychological counseling. Duarte Vilar pointed out that only 10% of women seeking services in Portugal



request a consultation with a counselor. Christina Villarreal of Colombia highlighted the importance of listening carefully to understand how the woman feels about her decision, her past experiences with touching her genitals and with pain and bleeding. Each woman is different, but by creating a friendly and supportive relationship, accurate and clear information can be shared that will help the woman handle her medical abortion. Danish Khan and Mary Fjerstad shared information developed by Ipas for women and men with low-literacy levels. These picture-based materials can be very helpful in ensuring that the directions for taking medicines and handling complications are thoroughly understood.

“Network of advocates should be improved, since this is our power.”

## Mexico

When Mexico City liberalized its abortion laws in 2007, public health administrators and medical professionals worked closely with international experts to introduce medical abortion at 14 public hospitals. Dr. Patricio Sanhueza described the pressure to move quickly from the Ministry of Health and the vocal opposition from the Church and antichoice

activists. Building on a collaboration between the government and NGOs, international expertise was mobilized to identify models of service delivery, train professionals in a team approach and identify a service delivery model that could be scaled up to meet the needs of women in one of the world's largest urban areas. At present, 70% of the abortions provided in the public health system are with misoprostol alone. The process for registering mifepristone

has started, and there are plans for new satellite medical abortion sites that will be linked to facilities with the capacity for surgical abortion as needed. Dr. Sanhueza proudly announced the dedication of the Beverly Winikoff clinic that will open soon, in honor of the international support that was instrumental in developing services. Mexico City is an exciting success story for improving women's health by increasing access to medical abortion!

## Increasing the Availability of the Medicines

*There should be as much supervision of a medical abortion as the woman thinks there should be.*

*Ann Furedi, British Pregnancy Advisory Service*

There are myriad factors that impact the availability of mifepristone and misoprostol in each country. Suchitra Dalvie described the situation in India, where sales of mifepristone increase by 40% each year, but most of this is outside of the healthcare system. Pharmacists assume that the medicines are being “misused” if they are used by unmarried women, and pharmacists and physicians use a range of protocols for medical abortion. Peter Hall of the Concept Foundation addressed the issue of quality of the medicines. While misoprostol is manufactured in many countries around the world and mifepristone is made in 3 countries, poor women do not have access to quality medicines. Efforts are underway to register mifepristone and misoprostol in additional countries and to disseminate a combination packaged product. Beverly Winikoff of Gynuity, USA, warned about the pitfalls in how the medicines are labeled and noted that there is widespread off-label use of mifepristone, whose labeling is based on 20 year-old science, and of misoprostol. She advocated that service delivery ideas not be integrated into drug labels, noting that “information and practice change quickly; laws and drug regulations change slowly”. Peter Fajans of WHO proposed a strategic model for introducing medical abortion into new settings, with a focus on the need to involve a broad range of stakeholders and the use of clinical trials and local evidence to train health professionals before scaling up.



# Organizing to Overcome Opposition to Abortion

*When you are committed to women's health, you will find a way.  
Ejike Oji, Ipas Nigeria*

A primary barrier to expanding women's access to medical abortion and safe abortion services is the continuing vociferous anti-choice movement, which is often supported by religious institutions and by international think tanks with vast financial resources. Wanda Nowicka (Poland), outlined strategies at international forums, where the Bush administration and the Catholic Church have created an increasingly negative climate for abortion. To counter this frontal assault, strategies have included addressing abortion within language around sexual rights and health, in initiatives on maternal health, and within the framework of post-abortion care. The recent goals have been to secure the gains outlined in the Cairo and Beijing forums and overcome attempts to undermine these gains. While campaigns to remove legal restrictions to abortion are critical, advocacy groups continue to focus on ways to increase women's access to abortion while simultaneously working on legal reform.



Silvana Ramos of ICMA outlined organizing principles for the future. In each country, advocates should consider the visibility of the abortion issue, the emergence of other social change movements, the availability of communications technologies, how to allocate resources, and the strength and nature of anti-abortion activism. Careful linkages between the national, regional and global levels are needed to inform local activism. To create social change, passionate messages are needed. It is critically important to engage youth, especially since the anti-choice movement is trying to bring their message to the next generation. Messaging should include highlighting the attempt of religion to influence government policies. To create meaningful change, a critical mass of support must be created and sustained.

*“All care is local, all change is local however we learn together and share a similar passion.”*

Five regional caucuses convened to identify particular challenges in each geographic area. The ICMA regional network coordinators led the Africa, Asia, Eastern Europe and Latin American caucuses. Lively discussions informed the future strategies of Consorcio Latinoamericano y del Caribe contra el Aborto Inseguro (CLACAI, the Latin American and Caribbean Consortium against Unsafe Abortion), the Asia Safe Abortion Partnership (ASAP), the Eastern European Alliance for Reproductive Choice (EEARC) and the African Network for Medical Abortion (ANMA), respectively. (See the ICMA website for details of the regional strategies.) A caucus of participants from North America and Europe also convened to explore similarities and differences in protocols and access to medical abortion in those regions and identify possible shared strategic activities.

*“No style, approach or strategy fits all systems.”*

## Nigeria

*In Nigeria, unsafe abortion is the leading cause of infertility. Nigeria has a maternal mortality rate of 1,100 per 100,000 births, and annually 760,000 abortions contribute to 34,000 deaths and countless numbers of maternal injuries. Women*

*use sharp tools and caustic substances and are victimized by unskilled and unscrupulous practitioners. To raise awareness about the potential impact of safe abortion, Ejike Oji of Ipas described his campaign using graphic images of injured women to build support among medical professionals and alliances with women's*

*groups to reform the abortion laws and counter antichoice activists. While the obstacles to safe abortion are enormous, there is an energetic women's movement and increasing numbers of medical professionals who are working to make access to safe abortion a reality for the women of Nigeria.*

## Vision for the Future

*Medical Abortion is not a magic bullet. The empowerment of women is!*  
*Bela Ganatra, Ipas India*

The third international ICMA conference ended with a lively session on “next steps”. Each of the four ICMA-affiliated regional networks shared a brief summary of their current membership and structure, and their strategic plans for the future. ICMA pledged to convene a fourth international conference to move the global agenda forward while continuing to support regional work. From the floor, innovative suggestions included convening regional network meetings of physicians and midwives, partnering with the International Federation of Gynecology and Obstetrics (FIGO) to work closely with obstetric/gynecological associations on the national and regional levels, inviting more policy makers to regional and international forums on abortion, and collaborating on a World-wide Day of Action. An initial consensus statement of future activities was generated. (See Appendix 1.)

Energized by the conference, participants also shared how the conference had shaped their individual plans for continuing work in their countries. New partnerships and relationships were fostered by the conference, and the convening of regional caucuses generated new ideas for collaborative work. By the next international conference, the participants pledged that there will more gains to celebrate on the global, regional, and national levels as ICMA continues to work to improve maternal health by expanding women’s access to safe medical abortion.

“Efforts to legalize abortion are like a war.”

### Future Research Agenda

To increase access to medical abortion and improve services, more information is needed about

- Pain management
- Second- trimester abortion in low-resource settings
- Post-abortion contraception
- Providing medical abortion for certain special populations, including adolescents, anemic women, and HIV-positive women
- The efficacy of mifepristone/misoprostol after 63 days
- Impact of choice on women’s experience

### Russia

*Geographically, Russia is the largest country in the world and is ranked 9th in total population. The health system is huge and disorganized, and the quality of care varies by region. Abortion has historically been widely practiced because it is seen as safer than contraception, and many women have multiple abortions. Medical abortion is expensive (approximately \$160 US) while surgical abortion costs from \$100 – \$2,000. Recently the government, influenced by religious institutions, has started to restrict abortion access and now limits indications for second trimester abortion. Medical practitioners and activists face enormous challenges in maintaining abortion access and improving the quality of abortion care for women in Russia.*



## Conference Organising Committee

### ICMA Staff

- Rodica Comendant, ICMA Coordinator
- Silvina Ramos, ICMA Network Liason Officer
- Ludmila Tulus, ICMA Assistant

### ICMA Steering Committee

- Marge Berer, Chair
- Mariana Romero, Co-chair
- Bela Ganatra
- Wanda Nowicka
- Beverly Winikoff
- Peter Fajans, WHO Observer

### Coordinators of the Regional Networks

- Susana Chávez, Latin American Consortium Against Unsafe Abortion (CLACAI)
- Suchitra Dalvie, Asian Safe Abortion Partnership (ASAP)
- Djingarey Maiga, African Network for Medical Abortion (ANMA)
- Galina Maistruk, East Europe Alliance for Reproductive Choice (EEARC)

In collaboration with Ipas and Gynuity Health Projects

*ICMA thanks the Donors and Participant Sponsors who made the conference possible*

### Donors

- Gynuity Health Projects
- Ipas
- Netherlands Ministry of Foreign Affairs
- Safe Abortion Action Fund
- Swedish International Development Authority
- Tides Foundation

### Participant Sponsors

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- Doctors for Choice
- FIAPAC
- Fundación Oriéntame
- Ibis Reproductive Health
- International Planned Parenthood Federation
- Marie Stopes International
- National Abortion Federation
- Population Services International
- Women on Waves



“Thanks for the organizing committee and ICMA. ✨”

*Conference Report prepared by Susan Yanow, MSW, Consultant*

## Appendix 1

### Conference Statement

Six years after the first ICMA conference, “Medical Abortion: An International Forum on Policies, Programmes and Services”, 17-20 October 2004, Johannesburg, South Africa progress has been made toward many of the objectives highlighted at that meeting: misoprostol and mifepristone have been included in the WHO list of essential medicines, mifepristone has been approved in many more countries, and women have access to better information about medical abortion, to name a few. New developments in the area of medical abortion have been highlighted at the 3rd ICMA conference and will drive our future work in the following areas:

“Congratulations to conference organizers and steering committee for an extremely well conceptualized and executed conference! ❄️”

#### Law and policy

- Several countries have either legalized abortion or expanded the legal indications permitted for abortion, and it is critical that we develop and promote guidelines to ensure that women are able to fully exercise their right to a legal abortion.
- Historically, the evidence strongly shows that making abortion legal has been a precondition for eliminating the public health problem of unsafe abortion. Legalisation of abortion also reduces stigma for women, as well as eliminating the legal risks for providers.
- While legal reform remains a priority, in the era of medical abortion, access to safe options for pregnancy termination have become less dependent on the law.

#### Access to services/service delivery systems

- Over-medicalisation of first trimester abortion imposes barriers to access. Greater efforts to reduce unnecessary medicalisation are needed, affecting law, regulations and service delivery norms. For example, research shows that medical abortion can be provided safely at primary level by suitably trained nurses, midwives and other mid-level providers, and task-shifting should be implemented to these providers wherever possible in order to improve women's access to services.
- There is evidence from many countries that the use of medical abortion at home at least up to 63 days of pregnancy is safe, with back up where needed from health services. Some women want more support during the process of medical abortion, however, such as a telephone line to be able to ask questions and get reassurance, and those services should be available for women who want them, especially for young women. Health systems need to respond to women's needs and provide supportive care.

“Learned issues: Experience of different countries – Mexico and Portugal – challenges and ways they have been overcome! ❄️”

#### Access to drugs

- Internet provision of medical abortion pills, including through telemedicine services, has become a reality, and women need information in

order to be able to access sources of bona fide, reasonably priced, high quality drugs through this outlet. The Internet and other modern technologies, such as cell phones, can be an important source of information for women, and more work is needed to take advantage of these tools.

- Medical abortion provision has expanded within the private sector and through public-private partnerships in recent years, as well as through pharmacies and other drug sellers. Still, we recognize that it is the responsibility of the public health sector to provide care for all women, and we call on government health systems to guarantee all women access to safe abortion services.
- Low-cost mifepristone and misoprostol products, including combined products, have become available in recent years. We need to work with the pharmaceutical industry and other partners to improve access to high quality medical abortion drugs at affordable prices.

*“I got new energy and optimism to continue our struggle for safe abortion.”*

## Information needs

- More needs to be known about certain new and existing models for provision of medical abortion, including through social marketing and post-abortion care services. Researchers should study the quality of care that women receive with these, to better understand their experiences and sources of information and to document whether and how these models improve access to safe abortion.
- We recognize the importance of providing accurate information based on the situation and needs of women in the locale and countries concerned, including information designed for low literacy populations. We call on all partners developing informational and advocacy materials to share them freely with other organizations working in this area.
- While providing women information is a critical component of medical abortion, not all women need counseling in order to decide whether to have an abortion or which abortion method they prefer to use. Mandatory counseling or evaluation can be a barrier to access and should be optional and only at the woman's request.
- Despite the large body of research on women's experiences with medical abortion in various settings, there are still significant gaps in knowledge, especially related to the experiences of women who obtain medical abortion drugs outside of clinics and never present for clinical care.

*“Amazing logistical support, great adherence to time more than well, excellent.”*

**Several clinical areas have been neglected and deserve further study, including:**

- Pain management
- 2nd trimester abortion in low-resource legally restricted settings
- Post-abortion contraception
- The experience of certain population groups with medical abortion, e.g. adolescents, which may have been documented in several countries but is not widely known

## Appendix 2

### Conference Agenda

## Expanding Access to Medical Abortion: Building on Two Decades of Experience

2 - 3 - 4 March 2010

### Agenda: 2 March – Day 1

- 8:00-9:00      **Registration**
- 9:00-9:05      **Opening Duarte Vilar, Director, Family Planning Association Portugal**
- 9:05-9:20      **Opening speech, Ministry of Health, Portugal**
- 9:20-9:30      **Welcome**  
  
*Silvina Ramos, ICMA*  
*Traci Baird, Ipas*  
*Beverly Winikoff, Gynuity Health Projects*
- 9:30-9:35      **About the conference**  
  
*Rodica Comendant, ICMA Coordinator*
- 9:35-9:55      **Expanding access to medical abortion**  
  
*Marge Berer*
- 9:55-10:15      **Best practice with medical abortion: current evidence**  
  
*Nathalie Kapp*  
  
*[Questions, discussion 15 minutes after both]*
- 10:30-11:00      **Coffee**
- 11:00-12:30 pm      **Panel: Medical abortion pills: how and where do women get them**  
  
*Chairs: Sandy García; Makgoale Magwentshu*  
  
**Hospital/ clinic provision** *Danielle Hassoun*  
  
**Pharmacist provision** *Joachim Odour Osur*



**Social marketing** *Vivek Malhotra*

**Provision via the web** *Kinga Jelinska*

**Provision through mid-level providers** *Elizabeth Talmont*

**Harm reduction models** *Ana Labandera*

**Self-medication in a war setting** *Pierre Panda*

*[Presentations 10 minutes each, questions and discussion 20 minutes]*

• 12:30–2:00 pm **Lunch**

• 2:00–3:30 pm **Breakout sessions: Strategies supporting access**

**1. Strategies for dealing with religious and political opposition** *[Room Douro 1]*

*Moderators: Raffaella Schiavon; Asma'u Joda*

**2. Strategies for engaging the media positively in abortion issues** *[Room Minho 3]*

*Moderators: Emmanuel Ugoji; Margareth Arilha*

**3. Mobilizing providers for political advocacy of medical abortion** *[Room Douro 2]*

*Moderators: Viktor Radzinzky; Ana Campos*

**4. Planning a campaign to make abortion safe and legal** *[Room Minho 2]*

*Moderators: Sim-Poey Choong; María Luisa Sánchez Fuentes*

**5. Ensuring that legal abortions are accessible in legally restricted settings** *[Room Tejo]*

*Moderators: Ana Cristina Gonzalez Velez; Cristina Hunguana*

**6. Pain control with first and second trimester medical abortion** *[Room Minho 1]*

*Moderators: Marijke Alblas; Sharad Iyengar*

• 3:30–4:00 pm **Tea**

• 4:00–5:30 pm **Debate: How much medical supervision do women need to use medical abortion safely and effectively in early pregnancy**

*Chairs: Marge Berer; Debora Diniz*

*Speakers: Victor Lara, Dhaval Patel, Ann Furedi, Galina Maistruk*

*[Presentations 5 minutes each, responses 2 minutes each, debate open to the floor]*

• 7:00 pm **Reception / Conference dinner / dance**

## Agenda: 3 March – Day 2

- 9:00–10:40 **Plenary: Informing Women About Medical Abortion**  
*Chairs: Daniel Grossman; Olga Pietruchova*  
**Women's perspectives on medical abortion** *Bela Ganatra*  
**Communicating with women in the clinic and the community** *Cristina Villarreal*  
**Information versus counseling** *Duarte Vilar*  
**Developing information and communication materials for different settings**  
*Danish Khan; Mary Fjerstad*
- 10:40–11:10 **Coffee**
- 11:10–1:30 pm **Plenary: Realizing the Potential Of Medical Abortion**  
*Chairs: Giselle Carino; Ronnie Johnson*  
**The transformative role of medical abortion: from manufacture to social change**  
*Suchitra Dalvie*  
**Drugs for medical abortion: where we are now** *Peter Hall*  
**Expanding access through off-label use of medical abortion** *Beverly Winikoff*  
**Introduction of medical abortion: thinking strategically** *Peter Fajans*  
**How cost influences access to medical abortion in the public and private sector**  
*Sharad Iyengar*  
  
*[Presentations 15 minutes each; questions 5 minutes each, discussion 40 minutes]*
- 1:30–3:00 pm **Lunch**
- 3:00–4:00 pm **Regional caucuses: led by the regional network coordinators**  
  
**Africa** *[Room Douro 1+2]*  
**Asia/New Zealand/Australia** *[Room Minho 2]*  
**Eastern Europe** *[Room Minho 1]*  
**Latin America/Caribbean** *[Room Tejo]*  
**Western Europe/North America** *[Room Minho 3]*
- 4:00–4:30 pm **Tea**
- 4:30–5:30 pm **Regional caucuses continue**

## Agenda: 4 March – Day 3

- 8:30–10:10 **Plenary: The Politics Of Abortion**

*Chairs: Mawaheb El-Mouelhy; Dominique Audouze*

**Politics of abortion rights work** *Wanda Nowicka*

**Organising in the current political context: the next decade** *Silvina Ramos*

*[Presentations 20 minutes each, discussion 60 minutes]*

- 10:10–10:40 **Coffee**
- 10:40–12:00 pm **Plenary: National Perspectives From Four Countries**

*Chairs: Susan Yanow; Nongluk Boonthai*

**Nigeria** [Ejike Oji]

**Mexico City** [Patricio Sanhueza]

**Nepal** [Indira Basnett]

**Russia** [Irina Savelieva]

*[Presentations 15 minutes each, questions and discussion 10 minutes each]*

- 12:00–1:00 pm **Lunch**
- 1:00–2:20 pm **ICMA: Our Vision: Who We Are, Current Activities, Future Priorities**

*Chairs: Daniela Draghici; Getachew Bekele*

**ICMA** [Marge Berer]

**Latin American Consortium Against Unsafe Abortion** [CLACAI]

**Asian Safe Abortion Partnership** [ASAP]

**East Europe Alliance for Reproductive Choice** [EEARC]

**African Network for Medical Abortion** [ANMA]

*[Presentations 10 minutes each]*

**Discussion: Working Together Internationally And Regionally To Further Our Goals**

*[Open to the floor 30 minutes]*

- 2:20 – 3:20 pm      **Conference consensus statement** *Mariana Romero*
- 3:20 – 3:50 pm      **Participants speak from the floor and say what they are planning to do as a result of this conference** *[1 minute each]*
- 3:50 – 4:00 pm      **Conference closing** *Mariana Romero*



## Appendix 3

### Conference Participants

*(Names are not listed to protect participants from countries where abortion is legally restricted)*

The 170 conference participants included representatives of international and national NGOs, departments of obstetrics/gynecology, and Ministries of Health. Countries represented included:

Africa	Asia	Eastern Europe	Western Europe/North America	Central / South America / Caribbean
Benin	Bangladesh	Albania		
Cameroon	Cambodia	Armenia		Antigua & Barbuda
Democratic Republic of Congo	India	Azerbaijan	Austria	Argentina
Egypt	Indonesia	Georgia	Canada	Brazil
Ethiopia	Japan	Hungary	France	Colombia
Gabon	Malaysia	Kazakhstan	Ireland	Costa Rica
Ghana	Mongolia	Kyrgyzstan	Italy	Dominican Republic
Kenya	Nepal	Latvia	Netherlands	Guatemala
Mozambique	Pakistan	Lithuania	Portugal	Mexico
Nigeria	Thailand	Moldova	Spain	Peru
South Africa	Turkey	Poland	Sweden	St. Kitts & Nevis
Sudan	Vietnam	Romania	Switzerland	Uruguay
Tunisia		Russia	United Kingdom	
Zambia		Slovakia	United States	
		Tajikistan		
		Ukraine		