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A Review of Literature on Global and Regional **Contraception and** Safe Abortion Trends (2015-2020)

ACKNOWLEDGEMENTS

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ACRONYMS AND ABBREVIATIONS

CPR Contraceptive prevalence rate

DHS Demographic and health surveys

FIAP Canada's Feminist International Assistance Policy

FP2020 Family Planning 2020

GFF Global Financing Facility

GGR Global Gag Rule

IPPF International Planned Parenthood Federation

FIGO International Federation of Gynaecology and Obstetrics

LAC Latin America and the Caribbean

LARCs Long-acting reversible contraceptives

LGBTQI+ Lesbian, gay, bisexual, transgender, queer, intersex

LMICs Low-to-middle-income countries

mCPR Modern contraceptive prevalence rate

mDFPS Demand of family planning satisfied with modern methods

MICS Multiple indicator cluster survey

MMR Maternal mortality rate

MNH Maternal and newborn health

MSI Marie Stopes International

MSM Men who have sex with men

NGO Non-governmental organization

PAC Post-abortion care

PLGHA Protecting Life in Global Health Assistance

SSA Sub-Saharan Africa

SARCs Short-acting reversible contraceptives

SIDA Swedish International Development Cooperation Agency

SRH Sexual and reproductive health

SRHR Sexual and reproductive health and rights

UHC Universal Health Coverage

UNFPA United Nations Fund for Population Activities

WHO World Health Organization

WRA Women of reproductive age

EXECUTIVE SUMMARY

Contraception and safe abortion are key components of sexual and reproductive health and rights. They are essential and critical sexual and reproductive health services that save lives and provide women, girls and communities the chance to live a life of dignity and wellbeing. Despite wide evidence of the multiple health, socioeconomic and environmental benefits of contraception and safe abortion, access to services and supplies in these two areas remains an urgent public health issue in various parts of the world. As part of Share-Net's Contraception and Abortion Community of Practice (CoP), this review seeks to inform practitioners, researchers, activists and policy-makers working around contraception, safe abortion and SRHR at large about current global and regional contraception and abortion trends, the major policy and financing dynamics around these areas for the 2015 – 2020 period. This report also has the goal of presenting promising practices and recommendations to increase and expand access and uptake of contraception and safe abortion.

Contraception and Abortion estimates and trends

- As of 2019, there were 218 million women in developing regions with an unmet need for modern contraception, meaning that they want to prevent a pregnancy but are not using modern contraceptive methods. These women account for 77% of the 111 million unintended pregnancies occurring each year in developing regions.
- Adolescent girls account for 6% (14 million) of all women in reproductive age with an unmet need for modern methods.
- An estimated 56 million abortions take place each year. Approximately 31 million are safe, 17 million less safe and 8 million least safe. Almost all less safe and least safe abortions (97%) take place in developing regions.

The policy and financing landscape around contraception and abortions services and supplies

Multiple actors and stakeholders shape and influence international policy and funding around contraception and safe abortion. The US is the single largest donor to family planning and contraceptive supplies and has a significant impact on the dynamics of this landscape. The reintroduction and radical expansion of the Global Gag Rule (GGR) in 2017 by the Trump-Pence administration is jeopardizing global progress around SRHR goal by cutting back the benefits from family planning and reproductive health programmes financed by the US. The 2015-2020 period has also seen a revival in the interest from donors in the areas of contraception and safe abortion. EU countries and Canada, for example, are taking the leading role in pushing for global progress and support towards sexual and reproductive global health targets. They have made commitments following pledges as part of initiatives such as the FP2020, the GFF and SheDecides, and have increased international policy focusing on SRH/FP. The European donor community has also been a prominent champion for the inclusion and monitoring of SRH/FP in the SDGs, especially within the framework of Universal Health Coverage (UHC). However, significant sustained efforts and resources are required to address current funding gaps and increase access to high-quality contraception and safe abortion services and supplies, especially for those who have the greatest needs.

The impact of the new Global Gag Rule: A disheartening outlook for sexual and reproductive health and rights

There is no evidence supporting the effectiveness of the GGR in decreasing abortion rates. Instead 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. This harmful policy puts ideology before evidence, and rather than protecting life it endangers the right to health, well-being and bodily autonomy of millions across the world. The effects of this dangerous anti-abortion policy are far-reaching and they disproportionately impact women, girls and vulnerable, under-served populations who already face systematic barriers in accessing contraceptive and safe abortion care and other essential sexual and reproductive health services. Although it is still difficult to quantify the full impact of the current GGR, the literature indicates that adolescents, LGBTQI+ people and sex workers have been severely affected by the policy. Mainly, the GGR is aggravating existing barriers to access and increasing economic vulnerability, eroding safe spaces, disrupting SRH services and emboldening anti-SRHR, anti-LGBTQI+ and anti-sex work sentiment.

Future directions

The recommendations arising from this literature review of contraception and abortion are as follows:

Research

- Improve and expand data collection on adolescents, particularly young adolescents (10-14 years), as most of the literature only include information for married or older women.
- Improve and expand data collection on abortion estimates. Current abortion data tends to be limited and estimates available have significant rates of underreporting and inaccuracy.
- Continue monitoring, documenting and publishing the impact of the GGR.
- Research new developments in contraceptive technologies that can expand contraceptive choices, thereby addressing many concerns that currently discourage people from using a method.

Policy

- Addressing funding gaps through collaboration between national governments, NGOs, donors, and the individuals receiving care.
- Mobilize political support in the US to permanently end the GGR through the Global HER Act.
- For policy-makers and donor governments, avoid applying conditionalities on development funding for health, including counter-conditionalities intended to respond to the GGR.
- Donor governments should include SRHR as part of their international aid policy and funding for UHC in developing countries. The mantra should be 'there is no UHC without SRHR'".

Practice

- Advance advocacy and mobilization efforts to increase access to contraception and safe abortion by findings avenues to advocate in partnership with other initiatives, such as the Global Fund to Fights Aids, Tuberculosis and Malaria. This could be good approach to improve services and stigma reducing strategies for LGBTQI+ people.
- Improve service delivery environment by prioritizing programmes that benefit under-served and vulnerable populations.

• Within Share-Net, examine whether combined strategies and work from the different Communities of Practice (CoPs) are addressing contraceptive and safe abortion access for all, including strategies to ensure that the most vulnerable groups can access these services.

Conclusions

The year 2020 marks a critical time to take stock of progress and shortfalls towards achieving UHC and other health-related SDG targets by 2030. Sexual and reproductive health is a key element of UHC, and this of course includes access to contraception and safe abortion. Current trends show that despite significant progress, millions of women and girls across the world are still deprived from the right to decide whether and when to have children.

Addressing unmet needs and gaps in contraception and safe abortion services and supplies in a comprehensive and efficient manner can only be achieved through the implementation of diverse, creative and sustained strategies. These should include advocacy and research, investments and financial commitments, and collaboration between donors, governments and civil society organizations focusing on various SRHR areas and populations.

Civil society organisations, funders, researcher and activists need to continue their strategic, deliberate and nuanced approaches to build on the recent successes to continue challenging the barriers which impede women, girls and individuals to control and make informed decisions about their fertility, health and wellbeing. Contraception and safe abortion are essential and life-saving health care and are fundamental rights for all people. This should be the norm rather than the exception, for every person, in every corner of the world.

CHAPTER 1: BACKGROUND, OBJECTIVES AND METHODOLOGY

1.1 BACKGROUND AND OBJECTIVES OF THE REVIEW

This review was commissioned by Share-Net Netherlands to provide an overview of current contraception and abortion trends on a global and regional scale, with a focus in three developing regions —Latin America and the Caribbean (LAC), South Asia and Sub-Saharan Africa (SSA). This work also presents the latest policy developments and financial trends around contraception and abortion services and supplies for the 2015-2020 period.

The reinstatement of the Mexico City Policy in 2017, also known as the 'Global Gag Rule' has significantly impacted the allocation of funds towards contraception and abortion services and supplies in developing regions. Hence, this review brings attention to the diverse ways in which the policy is affecting funding in these areas and presents its implication for three vulnerable populations — adolescents, LGBTQI+ people and sex workers.

Contraception and abortion trends presented in this report focus on data from cisgender women and girls. This focus is the result of a scarcity of data on other groups (e.g. transgender men and non-binary people), and not a methodological decision to exclude the experiences and challenges of LGBTQI+ in accessing contraception and safe abortion. Share-Net promotes a human-rights and intersectional approach to SRHR and recognizes that people across the gender spectrum use contraception and can experience pregnancy and abortion, therefore necessitating access to these services and supplies (See for example Light et al. 2018; Sutton & Borland 2018).

More specifically, this report addresses the following questions:

- 1. What are recent findings on contraception and abortion trends on a global scale as well as regionally?
- 2. How have international policy and funding for contraception and abortion services and supplies changed in the period of 2015-2020?
- 3. How has the reinstatement and unprecedented expansion of Mexico City Policy or 'Global Gag Rule' impacted vulnerable populations particularly adolescents, LGBTQI+ people and sex workers?
- 4. What are promising practices and recommendations for addressing gaps in access and uptake of contraception and safe abortion considering the current political context around SRHR?

1.2 METHODOLOGY

To gain a full picture and ensure a high-quality review of the subject at hand, this assignment followed various procedures. First, we completed a comprehensive search of peer-reviewed journals based on a wide range of key terms (see annex 1 for the list of keywords and inclusion criteria). We searched for eligible studies on databases and search engines, including PubMed, Google Scholar, Web of Science, and Scopus. Additionally, we used the snowball method to search the reference sections of relevant articles and locate further resources. Finally, we conducted a Google search of grey literature using a list of search terms.

The search was limited to the English language and included articles, reports, and documents published between 2015 and 2020. Some exceptions were made to include literature published before 2015 that

added significant value to the assignment. During the drafting process, researchers and members of Share-Net's 'Contraception and Abortion' Community of Practice provided input on the methodological approach and helped identifying other suitable sources.

The literature review process was divided into two parts. The first focused on a review of recent findings on contraception and abortion trends globally and in three developing regions¹ – Latin American and the Caribbean (LAC), South Asia and Sub-Saharan Africa (SSA). This part also included a search of the latest policy and funding trends around contraception and abortion services and supplies. To obtain data on contraception and abortion trends, we examined quantitative studies, systematic reviews and reports that draw data from the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and Performance Monitoring for Action (PMAs) Surveys. Qualitative and mixed-method assessments were also included.

Informed by the findings of Part 1, Part 2 focused on reviewing the impact of the most recent version of the Global Gag Rule, also known as the 'Protecting Life in Global Health Assistance' policy (PLGHA), on three vulnerable populations: adolescents, LGBTQI+ people and sex workers. This section is mainly comprised of findings gathered from grey literature — specifically NGOs reports and case studies. Lastly, we also identified good practices and recommendations from the various sources of literature that can inform future research and can help implement and foster evidence-based policy, initiatives and programs around contraception and safe abortion.

1.3 STRUCTURE OF THE REVIEW

This review is structured in 5 chapters. Chapter 1 provides the background, methodology and objectives of this report. Chapter 2 presents global and regional estimates and trends of contraceptive and abortion needs, services, and supplies. An overview of current costs, funding gaps, and economic returns of providing comprehensive contraceptive and abortion services is also included.

Chapter 3 outlines the current policy context around family planning and contraceptive supplies financing in developing countries—including the policy context and financial environment, donor trends, government and out-of-pocket spending for contraceptive procurement, and estimates of the funding gap for family planning and contraceptive. This chapter also presents financing trends of EU donors and the Canadian government, as well as the impact of recent changes in US funding affecting contraception and abortion services and supplies.

Chapter 4 provides an overview of the documented impacts of prior iterations of the Global Gag Rule on abortion rates and the implications of its current version—the PLGHA— on vulnerable populations. Efforts to mitigate the policy's negative consequences on the sexual and reproductive health and rights of these groups are also included. Lastly, chapter 5 provides promising practices for addressing gaps in access and

¹ In this report, we use the United Nations Population Division definition of developing countries, which designates all countries except Australia, Canada, Japan, New Zealand, the United States and all European nations, as developing. The designation of "developed" and "developing" regions is intended for statistical purposes and does not express a judgment about the stage reached by a country or area in the development process. More developed regions comprise all regions of Europe plus Northern America, Australia/New Zealand and Japan. Less developed regions comprise all regions of Africa, Asia (excluding Japan), and Latin America and the Caribbean as well as Oceania (excluding Australia and New Zealand).

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uptake of contraception and safe abortion considering the current political context around SRHR. This section also includes recommendations and conclusions.

CHAPTER 2: CONTRACEPTION AND ABORTION ESTIMATES AND TRENDS

Contraception and abortion are core components of sexual and reproductive health and rights. There are multiple benefits of contraception and safe abortion. First and foremost, it is a human rights issue, as access to comprehensive sexual and reproductive health, including contraception and safe abortion services, is critical for the fulfilment of people's reproductive rights and for leading a life of dignity and wellbeing. Furthermore, contraception and safe abortion are essential healthcare which saves lives, preventing millions of unintended pregnancies and unsafe abortions, as well as many hundreds of thousands of maternal deaths and disability every year (Amnesty International 2020).

On the individual level, when women and people can control their fertility and have bodily autonomy, they can expand their opportunities and choices such as staying in school, finding work, improving their socioeconomic status, choosing whether or when to have children, and participating in civic life. At the macro level, access to contraception and safe abortions is a crucial element of socioeconomic development, poverty alleviation, environmental sustainability, the promotion of health, and the wellbeing of the overall population.

Moreover, access to contraception and safe abortion has important implications for achieving global health objectives around the Sustainable Development Goals (SDGs), including achieving gender equality, eradicating poverty and hunger, reducing HIV transmission, and decreasing demands on ecological resources (Starbid et al. 2016). Also, women having the right to choose and control their fertility contributes to preventing child mortality, improves maternal and child outcomes and increases labour productivity resulting in higher work-force participation, income growth and GDP per capita (FP2020 2019).

2.1 CONTRACEPTION ESTIMATES AND TRENDS

According to UN DESA (2020), between the 1990-2019 period, the global fertility rate decreased from 3.2 to 2.5 live births per woman. Today, approximately half of the world's population lives in a country where the fertility rate is below 2.1 live births per woman. Over this period, the fertility rate dropped from 3.3 to 2 births per woman in LAC, while Central and Southern Asia experienced a decline in fertility from 4.3 to 2.4 births per woman. In SSA, the region with the highest fertility levels, the total fertility rate dropped from 6.3 to 4.6 births per woman.

Decreasing fertility rates are associated with increasing trends in contraceptive prevalence rates (CPR) in all regions of the world (Ibid.). Globally, 49% of all women in the reproductive age (WRA) range (15-49 years) were using some form of contraception in 2019, compared to 42% in 1990 (Ibid.). Moreover, among the 1.9 billion WRA worldwide in 2019, 1.1 billion had a demand for family planning, meaning that they

want to delay, space or limit childbearing. Of these, 842 million were using modern contraception,² and 270 million had an unmet need for modern methods³ (UN DESA 2019a).

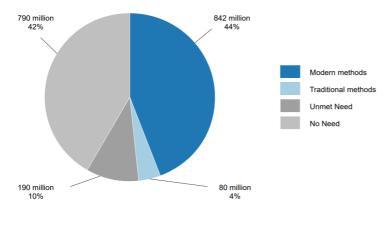


Figure 1. Estimated numbers of WRA (15-49 years) using modern and traditional contraceptive methods, having an unmet need for family planning and no need for family planning, worldwide, 2019

Source: UN DESA (2019a)

2.1.1 Mixed Method

Method mix⁴ varies greatly across regions (see Figure 2 below), with patterns of contraceptive method mix being complex and reflecting women's preferences which are influenced by social and cultural norms and the diverse contexts in which they live. Permanent⁵ and long-acting reversible contraceptives methods⁶ (LARCs), such as female and male sterilization, the IUD and implants are more prevalent in Asia and LAC than in other regions (UN DESA 2019a). Short-acting reversible contraceptive methods⁷ (SARCs) represent more than half of all contraceptive methods used in 125 countries, including SSA (Ibid). Traditional methods are less commonly used than modern methods in most countries—in 2019, 91% of all contraceptive users were using modern methods and 9% traditional methods. (Ibid).

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² Modern methods include female and male sterilization, pills, IUDs, male and female condoms, injectables, implants, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), emergency contraception, lactational amenorrhea method (LAM) and the contraceptive patch or vaginal ring. Traditional methods include rhythm (periodic abstinence), withdrawal and folk methods (douching, prolonged abstinence, gris-gris, incantation, medicinal plants, abdominal massage and other local methods) (UN DESA 2020).

³ A woman is considered to have unmet need for a modern method if she is able to conceive, is in a union or currently sexually active and wants to avoid a pregnancy for at least two years, but is using a traditional contraceptive method or is not using a method at all.

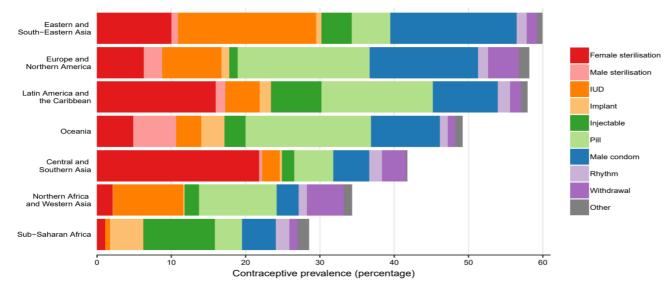
⁴ Method mix is the percentage distribution of contraceptive users in a given country or region, by method—is one measure that reflects the availability of a range of contraceptive methods.

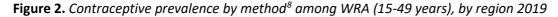
⁵ Permanent methods include female and male sterilization

⁶ Long-acting reversible methods include intrauterine contraceptives (IUDs) and implants

⁷ Short-acting reversible methods include the oral contraceptive pill, condoms, injectables and the contraceptive patch

Each contraception method has different failure rates, with permanent contraception and LARCs being the most effective at preventing unintended pregnancy. As such, the type of contraceptive method used in a country or a region is a significant determinant of fertility. For example, the high proportion of women using long-acting and permanent methods in LAC and in Central and Southern Asia is associated with the low levels of fertility achieved in these regions (Ibid.). In comparison, SSA shows a skewed method-mix towards short-term methods, which can explain the continuation of high fertility rates (Ibid).





Source: UN DESA (2019a)

Method mix also is also different according to women's marital status (see Figure 3 below). Among the 779 million contraceptive-using married WRA (15-49 years), permanent methods and LARCs represent close to 50% of contraceptive methods used (Ibid.). In contrast, among the 143 million unmarried contraceptive users, only 22.8% rely on permanent methods and LARCs, with the most common methods being male condoms and the pill.

Although there is no ideal method mix, a broad variety of methods, including SARCs, LARCs and permanent options, should be made available to meet the diverse and changing needs of women (FP2020 2019). Improving and increasing access to a wider range of contraceptive methods give women more choice and should reduce unmet need, which is increasingly the result of discontinuation of method use. In recent years, a focus on LARCs has gained special interest due to their high effectiveness and low cost. Nonetheless, their promotion has raised concerns about undermining women's reproductive autonomy (National Women's Health Network 2019). Therefore, a broad availability of methods along with provision

⁸ 'Other methods' in Figure 2 and 3 include modern methods such as female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method (LAM), emergency contraception and other modern methods (e.g., the contraceptive patch or vaginal ring), and traditional methods such as douching, prolonged abstinence, gris-gris, incantation, medicinal plants, abdominal massage and other local methods (UN DESA 2019a).

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of contraception services that are free of discrimination, stigma and coercion is imperative, so that women are able to make a voluntary and informed contraceptive choice that fits their needs. Factors influencing the use of contraceptive methods are discussed under the section on barriers to accessing contraception in later sections of the report.

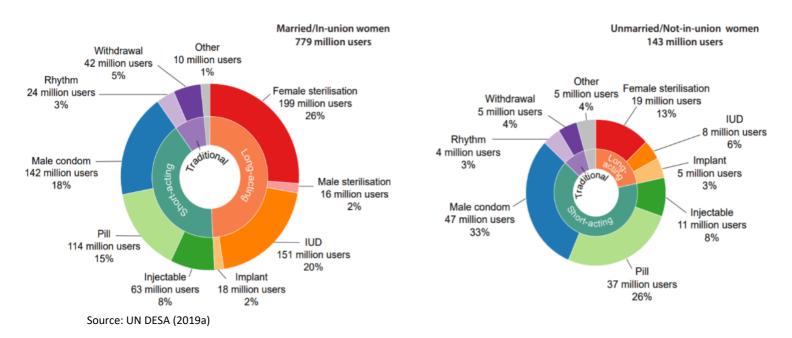


Figure 3. Estimated numbers of WRA (15-49) using various contraceptive methods, by marital status 2019

2.1.2 Contraception estimates and trends in adolescents

A recent analysis by the Guttmacher Institute (Sully et al. 2020) indicates that among the 261 million adolescent women aged 15–19 in developing regions, 32 million (14%) have a need for modern contraception. Of these, 18 million (57%) are using modern contraception and about 14 million (43%) have an unmet need for modern contraception. Adolescent women account for 6% of all WRA with an unmet need for modern methods. The most common contraceptive methods among this population are male condoms, the pill and injectables.

Adolescents have an unmet need for modern contraception significantly higher than the unmet need among all WRA (15-49 years) who want to prevent a pregnancy (43% vs. 24%) (Ibid.). The age disparity in modern method use is larger than disparities by rural-urban residence or socioeconomic status. In addition, adolescents living in low- and lower-middle—income countries have proportionally greater unmet need for modern methods, compared with adolescents living in upper-middle—income countries. Unmet need for sexually active adolescents wanting to avoid a pregnancy is higher in Africa and Asia (62% and 64%, respectively) than in other regions; in LAC this is 38% (Guttmacher Institute 2018).

Every year in developing regions, an estimated 21 million girls (15–19 years) become pregnant and approximately half of them give birth (Darroch et al. 2016). Among them, 27,000 die every year due to complications during pregnancy and childbirth (Sully et al. 2020). Furthermore, at least 777,000 births happen to adolescent girls below the age of 15 (WHO 2020). A recent UN DESA report on the fertility of

young adolescents (10-14 years) indicates that early adolescent childbearing is much more common in SSA, LAC and Bangladesh than in other parts of the world (UN DESA 2019b).

Around 5.6 million abortions take place each year among adolescent girls (15-19 years), from which 3.9 million are unsafe (Guttmacher Institute 2018). Box 1 below summarizes some of the major health and social consequences of early pregnancy and fertility among for adolescent mothers and their babies.

Box 1. Health and social implications of early adolescent fertility

- Early teenage pregnancies are often unplanned or unintended, and are sometimes the result of forced marriages, which tend to take place under social norms and traditions that perpetuate gender inequality, and lead to a pre-mature transition from childhood to motherhood.
- Pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally.
- Adolescent mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years.
- Early childbearing can increase risks for newborns too. Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and severe neonatal conditions.
- In some settings, rapid repeated pregnancy is a concern for young mothers, as it presents further health risks for both the mother and the child.
- Early adolescent fertility has a lasting impact on the socio-economic, physical and mental development of girls.
- Social consequences for unmarried pregnant adolescents may include stigma, rejection or violence by partners, parents and peers.
- Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership.
- Adolescent pregnancy and childbearing often lead girls to drop out of school, which may well jeopardize their future education, employment opportunities and wellbeing.

Source: WHO (2020) and UN DESA (2019b)

2.2 REGIONAL CONTRACEPTION ESTIMATES AND TRENDS: LATIN AMERICA AND THE CARIBBEAN, SOUTH ASIA AND SUB-SAHARAN AFRICA

Despite increasing trends on contraception on a global level, significant variations remain across regions. In 2019, CPRs⁹ ranged from a low of 34% in SSA to 49% in South Asia and 74% in LAC. In terms of modern contraceptive prevalence rates (mCPRs), LAC achieved 70%, South Asia 42%, and SSA 29%. Unmet need

⁹ These are rates for women who are currently married or in a union using any contraceptive method.

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ranged from 10% in LAC to 16% in South Asia and 23% in SSA (Kaneda & Greenbaum 2019; Mogelgaard et al. 2019).

As of 2019, 923 million women out of the 1.6 billion WRA living in developing regions want to avoid a pregnancy (Sully et al. 2020). From this group, 705 million use modern contraceptives and 218 million (24%) do not, meaning that they have an unmet need for modern contraception. Unmet need has a higher prevalence in low-income countries, where 46% of women wanting to avoid a pregnancy are not using a modern method (Ibid.). Although both the number of women wanting to avoid a pregnancy and the number of women using modern contraceptives has increased since 2000, population growth has outpaced increases in use of contraception. This has resulted in an increase in the number of women with an unmet need for modern contraceptives (Ibid.)

295,000 7,800 and the 57,000 200,000

Table 1. Sexual and reproductive health and rights indicators by region

Source: Mogelgaard et al. (2019). Estimates for South Asia were obtained from Kaneda & Greenbaum (2019) and crosschecked with data presented in Mogelgaard et al. (2019). The number of maternal deaths and MMRs were obtained from UNICEF et al. (2019)

A recent analysis of trends in demand for family planning satisfied (mDFPS10) in 73 countries over a period of 24 years (Hellwig et al. 2019) indicates that most of the countries have significantly increased mean mDFPS and that inequalities in access to contraception decreased across socioeconomic lines. However, the analysis points out that most countries in SSA, particularly in West and Central Africa, are unlikely to reach high coverage of mDFPS by 2030. According to the authors, tackling social norms against

¹⁰ Demand for family planning satisfied (mDFPS) is defined as the proportion of married WRA (15-49 years) in need of contraception that are currently using a modern contraceptive method (Hellwig et al. 2019).

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contraceptive use and providing users with information and the necessary infrastructure to increase uptake and coverage of mCPR can results in a higher coverage of mDFPS in the region.

In terms of maternal mortality, most maternal deaths take place in SSA and South Asia. Together, both regions account for approximately 87% of all annual maternal deaths in the world (UNICEF et al. 2019). Higher maternal mortality rates in these two regions mainly result from the lack of health care infrastructure, particularly limited numbers of trained health workers and the absence of essential services to provide adequate and comprehensive care to women before, during and after pregnancy (Singh et al. 2014). Nonetheless, these regions have also shown the largest MMR reduction between 2000 and 2017. South Asia had the biggest overall reduction with a decrease of nearly 60%, while SSA had a reduction of almost 40% (WHO 2019). Globally, the MMR in developing regions decreased by just under 50% under the same period (Ibid.).

2.2.1 Latin America and the Caribbean

According to research by the Guttmacher Institute (2017b), 66% of all WRA (15–49 years) in LAC want to prevent pregnancy, a total of 114 million women. However, 21% of women who do not want to get pregnant, or 24 million, either use no contraceptive method or use traditional methods with low efficacy. This unmet need for contraception accounts for 75% of unintended pregnancies in the region. While the number of women with an unmet need for modern contraceptive methods has seen a decrease in developing regions since 2014, LAC showed an increase of 1.2 million (Ibid.).

Recent data estimates the regional mCPR at 70% but with significant variations across sub-regions and countries (Kaneda & Greenbaum 2019) (see Table 3 below). Haiti, Guyana, and Trinidad and Tobago have the lowest mCPRs in the region with 34%, 44% and 41% respectively (Mogelgaard et al 2019). In contrast, mCPR is above 75% in Brazil (77%), Costa Rica (77%), Nicaragua (77%), Colombia (76%) and Uruguay (76%) (Ibid). The proportion of mDFPS is 83% (Mogelgaard et al. 2019). In terms of maternal mortality, the region has an MMR of 74% and an estimated 7,800 women die from complications of birth, abortion or miscarriage every year (UNICEF et al. 2019).

Region	Contraceptive prevalence rates – any method (%)	Contraceptive prevalence rates – modern method (%)	Unmet need rate (%)	Demand satisfied by any method (%)	Demand satisfied by modern method (%)
Latin America and the Caribbean	74	70	10	89	83
Central America	67	64	13	-	80
Caribbean	59	57	19	-	72
South America	79	74	-	-	-

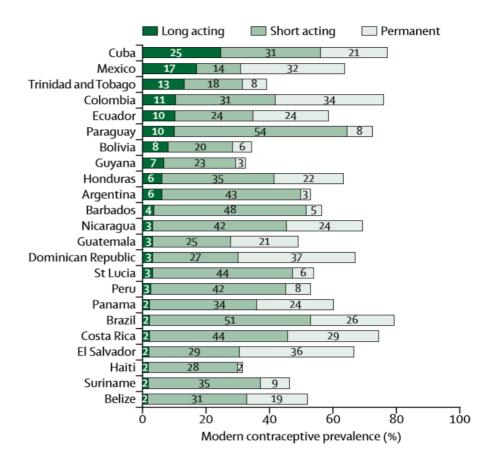
Table 2. Contraceptive incidence and trends in Latin America and the Caribbean, by sub-region

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Source: Mogelgaard et al. (2019)

A study by Ponce de León et al. (2019) found that contraceptive use in LAC shows significant variations across the region. In most countries, with the only exception of Mexico, SARCs are used much more frequently than LARCs. Permanent contraception has a high prevalence in a few countries (see Figure 4). The authors address that family programmes in the region should provide more attention to LARCS, as many women might benefit from them, compared to permanent methods or SARCS, due to their "high effectiveness, convenience, ease of continuation, and suitability for most women, including young and nulliparous women" (Ibid. 2019:e227).

Figure 4. Modern contraceptive prevalence (%) by type (LARCs, SARCs and Permanent contraception) in 23 countries of LAC

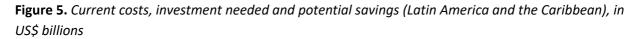


Source: Ponce de León et al. (2019)

Current costs, investment needed and potential savings in LAC

The Guttmacher-Lancet Commission¹¹ (2017b), estimates that the cost for contraceptive¹² and maternal and newborn health (MNH) care services in LAC is \$6.8 billion per year, with the former requiring \$1.7 billion and the latter \$5.1 billion. Completely satisfying the current demand and needs for MNH would require \$6.7 billion annually. Nevertheless, making an additional \$643 million investment in contraceptive services and supplies to fully meet the need for modern contraception would mean that MNH care costs would decrease by \$2.6 billion to \$4.1 billion, due to a reduction in unintended pregnancies.

Fully meeting the needs of women in both contraceptive and MNH care in the region would cost a total of \$6.5 billion annually, or an investment of \$10 per capita. This would result in improved and more comprehensive care and would yield savings on top of what is currently spent. If these investments were made in the region, unintended pregnancies would fall from 14 million to 5 million per year; unplanned births would decline by a third (from 6 million to 2 million), abortions would be reduced significantly by two-thirds and maternal deaths would drop by 75%, from 7,800 to 2,000 every year.





Source: Guttmacher Institute (2017b)

2.2.2 South Asia

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¹¹ We draw on the Adding it Up study by the Guttmacher-Lancet Commission (2017) to provide cost estimates for contraception and maternal and newborn health, investment needed to meet all demands for care in these areas and potential healthcare savings and benefits. The calculations of these estimates include direct costs (contraceptives, supplies and labor costs of providers and healthcare workers) and indirect costs (information and education on family planning, infrastructure, program and technical support and supply chain).

¹² Estimates for contraceptive services and supplies include direct costs (contraceptive commodities, drugs, supplies and health workers salaries all of which are required to provide clients with information and counselling, a range of methods, and removal services for implants and IUDs), and programs and systems costs (critical health systems elements, such as program management, staff supervision and training, infrastructure and equipment, and commodity and information management systems) (Sully et al. 2020).

Forty percent of all Asian WRA (15-49 years), or 470 million, live in South Asia (Guttmacher Institute 2017c). The region has a moderate mCPR rate at 42%, but with significant variations across countries (See table 4 below). The unmet need for family planning is 16%, with ranges between 23% and 8% within the region (Ibid). Unmet need is vastly different between subgroups of women in South Asia, both at the regional level and within countries. Unintended pregnancy is higher in the younger, poorer, less educated, or those who live in rural areas or slums; among married women, women aged 15-24 have the greatest unmet need (Khuda and Bharkat 2015).

Furthermore, South Asian countries face enormous public health challenges, especially in MNH, and the region has a great need for improved services in this area (Guttmacher Institute 2017c; uddin Mian et. al 2018). Due to such challenges, South Asia continues to have one of the highest MMR at 163, with an estimated 20% (57,000) of annual maternal deaths in the world occurring in this region (UNICEF et al. 2019).

Region	Contraceptive prevalence rates – any method (%)	Contraceptive prevalence rates – modern method (%)	Unmet need rate (%)	Demand satisfied by any method (%)	Demand satisfied by modern method (%)
South Asia	49	42	16	75	62
Afghanistan	27	24	15	78	69
Bangladesh	64	57	11	85	76
Bhutan	63	62	12	84	83
India	57	51	12	82	74
Maldives	45	38	23	67	56
Nepal	54	48	22	71	63
Pakistan	42	33	19	68	54
Sri Lanka	65	54	8	90	74

Table 3. Contraceptive incidence and trends in South Asia, by country

Source: Mogelgaard et al. (2019)

Current costs, investment needed and potential savings in Asia

The Guttmacher-Lancet Commission (2017c) estimates that the cost for contraceptive and MNH care in Asia is \$18.6 billion per year, with the former requiring \$3.7 billion and the latter \$14.9 billion. Completely satisfying the current demand and needs for MNH care would require an estimated \$23.5 billion annually. Nevertheless, making an additional investment of \$1.9 billion in contraceptive services and supplies to fully meet the need for modern contraception would mean that MNH costs would decrease by \$4.3 billion to \$19.2 billion, due to a reduction in unintended pregnancies.

Fully meeting the needs of women in both contraceptive and MNH care would cost a total of \$24.7 billion per year, or \$5.67 per capita, requiring 33% more than what is currently spent. If these investments were made in the region, unintended pregnancies would decline by 75% (from 52 million to 13 million per year); unplanned births would decrease from 13 million to 3 million; abortions would fall from 33 million to 8 million, and maternal deaths would decline by 72% from 90,000 to 25,000 annually.

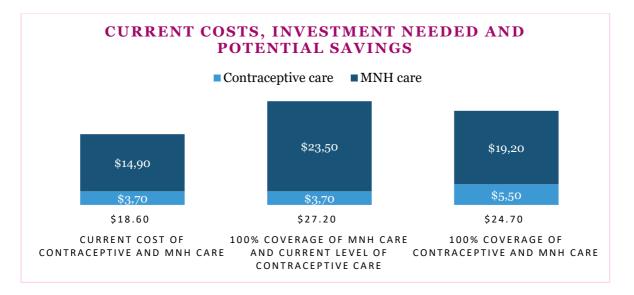


Figure 6. Current costs, investments needed and potential savings (Asia), in US\$ billions

Source: Guttmacher Institute (2017c)

2.2.3 Sub-Saharan Africa

The overall regional mCPR in SSA is 29% (Mogelgaard et al. 2019). However, this region presents a significant variation in mCPRs across sub-regions and countries. Eastern and Southern Africa combined have a modern contraceptive rate of 38%, while West and Central Africa have an mCPR of 18%. In terms of country variation, mCPR is lowest in Chad (7%), Guinea (9%) and South Sudan (7%), and highest in Zimbabwe (66%) and Eswatini (65%) (Ibid.).

SSA has an unmet need for modern contraceptives of 23% (Kaneda & Greenbaum 2019), the highest in the world. That means that nearly 1-in-4 married women have an unmet need for contraception. Despite rapid improvements, the region has the lowest level of coverage with an average proportion of mDFPS at 39% (Hellwig et al. 2019). In addition, the region presents the highest maternal mortality ratio in the world, with an MMR of 533. In 2017, 200,000 maternal deaths took place in SSA, accounting for 68% of all maternal deaths annually (UNICEF et al. 2019).

Region	Contraceptive prevalence rates – any method (%)	Contraceptive prevalence rates – modern method (%)	Unmet need rate (%)	Demand satisfied by any method (%)	Demand satisfied by modern method (%)
Sub-Saharan Africa	34	29	23	57	48
East and Southern Africa	42	38	22	66	60
West and Central Africa	22	19	24	47	30

Table 4. Contraceptive incidence and trends in SSA, by sub-region

Source: Mogelgaard et al. (2019)

Current costs, investment needed and potential savings in Africa

The Guttmacher-Lancet Commission (2017d) estimates that the cost for contraceptive and MNH care services in Africa is \$6.5 billion per year, with the former requiring \$942 million and the latter \$5.6 billion. Completely satisfying the current demand and needs for MNH care would require an estimated \$24 billion annually. Nevertheless, making an additional investment of \$4.2 billion in contraceptive services and supplies would mean that MNH care costs would decrease by \$5.8 billion to \$18.2 billion, due to a reduction in unintended pregnancies.

Fully meeting the needs of women in both contraceptive and MNH care would cost a total of \$22.4 billion per year, more than three times what is currently spent, or \$18 per capita. If these investments were made in the region, unintended pregnancies would decline by approximately 80% per year (from 23 million to 5 million per year); unplanned births would decrease from 12 million to 2 million; abortions would fall from 9 million to 2 million, and maternal deaths would decline by 73% from 211,000 to 56,000 annually.

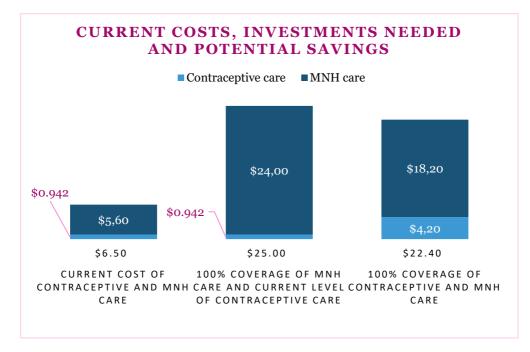


Figure 7. Current costs, investments needed and potential savings (Africa), in US\$ billions

Source: Guttmacher Institute (2017d)

2.3 BARRIERS TO CONTRACEPTION USE

Despite progress to increase modern contraception prevalence rates across the world, non-use of modern contraceptive methods remains a major public health concern in various parts of the world. 218 million women have an unmet need for modern contraception, accounting for 77% of unintended pregnancies in developing regions (Sully et al. 2020). Understanding both women's reasons for non-use and external factors, such as supply-side barriers, that affect women's ability to access and use contraception, is crucial for addressing unmet needs for modern contraception, and in turn to prevent unintended pregnancies, unsafe abortions, maternal death and morbidity and the transmission of sexually transmitted diseases. Below, we discuss some of these barriers.

2.3.1 Demand-side barriers

Among the main reasons women cite for non-use of contraceptive are concerns about side-effects and health risks, infrequent sex, not having resumed menstruation after a birth, and opposition to contraception by the women themselves or others (Rodrígues Moreira et al. 2019; Sedgh et al. 2016b). For never-married women, not being married is one primary reason for non-use. Sedgh et al. (2016b) found that across 52 countries in LAC, Asia and SSA women rarely cited lack of knowledge about contraception or lack of access to a source of supply or costs as barriers; countries where more than 10% of women cited any of these reasons are in West and Middle Africa.

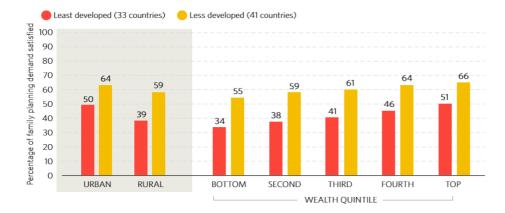
Reasons for non-use are also context-specific and vary significantly across regions and countries. Postpartum amenorrhea/breast-feeding and opposition to contraception are more prevalent in Africa than

in Asia or LAC. In contrast, infrequent sex and concerns about side-effects and health risks are the most common factors for non-use in the latter regions (Ibid.).

Despite significant achievements to expand contraceptive use, access disparities across gender, regions, and social groups remain. Research shows, for example, that disparities in contraceptive trends follow socioeconomic lines within countries, with a strong relationship between poverty and low contraceptive use. For example, in the poorest regions, modern contraceptive prevalence is extremely low, with less than 15% of married WRA using modern methods (Kaneda & Greenbaum 2019). As of 2017, in low-income countries, the proportion of WRA whose need for contraception is satisfied with modern methods was 49%, far lower than lower-middle-income (69%) and upper-middle-income countries (86%) (Guttmacher Institute 2017a).

Moreover, although contraceptive prevalence has increased across all income groups globally, poorer women are still left behind. Hellwig et al. (2019) found that contraceptive prevalence rates across 73 LMICs are lowest among women in the poorest wealth quintiles, especially those from rural areas (see Figure 4 below), those who are younger, and with less education. Main reasons that economically disadvantaged women cite for non-use in LMICs are lack of access, lack of knowledge or being fatalistic¹³ (Rodrígues Moreira et al. 2019). A lack of access to contraception among poorer women also results in higher maternal mortality and morbidity rates and higher unsafe abortion incidence among this group.

Figure 8. *Proportion of demand for family planning met with modern contraception, by development level, place of residence and wealth quintile*



Source: Mogelgaard et al. (2019)

¹³ Fatalistic or up to God or fate, meaning that the woman feels that pregnancies are determined by fate (Rodrígues Moreira et al. 2019)

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2.3.2 Supply-side barriers

One of the key elements for fulfilling the unmet demand for contraception is the process of supplying contraceptive commodities. The need or demand for contraceptives and meeting the supply of contraceptives are dependent on each other. As demand for contraception increases, so does the need for donors, governments, manufacturers, NGOs and other stakeholders to supply and meet demand levels.

Experts underline that supply chain failures lead to non-use and contraceptive discontinuation among women in LMICs (Ali 2017). According to Mukasa et al. (2017:384), supply-side barriers in these countries are associated with four key issues: "weak and poorly institutionalized logistic management information systems (LMIS), poor physical infrastructures in LMICs, lack of trained and dedicated staff for supply chain management, inadequate funding, and rigid government policies on task sharing". Weak supply chains in LMICs are also most common in rural and remote areas where it is more difficult to reach clients (Ali 2017).

As we will discuss later in the review, when in place, the Mexico City Policy, also known as 'Global Gag Rule' (GGR), severely aggravates supply-side barriers in affected countries, disrupting organizations' capacity to provide contraceptive commodities and leaving millions of women without access to contraception services and supplies. For instance, during the implementation of the policy under George W. Bush, the US decreased or stopped supplying contraceptive commodities to 16 countries in developing regions (Mavodza et al. 2019). Similarly, International Planned Parenthood Association (IPFF) underlines that the recent GGR has impacted contraceptives and commodity distribution across South Asia, resulting in increasing difficulties to source affordable, modern and safe contraceptives for clinics and communities (IPPF 2020).

Another supply-side barrier is the unavailability of specific contraceptive methods. Emergency contraception (EC) can prevent unintended pregnancy. However, it is still restricted or prohibited in many countries. According to data from the International Consortium for Emergency Contraception, as of 2020, 47 countries had no emergency contraceptive pill brands registered (ICEC 2020); and even in countries where these are registered, regular supplies are not always available, or access might require a prescription for purchase.

Furthermore, women's choice of contraceptive method is influenced by health providers and their policies. If the methods available in public and private-sector facilities do not respond to the needs of women, this can limit contraception use and uptake (Ponce de León et al. 2019). Therefore, it is important that women are provided with a broad method mix to give women a range of methods that suit their preferences (Kaneda & Greenbaum 2019; Nieto-Andrade et al. 2017).

2.3.3 Adolescent-specific barriers

Adolescent girls and young women (AGYW) often face more barriers in accessing contraception than married and older women (Smith 2020). AGYW-specific barriers that impede contraceptive use include limited access to sexual and reproductive health services (due to for example required parental or spousal consent), economic difficulties when buying contraceptive supplies, lack of information or access to comprehensive sexuality education, and social and cultural norms opposing contraceptive use (Sedgh et al.

2015). Young women's difficulties negotiating the use of contraception, especially condom use, with male partners also represent a significant barrier for this subgroup (Smith 2020).

2.4 ABORTION ESTIMATES AND TRENDS

According to the Abortion Worldwide 2017 report (Singh et al. 2018), 56 million abortions take place each year globally. The annual abortion rate for all WRA (15-44 years) is estimated to be 35 per 1,000 women. Married women have an estimated rate of 36 per 1,000 and unmarried 25 per 1,000 (Sedgh et al. 2016a). Women living in developing regions have a higher likelihood of experiencing abortion compared to those living in developed countries (36 vs 27 per 1,000). Between 2010-2014, an estimated 99 million unintended pregnancies occurred every year, with 56% ending in abortion. Furthermore, 1-in-4 pregnancies ended in abortion (Guttmacher Institute 2018b).

Unsafe abortion is one of the leading causes of maternal mortality with an estimated 8 to 11%¹⁴ of all maternal deaths resulting from unsafe abortion complications. This means that approximately 22,800–31,000 lives are lost each year unnecessarily (Singh et al. 2018). Besides, 6.9 million women are treated for complications associated with unsafe abortion procedures in developing regions, while 9 million women do not receive the care they need for complication after unsafe abortion (Sully et al. 2020).

There is extensive evidence showing that criminalization of abortion only increases mortality and morbidity, without decreasing the incidence of induced abortion, and that decriminalization rapidly reduces abortion-related mortality and does not increase abortion rates (Faúndes & Shah 2015). Abortion is safer in contexts where it is broadly permitted than in more restrictive settings. It also tends to be safer in countries with a higher gross national income (Singh et al. 2018). There is no significant variation in abortion rates in countries where it is legal compared to countries where it is restricted (Sedgh et al. 2016). On average, the abortion rate is 37 per 1,000 women in countries where abortion is banned or highly restricted, and 34 per 1,000 in countries without restrictions (Ibid.).

In the last 25 years, nearly 50 countries have expanded abortion access within different circumstances¹⁵. Of all the WRA (approximately 1.6 billion), an estimated 6% live in areas where abortion is totally banned, 37% where it is allowed without restriction, and most women live in countries with laws that fall between these two extremes. Abortion is prohibited altogether in only 6 countries worldwide, El Salvador, Dominican Republic, Haiti, Honduras, Malta and Nicaragua. Often, it is the lack of clarity about the laws and lack of guidelines, coupled with social and religious stigma, that prevents the existence of an enabling environment for safe abortion and which restricts the practice in many countries.

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¹⁴ A range of estimates is provided because these deaths are extremely difficult to estimate, and experts and organizations use different methodological approaches.

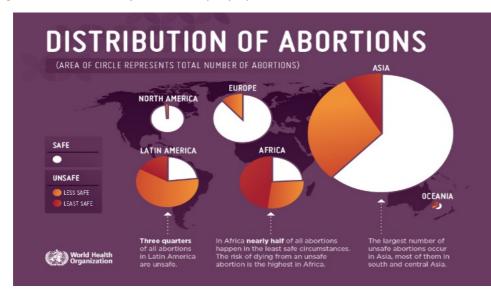
¹⁵ Changes in these countries' abortion laws have added grounds for abortions ranging from allowing it in cases of rape, incest, foetal impairment, to saving a woman's life, preserve the health of the women; abortion on broad social or economic grounds, or abortion on request (gestational limits vary across countries). For more information on the liberalization of abortion laws in the past 25 years see <u>Accelerating Progress: Liberalization of Abortion Laws since ICPD</u>

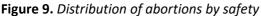
2.4.1 Classification of abortion by safety

Ganatra et al. (2017) provide a framework with three categories of abortion based on WHO recommendations for the practice of safe abortion: safe abortion, less safe abortion, and least safe abortion. This study also estimates global, regional and sub-regional distributions of abortion by safety categories.

According to the authors, during 2010-2014, from the 56 million abortion that took place every year, approximately 31 million abortions were safe¹⁶, 17 million less safe and 8 million least safe. The authors also found a direct relationship between abortion safety and the legal status of abortion. In countries where abortion was available on request, 87.4% of all abortions were categorized as safe. In contrast, in countries with restrictive abortion laws, where the practice is either completely banned or just allowed to save the woman's life, only 25% of abortions were safe. In highly restrictive contexts, almost a third (31.3%) of abortions were considered least safe.

The study also suggests a significant relation between abortion safety and country income level. In highincome and upper-middle-income countries, 82% of abortions were safe, compared to 21.8% in lowincome countries. Similarly, developed countries with the most restrictive abortion laws had a proportion of least safe abortion of 0.3% compared to 31.3% in developing countries with similar restrictive laws (Ganatra et al. 2017).





Source: WHO (2017)

¹⁶ Induced abortion is considered safe when WHO recommended methods (see WHO 2012; WHO 2018) are used by trained healthcare providers; less safe when only one of those two criteria is met, and least safe when neither is met. (Guttmacher Institute 2018a).

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2.5 REGIONAL ABORTION ESTIMATES AND TRENDS: LATIN AMERICA AND THE CARIBBEAN, SOUTH ASIA AND SUB-SAHARAN AFRICA

Abortion estimates vary greatly across regions (see Table 6 below). While the estimated abortion rate in LAC is 44 per 1,000 WRA (15-44 years), in South and Central Asia is 37 per 1,000 and 34 per 1,000 in SSA.

Region	Estimated abortions rates per 1,000 WRA	Estimated number of abortions (millions)	% of pregnancies ending in abortion
Global	35	56.3	25%
Latin American and the Caribbean	44	6.5	32%
South Asia and Central Asia	37	15.7	25%
Sub-Saharan Africa	34	6.4	16%

Table 5. Abortion estimates by region

Source: Sedgh et al. (2016a)

Ganatra et al. (2017) found that the proportion of safe abortions was 25% or less in LAC and SSA, except for Southern Africa where safe abortion procedures have increased due to the liberalization of abortion laws in the region. While most unsafe abortions in LAC fell under the 'less safe' category, most unsafe abortions in SSA were categorized as least safe (lbid.) (see Table 7 below).

Table 6. Classification of abortion by safety, globally and regionally

Region	Safe abortion (%)	Less safe abortion (%)	Least safe abortion (%)
Global	54.9	30.7	14.4
Latin America and the Caribbean	23.6	59.7	16.7
South and Central Asia	42.2	44.9	12.9
Sub-Saharan Africa	31.1	25.1	68.8

Source: Ganatra et al. (2017)

In these three regions, as it is the case for the rest of the world, poor and rural women are more likely to experience unsafe abortion and severe complications (Singh et al. 2018). LAC has the smallest number of

maternal deaths associated with unsafe abortions, likely due to having better functioning health systems and better access to care to treat complications when they occur (Ganatra et al. 2017). In contrast, postabortion care remains of poor quality in South Asia and SSA (Singh et al. 2018). Moreover, there has been a decreasing trend in abortion-related deaths, resulting in great part from an increase in the use of medical abortion, which has replaced unsafe abortion methods in many contexts, particularly where abortion is illegal or restricted (Barot 2018).

2.5.1 Latin America and the Caribbean

Abortion rates in LAC vary at the sub-regional level and between married and unmarried women (See Table 8 below). This region shows the highest rate of unintended pregnancy in the world, at 96 per 1,000 WRA. An estimated 14 million unintended pregnancies occur each year in the region, and nearly half (46%) end in abortion.

Region	Estimated number of abortions (millions)	Abortion rate per 1,000 WRA	Abortion rate (per 1,000 WRA) Married women	Abortion rate (per 1,000 WRA) Unmarried women
Latin America and the Caribbean	6.5	44	48	29
Central America	1.3	33		
South America	4.6	48		
Caribbean	0.6	59		

Table 7. Abortion estimates (LAC)

Source: Singh et al. (2018) & Sedgh et al. (2016)

Every year, about 760,000 women in the region are treated annually for complications from unsafe abortion, and at least 10% of all maternal deaths (900 deaths) are from unsafe abortion (Singh et al. 2018). But the region is experiencing a decrease in complications and maternal mortality and morbidity caused by unsafe abortions conducted with dangerous methods¹⁷ which is associated with the expansion in use of medical abortion (Ganatra et al. 2017; Jelinksa & Yanow 2018; Singh et al. 2018).

¹⁷ Dangerous and unsafe abortion methods include: "drinking toxic fluids such as turpentine, bleach, or drinkable concoctions mixed with livestock manure; inflicting direct injury to the vagina or elsewhere—for example, inserting herbal preparations into the vagina or cervix; placing a foreign body such as a twig, coat hanger, or chicken bone into the uterus; or placing inappropriate

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According to Singh et. Al (2018) more than 97% of WRA in LAC live in countries with restrictive abortion laws. Abortion is banned altogether in 5 countries, and fewer than 3% of the region's women live in countries where abortion is broadly legal or allowed without restriction as to reason or on socioeconomic grounds.

Table 8. Countries and territories in LAC can be classified into six categories, according to the reasons which abortion is legally allowed.

Reason	Countries and territories
Prohibited altogether (no explicit legal exception)	Dominican Republic, El Salvador, Haiti, Honduras, Nicaragua
To save life of woman	Antigua and Barbuda, Brazil (a), Chile (a,c), Dominica, Guatemala, Mexico (a,c,e), Panama (a,c,d), Paraguay, Suriname, Venezuela
To safe life of woman / preserve physical health *	Argentina (a), Bahamas, Bolivia (a,b), Costa Rica, Ecuador, Grenada, Peru
To save life of woman/preserve physical or mental health	Colombia (a,b,c), Jamaica, St. Kitts and Nevis, St. Lucia (a,b), Trinidad and Tobago
To safe life of woman / preserve physical or mental health / socioeconomic reasons	Barbados (a,b,c,d), Belize (c), St. Vincent and Grenadines (a,b,c)
Without restriction as to reason	Cuba (d), Guyana, Puerto Rico, Uruguay (d)

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. Notes: Some countries also allow abortion in cases of (a) rape, (b) incest or (c) foetal anomaly. Some countries restrict abortion by requiring (d) parental authorization. In Mexico, (e) the legality of abortion is determined at the state level, and the legal categorization listed here reflects the status for the majority of women.

Source: Guttmacher Institute (2018b)

2.5.2 South Asia

The annual rate of abortion for South Asia is an estimated 37 per 1,000 (See Table 10 below). The proportion of all pregnancies ending in abortion each year is estimated at 25%. Abortion is broadly legal in India and Nepal, and allowed to save the woman's life in Afghanistan, Bangladesh and Bhutan (in case of

medication into the vagina or rectum. Unskilled providers also improperly perform dilation and curettage in unhygienic settings, causing uterine perforations and infections. Methods of external injury are also used, such as jumping from the top of stairs or a roof or inflicting blunt trauma to the abdomen" (Haddad & Nour 2009: 123-124).

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rape or incest). The Maldives and Pakistan allow abortions to save the woman's life and preserve her physical health.

Region	Estimated number of abortions (millions)	Abortion rate per 1,000 WRA	Abortion rate (per 1,000 WRA) Married women	Abortion rate (per 1,000 WRA) Unmarried women
Asia	35.5	36	36	24
Central and South Asia	15	37		

Source: Singh et al. (2018) & Sedgh et al. (2016)

Table 10. Countries and territories in South Asia can be classified into six categories, according to the reasons which abortion is legally allowed.

Reason	Countries and territories
Prohibited altogether (no explicit legal exception)	
To save life of woman	Afghanistan, Bangladesh, Bhutan (a, b), Sri Lanka
To save life of woman / preserve physical health *	Maldives (e), Pakistan
To save life of woman/preserve physical or mental health	
To safe life of woman / preserve physical or mental health / socioeconomic reasons	India (a, c, d, g)
Without restriction as to reason	Nepal (f)

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. Notes: Some countries also allow abortion in cases of (a) rape, (b) incest or (c) fetal anomaly. Some restrict abortion by requiring (d) parental or (e) spousal authorization. Countries (f) that have abortion laws that prohibit sex-selective abortions, and countries that (g) ban sex-selective abortion as part of a separate fetal imaging law.

Source: Guttmacher Institute (2018c)

2.5.3 Sub-Saharan Africa

Between 2010-2014, an estimated 8.2 million induced abortions occurred each year in Africa, from which 6.3 million took place in SSA (Singh et al. 2018). The annual rate of abortion in the region is an estimated

33 per 1,000 WRA. In addition, an estimated 21.6 million unintended pregnancies occur each year in Africa and 38% end in abortion (Ibid.)

Region	Estimated number of abortions (millions)	Abortion rate per 1,000 WRA	% of pregnancies ending in abortion	Abortion rate (per 1,000 WRA) Married women	Abortion rate (per 1,000 WRA) Unmarried women
Africa	8.2	33	38 %	26	36
Sub-Saharan Africa	6.3	33	16%		
Western Africa	2.2	31	12%		
Middle Africa	1	34	13%		
Eastern Africa	2.7	34	14%		
Southern Africa	0.5	35	24%		

Table 11. Abortion estimates (Sub-Saharan Africa)

Source: Singh et al. (2018) & Sedgh et al. (2016)

In SSA, 31% of abortion are categorized as safe, 25% as less safe and 44% as least safe (Ganatra et al. 2017). Most unsafe abortions are categorized as least safe abortions, particularly in Central, Western and Eastern Africa, with a 69%, 52.1% and 46.9% incidence of least safe abortions respectively (Singh et al. 2018). These sub-regions also have the highest maternal deaths related to unsafe abortion. In contrast, Southern Africa has the highest incidence of safe abortions (73.5%). Gebremedhin et al. (2018:130) underline that "the burdens of unsafe abortion and its associated maternal mortality are disproportionately higher for women in Africa than in any other developing region". In 2014, at least 9% of maternal deaths (16,000) in Africa were caused by unsafe abortions (Singh et al. 2018).

There has been progress in Africa in relation to expanding legal access for abortion, as nearly half of the countries that liberalized their abortion laws in the past 25 years are in this continent (Center for Reproductive Rights 2019). Abortion is banned altogether in four countries and four others have relatively liberal abortion laws.

Table 12. Countries and territories in SSA can be classified into six categories, according to the reasons which abortion is legally allowed.

Reason	Countries and territories	
Prohibited altogether (no explicit legal exception)		
To save life of woman	Congo-Brazzaville, Côte d'Ivoire, Guinea-Bissau (e), Madagascar, Malawi, Mali (a,b), Mauritania, Nigeria, Senegal, Somalia, South Sudan, Sudan (a), Tanzania, Uganda	
To safe life of woman / preserve physical health *	Benin (a,b,c) Burkina Faso (a,b,c), Burundi, Cameroon (a), Cen. African Republic (a,b,c), Chad (c), Comoros, Djibouti, Equatorial Guinea (d,e), Ethiopia (a,b,c), Guinea (a,b,c), Kenya, Lesotho (a,b,c), Niger (c), Rwanda (a,b,c), Togo (a,b,c), Zimbabwe (a,b,c)	
To save life of woman/preserve physical or mental health	Angola (b,c,d), Botswana (a,b,c), Congo-Kinshasa (a,b,d), Eritrea (a,b), Gambia, Ghana (a,b,c), Gabon (a,b,c), Liberia (a,b,c), Mauritius (a,b,c,d), Mozambique (a,b,c), Namibia (a,b,c), Seychelles (a,b,c), Sierra Leone, Swaziland (a,b,c)	
To safe life of woman / preserve physical or mental health / socioeconomic reasons	Zambia (c)	
Without restriction as to reason	Cape Verde, São Tomé and Príncipe, South Africa	

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. Notes: Some countries also allow abortion in cases of (a) rape, (b) incest or (c) fetal anomaly. Some restrict abortion by requiring (d) parental or (e) spousal authorization.

Source: Guttmacher Institute (2018d). Some of the information has been updated to reflect recent liberalization of abortion laws in the region.

2.6 ECONOMICS OF ABORTION

Costs for abortion procedures depend on the type of provider, intervention, and the cost of living based on a specific region or country. Singh et al. (2018) indicate that there is wide variation by country—while women in South Asia pay an average of \$21 for a first-trimester abortion, women in SSA pay \$38, and those in LAC pay \$76.

A recent study by Lince-Deroche et al. (2020) estimates that current costs for safe and less safe¹⁸ procedures total US\$525.9 million annually across all LMICs, and that the average direct cost for providing safe abortion methods—including both medical and surgical—is approximately US\$12 per woman. In contrast, "the average direct cost of providing PAC for either shock, sepsis, uterine perforation or haemorrhage is roughly US\$75, and providing PAC for all of these complications would cost an average of roughly US\$300 per women served" (Ibid. 2020:7-8).

Total annual health-system costs of providing post-abortion care in LMICs is estimated at US\$ 869.4 million (Ibid.2020). However, meeting all PAC needs comprehensively, and following WHO recommended guidelines, would instead require an additional US\$ 1.5 billion. As Table 14 shows, if all unsafe abortion were to be provided under safe conditions, PAC costs would reduce significantly, and the combined cost for providing abortion and PAC services to health systems in developing regions for would decrease 45%, from current total costs.

Table 13. Current abortion services and PAC costs, investment needed and potential savings for alldeveloping regions

Cost	Current cost of abortion services [*] and PAC ¹⁹	100% coverage of PAC and current level of cost for abortion services*	100% coverage of safe abortion services and PAC ^{**20}
Abortion services	\$ 525.9 million	\$ 525.9 million	\$ 642.9 million
РАС	\$ 869.4 million	\$ 1.5 billion	\$ 119.3 million
Total	\$ 1.4 billion	\$ 2.3 billion	\$ 762.2 million

*Safe and less safe procedures; "Least safe" abortion services are assumed to be provided outside of the health system, or selfinduced, and as a result, no costs are included.

** A low level of PAC persists due to complications from safe abortion

Source: Lince-Deroche et al. (2020)

Moreover, the increasing trend in the use of medication (typically misoprostol) in treating incomplete abortion could lead to a decline in post-abortion care costs in the future (Ibid). This is mainly because the

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¹⁸ "Least safe" abortion services are assumed to be provided outside of the health system, or self-induced, and as a result, the authors of the study do not include costs for this category.

¹⁹ In the current coverage scenario, Lince-Deroche et al. (2020) included all costs for providing postabortion care (PAC) for abortionrelated complications.

²⁰ For the all-needs-met scenarios, the Lince-Deroche et al. (2020) assumed that abortions would continue to happen under current, country-specific conditions, but that all need for PAC would be met. Then, they assumed that all abortions would be provided in safe conditions (requiring hypothetical liberalisation of laws and full access to care). Some need for PAC would persist due to low levels of complications from safe abortion. The authors assumed that all need for this PAC would be met.

"use of mifepristone in safe manual aspirations (MA) regimens results in higher costs than for surgical safe abortion methods, due to the relatively high cost of mifepristone; however, the average cost of offering a safe MA is still lower than the average cost of offering PAC for severe complications from unsafe abortion" (Lince-Deroche et al. 2020:7-8).

Fulfilling the unmet need for modern contraception, which would, in turn, decrease the need for postabortion care, would cost significantly less than the current average expenditure of post-abortion care – one year of modern contraceptive services and supplies would only require 3–12% of the average cost of treating a woman for post-abortion care (Vlassof et al. 2016).

Besides the cost in human lives and health, the financial burden of post-abortion care on national health systems is substantial, often depleting resources from already under-resourced and weak health care systems and exceeding the total per capita health expenditure considerably (Guttmacher Institute 2016; Singh et al. 2018). Vlassof et al. (2016) conducted a comparative analysis of post-abortion care costs in Colombia, Ethiopia, Rwanda, and Uganda and found that post-abortion care from unsafe abortion range from \$334 in Ethiopia to \$972 in Colombia for each woman. These costs represent a significant proportion of the annual per capita income in these countries—11% Colombia, 29% in Rwanda, and 35% in Ethiopia and Uganda.

Experts have also proposed a methodological and analytical framework to understand the economic implications of seeking and procuring an abortion. Coast et al. (2019) suggest that there should be a deeper consideration of the broader economic impact of abortion care-seeking, beyond out-of-pocket expenses or the monetary cost of abortion procedures. For example, identifying other indirect costs that abortion patients incur—such as forgone work or education, loss of time, productivity and income, transport, food and accommodation expenses—would provide a better understanding of both the factors influencing access to safe abortion services, as well as the economic and social impact of abortion care and abortion policies at the micro, meso, and macro levels.

2.7 BARRIERS TO SAFE, LEGAL AND AFFORDABLE ABORTION

In countries where abortion is denied, anti-abortion policies and laws are the main reason women and people fail to access comprehensive, safe abortion care. Nonetheless, even in contexts where abortion is widely permitted, women face significant barriers to accessing safe and legal abortion services, which in turn makes unsafe and illegal abortions highly prevalent (de Vries et al 2020; Puri et al. 2019; Singh et al. 2019). For example, a recent report by Sonke Gender Justice (Mabaso 2019) underlines that nearly 54% of the 260,000 abortions that take place each year in South Africa are unsafe abortions. The report suggests that although South Africa has one of the most progressive abortion laws in the region, health care providers often stigmatize and discriminate women seeking abortion, affecting the quality of delivery of abortion services.

Similarly, in Nepal where abortion has been legal since 2002, 58% of abortions that occur every year are categorized as unsafe (Puri et al. 2019). Barriers to safe abortion involve difficulties in locating providers that can administer abortion, inadequate services in health care facilities, women's lack of knowledge of the legal status of abortion and stigma (Puri et al. 2019; Singh et al. 2018). This shows how even in contexts where abortion is broadly legal, outdated penal codes and inadequate budget allocation towards resources and health care infrastructure reduce accessibility to comprehensive, safe and legal abortion services and supplies.

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Other barriers include women's lack of awareness of the legal status of abortion, gender norms that hinder women's decision-making autonomy, fear of abortion-related stigma, socioeconomic status and geographical location, with poorer women and those living in rural and remote areas facing greater challenges (Assifi et al. 2016; Mabaso 2019; Puri et al. 2019; Singh et al. 2018). In addition, providers' lack of awareness and misinformation of existing abortion legal frameworks resulting from a lack of specific abortion guidelines also hamper the provision of safe abortion (de Vries et al. 2020).

Furthermore, abortion remains a controversial or 'taboo' topic all around the world, and stigma remains significantly prevalent even in countries where abortion has been fully legalized, often representing a key barrier to safe abortion care (de Vries et al. 2020; Makleff et al. 2019). Makleff et al. (2019) found that factors that influenced negative feelings about abortion, include the role of community stigma and social norms related to religion, sexual activity, motherhood, responsibility for contraception, procreation and sexual mores for young and unmarried women. In SSA, for example, "whether the law is liberal or restrictive, abortion is commonly stigmatized and frequently censored by political and religious leaders, and a public stigma of abortion pervades local discourse" (Blystad et al. 2019:2)

CHAPTER 3: THE FUNDING LANDSCAPE OF CONTRACEPTION AND ABORTION SERVICES AND SUPPLIES (2015 – 2020)

3.1 FAMILY PLANNING POLICY AND FINANCING ENVIRONMENT

According to new estimates presented by the Guttmacher Institute (Sully et al. 2020), providing modern contraceptives services and supplies²¹ to 705 million users in developing regions costs \$7.1 billion or \$1.10 per person. Fulfilling the unmet need of all users in developing regions (an additional 218 million) would require \$12.6 billion or \$1.94 per person per year. Fully meeting the needs for modern contraceptive services and maternal and newborn care would cost \$77.4 billion. Integrating modern contraceptive services and maternal newborn care²² would yield in savings of \$10.8 billion, at a cost of \$66.6 billion, as compared to investing in these two areas separately (Ibid.).

Meeting these estimated costs for family planning and contraceptive services and supplies will require tremendous efforts. Fortunately, in recent years, international fora such as the London Summits on Family Planning in 2012 and 2017; ICPD 2014 and 2019; the UN Commission on the Status of Women and the 2030 Agenda for Sustainable Development have seen government officials, global leaders, civil society organizations, advocates and young people reaffirming their commitment to ensuring that every woman

²¹ These estimates include direct costs (contraceptive commodities, drugs, supplies and health workers salaries all of which are required to provide clients with information and counselling, a range of methods, and removal services for implants and IUDs), and programs and systems costs (critical health systems elements, such as program management, staff supervision and training, infrastructure and equipment, and commodity and information management systems) (Sully et al. 2020).

²² Estimates for maternal and newborn health care include direct costs (antenatal care, delivery and postnatal care, newborn care, HIV care for pregnant women and newborns, abortion and post abortion care) (Sully et al. 2020).

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and girl can access comprehensive and affordable family planning, including contraception and safe abortion as crucial components of these services.

Funding for family planning ²³ goes to a variety of activities, including commodity procurement, programming, capacity strengthening, technical support, advocacy, and research and development (Countdown2030 2018). There are multiple stakeholders involved in financing and procuring family planning services, including contraception and abortion services and supplies. These include donors, multilateral institutions ²⁴; partnerships, coalitions and movements (such as the UNFPA Supplies programme, Reproductive Health Supplies Coalition, Every Woman Every Child's Global Strategy for Women's, Children's and Adolescents' Health, FP2020, GFF and SheDecides), country governments in developing regions, NGOs and foundations, the private sector, research institutions, and advocacy networks. All these stakeholders influence the international policy and financing environment around contraception and abortion services and supplies.

3.1.1 Donor government funding towards family planning and contraceptive supplies

SRHR donor funding for family planning increased from 6% (US\$1.1 billion) in 2011 to 10% (US\$1.3 billion) in 2015, but it fell again in 2016 (8%) and 2017 (9%) (Schäferhoff et al. 2019). According to Kaiser Foundation, donor government funding for family planning increased from US\$1.1 billion in 2011 to US\$1.5 billion in 2018²⁵, reaching its highest level (see Figure 1) (Kates & Wexler 2019). New commitments emerging from the 2017 London Summit on Family Planning might have prompted such increments (Schäferhoff et al. 2019).

Ten donor countries account for 98% of the total funding for family planning and contraceptive supplies in recent years—Australia, Canada, Denmark, France, Germany, the Netherlands, Norway, Sweden, the United Kingdom and the United States (Kates & Wexler 2019).

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²³ "European donors' funding in the area of family planning and contraceptive supplies goes towards a broad range of activities: filling the gap in contraceptives supply at country level, improving international information flows and transparency of procurement processes, providing technical support and negotiating deals at global level, Supporting development of sustainable reproductive health commodity security processes and structures at country level through supply chain strengthening, capacity building and technical support to improve efficiency and efficacy; promoting advocacy to increase country ownership and commitment; providing contraceptive supplies in humanitarian and emergency situations and market shaping. Some donors focus *specifically* on commodity supply, which gives more tangible and visible results than more integrated approaches. Other organizations also propose a specific focus on contraceptive supplies on the grounds that donors can only have an impact on some elements of sexual and reproductive health and rights and that focusing on contraceptive supplies will at least help solve one important problem area" (Countdown2030 2018).

²⁴ For a description of each of these initiatives, see Annex 1.

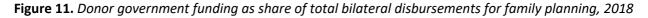
²⁵ Latest available data/year on donor government funding at the time of drafting this review

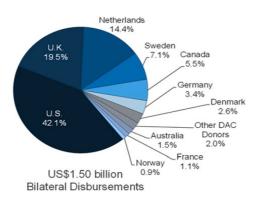


Figure 10. Donor government bilateral funding for family planning and contraceptive supplies

Source: Kates & Wexler (2019)

Since the London Summit²⁶ in 2012, eight donors have raised their funding for family planning and contraceptive supplies (Canada, Denmark, Germany, the Netherlands, Norway, Sweden, the UK, and the US), resulting in an increase of funding by \$405 million up until 2018 (Kates & Wexler 2019). Donor contributions to the UNFPA have also increased, with five donors (Canada, Denmark, the Netherlands, Norway, and Sweden) expanding bilateral funding by two times or more over the same period. In 2018 the United States was the leading donor, accounting for 42% of all donor funding. The second-largest donor was the United Kingdom with 19%, followed by the Netherlands (14%), Sweden (7%) and Canada (5%) (See Figure 4 below).





Source: Kates & Wexler (2019)

Besides the donor community, other significant funding sources are multilateral organizations, the private sector, domestic resources and household expenditures. UNFPA is the leading multilateral agency focusing on family planning and contraception, with an estimated expenditure of \$356.2 million in 2018 (Ibid.). The World Bank also provides multilateral assistance in this area and hosts the Secretariat for the Global

²⁶ During the London Summit on Family Planning in 2012, the global community pledged to increase contraceptive access to an additional 120 million women and girls by 2020.

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Financing Facility (GFF) (Ali & Bellows 2018). It is important to note, however, that UNFPA and other multilateral institutions are not donors; they receive donor funds themselves and channel them to governments and other recipients (Countdown 2030 2018).

Developing countries vastly rely on funding from the private sector (foundations, INGOs, NGOs, and companies) for supporting their family planning programmes. The Bill and Melinda Gates Foundations is one of the major funders of family planning providing \$296 million in 2018. It is also one of the core partners of the FP2020 initiative (Ibid.) Also, some pharmaceutical companies have entered a partnership with donors to provide contraceptive at significantly reduced prices (Ibid). Among the main INGOs working around contraception and abortion services and supplies, are Marie Stopes International (MSI), the International Planned Parenthood Federation (IPPF), Population Services International (PSI), and DKT International (Ibid.).

Another primary funding source for family planning is developing countries governments' public sector expenditures, which are also supported by international assistance. Efforts such as FP2020 and the GFF aim to support country governments in becoming less donor-dependent and increasing country ownership, by mobilizing domestic resources to expand access to family planning and contraceptive procurement. For example, since 2012, 46 out of the FP2020 69 priority countries have made commitments to increase domestic family planning spending (Kates & Wexler 2019). This has been a critical step towards the sustainability and success of family planning programmes in developing regions (Countdown 2030).

Household and individual, or out-of-pocket expenditures, represent the most substantial portion of the funding towards family planning (Ali & Bellows 2018). Lie et al. (2015) underline that households and individuals are the major sources of funding for reproductive, maternal, newborn and child health, contributing to 49% of total expenditure in these areas in 12 developing countries. In contrast, country governments and donor funding contribute 21% and 30% respectively.

Out-of-pocket spending on contraceptive commodity supplies has socioeconomic and gender implications which can lead to an increase in economic and gender inequalities (Countdown2030 2018). Therefore, current and future efforts to decrease unmet need for contraception and expand services should be addressed through an equity lens to be mindful of consumers' out-of-pocket costs and the impact they can have in deepening already existing inequalities.

EU funding

Since 2015, European donors have taken a leading role in pushing for global progress and support towards fulfilling global commitments in sexual and reproductive health and family planning (SRH/FP) (Countdown2030 2019).²⁷ Many EU governments have made commitments following pledges as part of initiatives such as the FP2020, the GFF and SheDecides (Ibid). Furthermore, the European donor community has also been a prominent champion for the inclusion and monitoring of SRH/FP in the SDGs (Ibid).

A recent analysis by Countdown2030 (2019) shows that international policy focusing on SRH/FP has increased within EU countries, which can be seen in policy stances from governments and donors. Many

²⁷ For a thorough review of specific policy and funding commitments from EU governments and donors towards family planning and contraceptive supplies financing see Countdown 2030 (2018; 2019a; 2019b)

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governments' policy frameworks now include SRH/FP as a core component to achieving gender equality, well-being and education. Also, Finland, Sweden, Denmark and the Netherlands have prioritized SRH/FP in humanitarian and fragile contexts. After recent US' funding cuts to the UNFPA, EU governments and donors have also stepped in to mobilize financial resources and help offset the agency's financial loss (Countdown 2019; Kate & Wexler 2019).

Canadian funding

Canada's Feminist International Assistance Policy (FIAP) released in 2017 focuses on women's rights as human rights. This includes sexual and reproductive rights, and the right to access safe and legal abortions (Global Affairs Canada 2017). The Canadian government has advance efforts to close persistent gaps in SRHR by supporting an investment of \$650 million from 2017 through 2020. In 2019, Prime Minister Justin Trudeau announced that Canada would increase its funding towards global SRH to \$700 million a year through 2023, as part of a \$1.4 billion commitment for global health (Action Canada for Sexual Health and Rights 2019). Canada will prioritize investments in the most neglected and stigmatized areas of SRHR– including comprehensive contraceptive care, safe and legal abortion, adolescent SRHR (including comprehensive sexuality education), support for advocacy, and emphasising SRHR in emergency and conflict settings. According to Oxfam Canada (2019) this funding has the potential to empower 18 million and adolescents around the world.

US funding

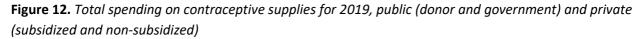
As the leading donor of international family planning assistance, the United States plays a substantial role in providing essential reproductive health services that save the lives of millions of women and children worldwide. The US also provides significant technical and policy support to country governments, multilateral organizations, and NGOs in the implementation of family planning programmes.

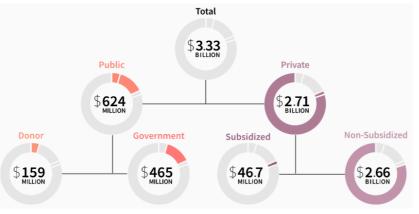
In 2017, the US contributed \$607.5 million. This provided 25 million women and couples with contraceptive services and supplies, preventing 7.4 million unintended pregnancies, 3.1 million abortions, and 15,000 maternal deaths (Barot 2018). In 2018, funding from the US increased to \$630.6 million, but this was a result of the timing of disbursements rather than an actual increase in US appropriations by Congress, which have remained the same since 2011, at approximately \$630 million (Kates & Wexler 2019). Moreover, the US is also the largest donor of contraceptive commodities, contributing 46% of all donor-funded contraceptives in the 69 FP2020 priority countries between 2012 to 2016 (Countdown2030 2018).

However, the current Trump-Pence administration is threatening to cut back the benefits from global family planning and reproductive health programmes financed by the US. The reintroduction of the Mexico City Policy, and its unprecedented expansion, along with the withholding of funding to the UNFPA and other proposed budget cuts to the US family planning program, are some of the relevant changes in US funding under the Trump administration which go against the progress on global sexual and reproductive health and rights. Besides, the US has yet to fulfil its commitment towards international family planning aid—currently at \$1.5 billion, which is based upon concerted efforts made at the ICPD 1994 in Cairo (Ibid).

Contraceptive commodity procurement

A key element in the funding of family planning services is contraceptive commodity procurement. A recent commodity gap analysis by the Reproductive Supplies Health Coalition (Weinberger et al. 2019) indicates that in 2019, total expenditure on contraceptive supplies across developing regions was \$3.33 billion.





Source: Weinberger et al. (2019)

Household and individuals' out-of-pocket expenditures in lower- and middle-income countries for purchasing contraceptives are significantly higher than contributions from domestic governments and donors (Ali & Bellows 2018). In 2019, this group had the largest share of spending with over 80%. Governments spent almost three times more than donors with a share of 14% and that of donors at 5% (see Table 15 below).

Table 14. Shares of spending	on contraceptive	procurement in develop	ina reaions (2019)

All 135 LMICs	Actual % share
Donors	5%
Domestic governments	14%
Individuals	81%

Source: Weinberger et al. (2019)

Multiple sources indicate that international funding for contraceptive commodity procurement is decreasing and will either continue to decline or will remain stagnant in the next years (Countdown2030 2018; Schäferhoff et al. 2019; Weinberger et al. 2019;). Moreover, although there has been an increase in commitments to family planning and contraceptive supplies, neither donors nor country governments have been able to harmonize funding available with the increasing demand for contraception in developing regions (Mukasa et al. 2017).

Issues related to supply-chain management in developing countries are associated with inadequate domestic and international funding for the procurement of commodities. In particular, the lack of

consistent and sustained donor funding negatively impacts the supply chain and contributed to high stockout rates in developing regions (Mukasa et al. 2017).

Funding for contraceptive commodities is facing a crisis. UNFPA, the largest provider of donated contraceptives, has said that it is facing a current funding gap of almost \$700 million throughout 2020. The agency cites that 'without products, there will be no progress' and has stated that without filling this gap it will not be able to sustain its work and serve growing target populations (UNFPA 2017). Besides, Weinberg et al. (2019) estimated the contraceptive commodity funding gap to be \$176 million in 2020, which will continue to increase up to a 5-year cumulative gap funding of \$1.7 billion in 2025 (see Table 16 below).

Table 15. Contraceptive commodity projected funding gap 2019 and 2025, assuming donor, governmentand individual spending in the private sector stays at current level

Year	Spending	Gap
2019	\$3.33 billion	\$175 million
2020	\$3.51 billion	\$178 million
2025	\$3.6 billion	\$266 million
Cumulative	\$17.8 billion	\$1.17 billion

Source: Weinberger et al. 2019

3.2 A CHALLENGING AND COMPLEX POLICY AND FUNDING ENVIRONMENT

Many country governments and other relevant stakeholders are reluctant to increase their economic and political support to SRHR. One of the significant challenges for meeting funding gaps and increasing access to contraception and abortion services and supplies is the lack of political will of many governments, as well as the increasing presence of conservative leaders and groups in policy spaces who not only oppose but who are advancing policy and legislative changes at the national and international levels which threaten progress achieved around gender equality and SRHR, particularly around its sexuality and rights component.

In 2019, during the 74th United Nations General Assembly's High-level Meeting on Universal Health Care (UHC) some governments, including the Trump administration, tried to remove SRHR and gender equality language from the UHC political declaration (Glenza 2019). A coalition of countries, however, opposed this action and succeeded in keeping the reference to SRHR and women's rights in the declaration. Another example of anti-SRHR sentiment is evidenced in the fact that European anti-abortion organizations have spent ≤ 2.1 to ≤ 3.1 million annually for lobby and advocacy activities in the European Parliament and other European institutions (Schäferhoff et al. 2019). Similarly, in the US, conservative groups are funding anti-abortion and anti-SRHR campaigns abroad, bolstering their influence in all corners of the world. The reinstatement and unprecedented expansion of the Mexico City Policy in 2017 has only fuelled and

strengthened such initiatives. These examples evidence how the current political environment might feel like a setback for the SRHR community, with civic space being challenged and anti-choice and anti-feminist sentiment being emboldened across the world.

Reinstatement of the Mexico City Policy or 'Global Gag Rule'

A report by the Partnership for Maternal, Newborn & Child Health (Schäferhoff et al. 2019:2) accurately highlights that "as the largest international funder of global health, US anti-abortion policies are particularly influential worldwide." On Jan 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) by its critics. In short, the policy forbids foreign NGOs²⁸ from receiving US bilateral health funding if they provide information, referrals, abortion services or engage in abortion advocacy, even when using their own non-US funds.²⁹ Abortion provision and care in cases of rape, incest and to save the woman's life is allowed under the policy, as it is post-abortion care. Due to these restrictions, impacted organizations are prevented from carrying out abortions and are 'gagged' from providing comprehensive care, information, counselling, advice or referrals.

The latest GGR, renamed as 'Protecting Life in Global Health Assistance Policy' (PLGHA), is an expanded version of the previous policy iterations. The Trump administration has gone further by placing unprecedented and radical restrictions that not only apply to family planning funding, but also to all US global health assistance from government departments and agencies. This includes assistance towards HIV, tuberculosis, malaria, Zika and water, sanitation, and hygiene, among other programmes. As a result, while preceding versions only affected family planning funding, which averages at \$600 million per year, the PLGHA is estimated to affect between \$8.5 to \$10.00 billion annually, an amount 15 times bigger (Ibid.). By creating or increasing barriers to accessing contraceptives, safe abortion care and other essential and life-saving SRH services, the GGR is pushing millions of lives into great danger.

The GGR is also affecting how non-US donors work with compliant organizations. NGOs face a dilemma around whether to comply with the GGR, as compliance can interfere with organizations' abilities to receive funds from non-US others (Rios 2019). In 2017 the Swedish International Development Cooperation Agency (SIDA) communicated that compliance with the GGR would interfere with its prime partners and subgrantees ability to implement SIDA's funded SRHR programmes (Edwards 2017). SIDA mentioned that this could result in the agency choosing to discontinue funding to GGR-compliant organizations.

Due to this dilemma, organizations have been "forced to choose between US and Swedish funding" (Ibid.). SIDA, which has been a vocal critic of the GGR, bases its position on setting moral standards around women's rights, which consider access to legal and safe abortion as an integral part of successful SRHR and

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²⁸ The GGR does not affect assistance to foreign governments, US organisations, multilateral agencies (such as United Nations agencies) and multilateral partnerships with other donor governments (such as the Global Fund or the GFF), including sub-grants from these organisations.

²⁹ Since 1973, all recipients of US foreign assistance are bound by the Helms Amendment (Helms) to the US Foreign Assistance Act. This amendment prohibits the use of US funds for the 'performance of abortion as a method of family planning, or to motivate or coerce any person to practice abortion'. Hence, even when the GGR is not in place, NGOs *cannot* use US federal assistance for abortion-related activities.

better health policy. However, its counter-conditionality could have significant funding implications for compliant organizations to whom SIDA might halt aid.

US decision to withhold funding to UNFPA

Since 2017, the US has withheld its annual contributions to the UNFPA by invoking the Kemp-Kasten³⁰ amendment, and stating that UNFPA supports coercive practices, such as forced sterilization and coerced abortions in China. UNFPA has rejected these allegations and has requested the US to reconsider its position (UNFPA 2019). The funds withheld amount to \$32.5 million in core support and \$38 million in non-core resources per year (Deen 2019), these restrictions have severely impacted UNFPA's programmes in conflict and humanitarian contexts, leaving some of the most vulnerable women and girls without support and care (Banwell 2020).

CHAPTER 4: THE GLOBAL GAG RULE AND ITS IMPACT ON VULNERABLE POPULATIONS

"Restrictions to women's and girls' bodily autonomy and integrity, such as the GGR, exacerbate prevailing structural barriers to accessing health. At the same time, they reinforce the continued marginalization and discrimination of women and girls on the basis of their sexual and reproductive identities. As a result, the wellbeing of households and communities reliant on the sustainable provision of care is undermined too".

Maria Tanyag³¹

This chapter provides evidence documenting the impact of previous GGR versions on abortion rates and the implications of the current GGR, also known as the 'Protecting Life in Global Health Assistance' (PLGHA) policy, on three vulnerable populations— adolescents, LGBTQI+ people and sex workers. The chapter also discusses some initiatives being implemented to mitigate the effects of the GGR.

4.1 ASSESSING THE IMPACT OF THE GLOBAL GAG RULE

The effects of the GGR are far-reaching. Foreign NGOs, primarily those from or based in developing regions, are impacted the most, as they heavily rely on foreign assistance. These NGOs are forced to either comply with the policy or lose desperately needed US federal funding. This is extremely concerning given that the US remains the largest bilateral donor to global health, including contraceptive supplies. In turn, because

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³⁰ "The Kemp-Kasten amendment, first enacted in 1985, is a provision of US law that states that no US funds may be made available to 'any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.' It was the congressional response to a Reagan Administration decision in 1984 to temporarily withhold some funding from UNFPA and begin conditioning its funding on assurances that the agency did not engage in or provide funding for abortion or coercive family planning" (Kaiser Family Foundation 2019).

³¹ Tanyag, M. (2017, March 27). 'Global Gag Rule and the Political Economy of Sexual and Reproductive Freedoms'. *Australian Institute of International Affairs*. Retrieved from: http://www.internationalaffairs.org.au/news-item/global-gag-rule-and-the-political-economy-of-sexual-and-reproductive-freedoms/

the GGR impacts foreign NGOs working developing countries the most, the policy disproportionately affects women, girls and vulnerable populations from these regions.

To date, seven peer-reviewed studies have analysed the impact of the GGR on access to sexual and reproductive health services and abortion rates. The first four studies (Bendavid et al. 2011; Jones 2015; Rodgers 2018; Brooks et al. 2019) are systematic reviews that assess the implications of previous iterations of the GGR. All four studies associate the policy with an increase in abortion rates in high exposed countries, rather than the opposite.

Bendavid et al. 2011 draw on household-level data from the DHS and look at the impact of the GGR under the George W. Bush presidency (2001-2008) on abortion rates in 20 Sub-Saharan countries. The authors found that the policy resulted in higher abortion rates in countries that depended on US funding, with women in countries that were significantly exposed to the policy being 2.55 times more likely to report induced abortions than women in less affected countries.

The second study by Jones (2015) uses DHS individual-level data from Ghana to estimate the impacts of the 1984 and 2001 versions of the GGR. The author found that during policy's implementation period, there was an increase in unintended pregnancies in Ghana, particularly in rural areas, with about 20% of rural pregnancies ending in abortions.

In a third publication, Rodgers (2018) draws on Bendavid et al.'s analysis to assess the impact of the GGR under the George W. Bush presidency, but expands the analysis beyond SSA, examining the policy's implications also in LAC, South/South East Asia, Eastern Europe and the Middle East. Rodgers analysis indicates that in LAC and SSA, the GGR increased the odds of having an induced abortion in a high exposure country by approximately 3 and 2 times, respectively. All these three studies attribute the increase in abortion rates in affected countries to the disruption of SRH services resulting from the policy, which left thousands of women without access to contraception, thereby increasing rated of unintended pregnancies and abortions.

A fourth study by Brooks et al. (2019) found that during the GRR under President George W. Bush's administration (2001-2008) abortion rates went up by 40%, there was a 14% reduction in modern contraceptive use and pregnancies increased by 12% among women in countries profoundly impacted by the policy. The authors note that after the policy was rescinded under President Obama's administration (2009-2014), the GGR effect reverse, which provides additional evidence for the policy's role in impacting abortion, contraception and fertility trends.

Two reviews and one study analyse the implications of the PLGHA, the current and expanded version of the GGR. Mavodza et al. (2019) provides an analysis of the literature which describes and maps out the impact of the current GGR on global health and identifies research and policy impacts. The authors indicated that the policy's implementation is broadly associated with poor impacts on the health system's function and outcomes.

Among the authors' main findings are that foreign NGOs experience confusion and misunderstanding of the GGR. For example, organizations have lost significant funding, which has led to a reduction or closure services. At the same time, organizations are experiencing a 'chilling effect,' which means that they often are overly compliant and overly restricting in their programmes and activities for fear of losing US funding.

The policy has also negatively impacted advocacy and coalition in SRHR spaces, especially mobilization efforts to increase and ensure safe abortion.

A second recent review by Schaaf et al. (2019) summarizes the impact of the GGR's previous iterations and provides hypotheses of the PLGHA's potential key impacts on health systems in affected countries. The review suggests that the recent increasing shift towards integrating services and healthcare means that funding disruptions will be likely to experience a domino effect under the PLHGA, and that "disruptions to funding streams, referral systems and service delivery can lead to siloing within each of these areas" (Ibid.:5).

The most recent study by Giorgio et al. (2020) assesses the PLGHA's impact in Uganda. It focuses on the policy's impact on SRH service delivery by drawing data from the 2017 and 2018 Performance Monitoring and Accountability 2020 (PMA2020) service delivery points and surveys with Ugandan women. The authors observed that the PLGHA significantly affected the number of community healthcare workers (CHWs), with those facilities more heavily affected deploying 3.8 less CHWs to provide family planning services after the reintroduction of the policy.

This reduction in CHWs could decrease the contraceptive prevalence rate and lead to more unintended pregnancies. Given that the study assessed the policy's impact after just one year of its reintroduction, the authors did not observe early impacts on other service delivery outcomes. Moreover, they suggest that in the case of Uganda, the rapid organizational responses by non-compliant NGOs to implement strategies to help absorb the impacts of the policy besides funding from non-US donors might have mitigated the GGR's potential adverse effects.

There is also significant qualitative evidence from grey literature — mainly reports and case study interviews — conducted by various NGOs, which document the adverse effects of the GGR's prior and current iterations. In the past two decades, Population Action International (PAI), in conjunction with other SRHR advocacy organizations, has documented the policy's impact in developing countries through its Access Denied series (PAI 2018). The evidence that it has collected shows that when implemented, the GGR causes significant disruptions to the provision of family planning services, including the closure of clinics, staff reductions and contraceptive shortages, which are associated with higher unintended pregnancy and abortion rates in countries affected by the policy (PAI 2020).

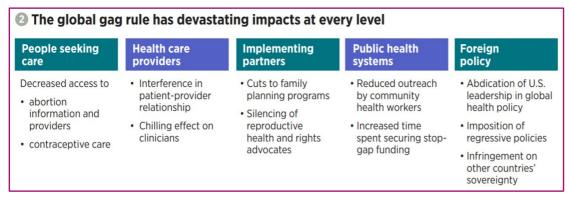
As discussed earlier, the GGR has brought severe economic implications for non-compliant NGOs. For two of the largest international organizations providing contraception and safe abortion services and supplies, Maria Stopes International (MSI) and International Planned Parenthood Federation (IPPF), non-compliance has resulted in the loss of \$100 million and \$80 million in funding through 2020, respectively (Mavodza et al. 2019). For MSI, cuts to its services under the expanded GGR resulted in an estimated 5.2 million women being denied access to services, which led to additional 6.8 million unintended pregnancies, 3.4 million unsafe abortions and more than 16,000 maternal deaths (MSI 2020). In the case of IPPF, the policy's funding gap led to a projected 4.8 million unintended pregnancies, 1.7 million unsafe abortions, and 20,000 maternal deaths (IPPF 2019).

Of course, the impact of the GGR goes beyond its economic implications. The GGR undermines progress and gains in SRHR, as well as advancement of the SDGs goals, mainly SDG 5 (Gender Equality) and targets 5.6 (providing universal access to sexual and reproductive health and reproductive rights); target 3.7 (ensuring universal access to sexual and reproductive health-care services by 2020) and target 3.1 (reducing

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global maternal mortality to less than 70 per 100 000 live births) (Bingenheimer and Skuster 2017; Pugh et al. 2017).

Figure 13. Impacts of the GGR



Source: Ahmed (2020)

Besides, the GGR forces health providers to decide between eliminating the provision of comprehensive sexual and reproductive care or declining US assistance. Non-compliance with the policy has meant that many NGOs have been forced to reduce their services, compromising the quality of care provision or having to doors to clients altogether (Rios 2019). For compliant NGOs, it means that they have to stop providing comprehensive SRH care. In many cases, this has led to a loss of trust between health providers and clients. In addition, the policy also conflicts with national legal frameworks around abortion, as 37 of 64 countries that receive development aid from the US allow for legal abortion in at least one case not permissible by GGR (Kates & Moss 2017). This discrepancy creates misunderstandings and fear, as providers have to negotiate between local legal frameworks while trying to ensure compliance with the GGR (Mavodza et al. 2019).

Critics of the Global Gag Rule have voiced that the policy puts "ideology before evidence" (Pugh et al. 2017) and that rather than protecting life, it endangers the health, well-being and the right of women and people to have bodily autonomy and make their own choices. Others have indicated that the policy has an imperialistic nature, by exporting the US "domestic ideological divide to the Global South, where women's lives are risked for political gain" (Shahvisi 2019:180).

4.2 IMPACT ON ADOLESCENTS, LGBTQI+ PEOPLE AND SEX WORKERS

"When the Trump administration attacks reproductive health providers with the Global Gag Rule, by extension it attacks LGBT and other marginalized populations who may have nowhere else to access the health care they need and deserve".

Serra Sippel³²

In this section we draw on information from NGO reports and case studies to provide an overview of the documented PLGHA's impact on adolescents, LGBTQI+ people and sex workers. Although it is too early to quantify the full impact of Trump's PLGHA, the available literature highlights that current restrictions imposed by this harmful policy is significantly affecting these vulnerable populations who already face systemic barriers to care.

Aggravation of existing barriers

The LGBTQI+ community , sex workers, adolescents and economically disadvantaged women already experience severe barriers in accessing comprehensive SRHR services. Due to the GGR, vulnerable populations will face greater challenges in obtaining safe abortion care, family planning and contraceptive services, HIV/AIDS testing and treatment, screening for cervical cancer, breast cancer, prostate cancer, and support for survivors of gender-based violence (Rios 2018). Some of the health facilities affected by the policy and which provide integrated services, including sexual and reproductive health care, are the only providers of primary healthcare to these populations and hence their closure might dissolve these groups' only contact with the health system.

Disruption of service delivery

The first identified impact of the GGR is the disruption of SRHR-services for vulnerable populations. According to MSI's website (MSI 2019), the funding gap experienced due to non-compliance with the GGR forced the organization to close an outreach programme in Uganda that provided contraceptive care to remote communities. In Zimbabwe, MSI had to reduce the number of outreach sites in half, from 1,200 to only 600. Similarly, an NGO in South Africa who did not comply with the policy was forced to close an on-premise safe abortion clinic (Mabaso 2019). The clinic had been operating since 2000 and served disadvantaged populations, mainly migrant women, adolescent girls and low-income women.

IPPF reported that in Ethiopia, the GRR has put at risk 10 clinics that provide HIV and STI prevention and family planning services to 15,000 sex workers (IPPF 2020). In Cambodia and Malawi, the policy has led to the fragmentation of previously integrated HIV/SRHR services for sex workers and MSM (Frontline AIDS 2019). A sex worker-serving organization in Kenya chose to comply with the GGR because they feared their clients would be left without urgent HIV/AIDS services if they faced funding restriction. In turn, the organization stopped its partnership with a safe abortion service provider, compromising their clients' needs for comprehensive abortion care (Rios 2019).

Significant impacts to adolescent- and youth-friendly programmes

³² Sippel, S. (2018, June 5). 'The collateral damage of Trump's Global Gag Rule: LGBT Rights'. *Advocate*. Retrieved from: https://www.advocate.com/commentary/2018/6/05/collateral-damage-trumps-global-gag-rule-lgbt-rights

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The GGR increases the vulnerability of adolescents and young people. Many non-compliant NGOs understand the needs of adolescents and young girls and prioritize the implementation of youth-friendly programmes. These organizations are now being forced to reduce their services and programmes, leaving already-vulnerable adolescents and young people at a higher risk of HIV, STIs and unintended pregnancies (CHANGE 2018; Rios 2019).

In Mozambique, the Associção Moçambicana Para o Desenvolvimento da Família (AMODEFA) had to drastically reduce its provision of HIV services for adolescent girls and young women (AGYW) and closed a US-funded programme that aimed to increase health services for adolescents and young people, including HVI, STIs and family planning services (Ibid.). AMODEFA also had to close 10 of its 20 youth-friendly clinics in the country. Another organization in Mozambique had to stop a project that reached 14,000 adolescent girls and young women with information and services on HIV and economic empowerment because their prime partner could not comply with the GGR. In Kenya, an organization's funding loss meant that 40,000 adolescent girls and young women would lose access to family planning services and contraceptives (Rios 2019).

Further, LGBTQI+ youth are severely affected too, as the GGR will impact organizations that run youth programmes which address young people's specific needs (CHANGE 2018). Young lesbian and young bisexual women are particularly affected by the policy. In certain regions they can experience higher rates of unintended pregnancy compared to heterosexual women, which may be due to lower contraceptive use and sexuality education that is not inclusive of LGBT people. Organizations that do promote an inclusive approach to sexual and reproductive health care for LGBTQI+ youth are often affected by the GGR (Sippel 2018).

Erosion of 'safe spaces'

SRHR groups and organizations have long been allies of LGBTQI+ people and sex workers. NGOs working on SRHR provide safe spaces for these populations, welcoming them and facilitating peer-to-peer support opportunities for them (CHANGE 2018; Frontline AIDS 2010). Thus, by forcing organizations to limit service provision or close their facilities, the GGR also erodes safe spaces for disadvantaged groups. Marginalized populations are left vulnerable without these spaces and are forced to visit public or private health facilities where they might face stigmatization and discrimination. As a result, they might decide to stop visiting health centres altogether and compromising their health and wellbeing (Frontline AIDS 2019).

For instance, the clinic that provided safe abortion services in South Africa was also a safe environment where underprivileged women and adolescents were treated with respect, confidentiality and dignity, a treatment they do not always get at public health facilities and other private clinics (Mabaso 2019). In Malawi, where men who have sex with men (MSM) are highly stigmatized, the GGR has led to a reduction of tailored services and the closure of safe spaces for this group (Frontline AIDS 2019). Similarly, the Botswana Family Welfare Association (BOFWA) did not certify the PLGHA and had to close HIV clinics in two districts. As a result of this action, the organization expected HIV services to be scaled down by 62.3% (Schaaf et al. 2019). In turn, MSM and female sex workers had no other choice than discontinuing care in safe spaces at BOFWA and had to be referred to government facilities against their wishes.

Escalation of anti-SRHR, anti-LGBTQI+ and anti-sex work rhetoric and sentiments

Since the reintroduction of the policy, much of the reallocated funding has gone towards faith-based and conservative organizations with vocal anti-SRHR, anti-LGBTQI+, anti-sex work rhetoric and policies (Samuels & Redner 2019). As such, the GGR is helping to strengthen anti-rights groups that oppose sexual and reproductive rights and women's rights. For example, in South Africa, the US Embassy issued funding that focused on promoting traditional and heteropatriarchal family models through the implementation of abstinence-only programme across 90 schools, including to LGBTQI+ students (Ibid 2019). The diversion of funds towards anti-rights organizations is serving to promote initiatives that go against the fundamental human rights of vulnerable populations.

Increasing economic inequality

Restrictions and loss of funding caused by the GGR mean that more costs are being passed on to service users, as they are now the ones who bear the burden of paying additional costs for SRH services that used to be free or subsidized before the reintroduction of the GGR. For example, Marie Stopes Madagascar had to stop its voucher programme which provided 170,000 free contraceptive services to women living in rural and remote areas. This program was the only way these women could access such services (MSI 2019; Schaaf et al. 2019). Vulnerable populations and marginalized groups already face economic challenges, and the GGR is thus highly likely to deepen economic disparities (and gender inequities) by putting economic disadvantaged groups in an even more precarious situations and preventing them from accessing essential SRH services.

4.3 'NOT WITHOUT A FIGHT': RESISTING THE GGR

Against the adversity and hostile environment created by the GGR, multiple actors have devised creative and innovative ways to mitigate the impact of the policy and to continue defending and expanding sexual and reproductive health and rights for everyone.

One of the key initiatives is SheDecides which emerged in 2017 as an invigorating response to the reinstatement of the GGR. SheDecides has received an enthusiastic response from people across the globe and has gained the support of several governments, and has now become an established international movement aiming to raise awareness and unlock resources for contraception and abortion services for women and girls in developing regions. In 2019, the Global Health, Empowerment, and Rights Acts (Global HER Act) was introduced in the US Congress. If passed, this bill will repeal the GGR and prevent its future reinstatement (Population Connection Action Fund 2019). Affected NGOs have turned to European donors and foundations such as the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation.

From 2017 onwards, various donors have rushed to make new commitments to SRHR to address the severe funding gap created by the GGR (Giorgio et al. 2020) (see Table 17 below). Although these commitments make up less than half of the funding needs, they are a step on the right direction and have been key in addressing the policy's immediate impacts. However, as Pugh et al. (2017:16) emphasized, "while these

new commitments and fundraising efforts are encouraging, they also highlight the urgency of developing a long-term, sustainable and diversified funding strategy that is independent of the domestic political circumstances of any individual country". Besides, it is still difficult to distinguish donor commitments that are actually new from those that are re-commitments of funds already pledged in previous moments (Countdown2030 2018; Schäferhoff et al. 2019); or whether actual sums of aid will meet the amounts actually pledged (Rominski & Greer 2017).

Reproductive rights advocate also continue to be substantially vocal about the policy's social, economic, ethical and human rights implications (Girard 2017; Singh & Karim 2017). Around the world, SRHR champions and organisations are denouncing the GGR attack to global health and how it directly undermines the sexual and reproductive rights of millions of women, girls and individuals around the world, with the harshest consequences affecting the most vulnerable and disadvantaged groups (The Lancet 2019).

Funding commitment	Description
SheDecides ³³	The SheDecides initiative has galvanised donor countries to increase their funding for SRHR to support NGOs adversely affected by the Mexico City policy. Up until now, US\$453 million has been pledged as part of the SheDecides initiative by public donors (Belgium, Denmark, Finland, France, the Netherlands, Norway, Sweden, Canada and Finland), private foundations, and an anonymous individual. SheDecides also had a positive ripple effect beyond pledges, for example by inspiring the Netherlands to begin supporting the Global Financing Facility for Women, Children and Adolescents (GFF).
2017 Family Planning	Donor governments and foundations pledged a total of US\$2.6 billion at the July 2017 Family Planning summit. While new commitments were made at the summit by several donors (e.g. UK, Norway) and part of the US\$2.6 billion raised was from new financial commitments, other donors referred to their pledges made earlier in 2017, including at the SheDecides conference (e.g. Sweden) or at other occasions (e.g. Canada).
GFF ³⁴ replenishment	In November 2018, donors pledged US\$1 billion to the GFF to improve health and nutrition for women, children, and adolescent girls in LMICs. The government of Norway, which hosted the conference in Oslo, was the biggest

Table 16. Recent funding commitments towards family planning, contraception and safe abortion

³³ For more information and details about SheDecides pledges see https://www.shedecides.com/pledges/

³⁴ "The Global Financing Facility (GFF) is a financing mechanism in support of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH+N). It was launched at the Third International Conference on Financing for Development in 2015. The GFF's Secretariat is based at the World Bank" (Countdown 2030 2019).

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	single donor, pledging US\$360 million through 2023. Contributions were also made by Denmark, the European Commission, Germany, Japan, the United Kingdom, Canada, and Qatar, as well as MSD for Mothers and Laerdal Global Health. These pledges were not focused solely on SRHR (but on SRMNCAH+N more broadly).
GFATM ³⁵ replenishment	In October 2019, the Global Fund to Fight AIDS, TB and Malaria raised US\$14 billion for the period 2020-2022. To date, the Global Fund has allocated about 50% of its annual disbursements of US\$4 billion to HIV. While the Global Fund reached its replenishment target, the pledged amount is only US\$1 billion more than the previous three-year period and is thus expected to result in only modest increases in its HIV disbursements.
ICPD Nairobi Summit	Only 6% of the 1,200 commitments made at the summit were focused on financing and only a few donors made significant financial commitments. The two largest donor commitments were made by Norway and the United Kingdom, but the pledges involve a continuation of funding at current levels for the period 2020-2025 rather than additional funding. Smaller financial pledges were made by the European Commission's (US\$31 million), Germany (US\$22 million), and Denmark (US\$15 million).

Source: the above data has been reproduced from Schäferhoff et al. (2019).

CHAPTER 5: PROMISING PRACTICES, RECOMMENDATIONS AND CONCLUSIONS

5.1 PROMISING PRACTICES

Despite challenges in ascertaining access to contraception and abortion, there have been some examples of successful advocacy and strategies over recent years. Here we highlight a few, but by no means all of them.

Increasing contraception use and uptake

Political and economic commitments from country governments: Commitment by the governments of Mozambique and Rwanda are often cited in the literature as recent successes in achieving higher contraceptive prevalence rates, decreasing fertility rates and expanding access to contraceptive methods. Since 2012, Mozambique has implemented efforts to expand access to family planning, including

³⁵ "The GFATM provides countries with funds for supplies purchase including condoms, which have a dual purpose of protection against HIV/STI transmission and prevention of unplanned pregnancies" (Ibid.)

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prioritizing the access among adolescents and women living in rural settings. In a matter of 5 years, modern contraceptive prevalence rate went from 30% to 50% (Hellwig et al. 2019). In Rwanda, due to the government's concerted effort to expand access to contraception through a national-wide policy, mDFPS went from 9% in 2000 to 64% in 2014.

Community-based provision of contraceptive services: Community outreach programmes, including mobile clinics have proven effective at reaching remote areas and serving vulnerable populations. Across developing regions, for example, many women access contraception through mobile services: 41% in SSA, 36% in South Asia and the Middle East and 23% in LAC (IPPF 2017).

Increasing access to safe abortion

Increasing women's access to telemedicine abortion: In recent years, there has been growing debate around the use of telemedical abortion to terminate pregnancies. Telemedical abortion services are an alternative for women living in countries with highly restrictive abortion laws, or for women who might face barriers to accessing safe abortion even in countries where is the practice is legal. Since 2005, Women on Web (WoW) has provided "safe, accessible and affordable online abortion care to women and people around the world" (WoW 2020). Women or pregnant people who require safe abortion or contraception make an online consultation at the organization's website. Every case is reviewed by doctors and after abortion pills or contraceptives are sent via mail. WoW provides support throughout all stages of the process (Ibid.).

The current Covid-19 pandemic has led to a (temporary) expansion in the provision of medical abortion in the United Kingdom, France and in some parts of the US. These changes are the result of advocacy efforts from pro-safe abortion organizations (like BPAS in the UK), obstetricians and gynaecologists associations and safe abortion rights groups who have raised concerns about the difficulty in accessing safe abortions during the pandemic due to lockdown restrictions and closure of clinics and hospitals (Haynes 2020).

Implementation of Safe Abortion Information Hotlines: Another promising practice is the implementation of Safe Abortion Information Hotlines (SAIH) by feminist collectives in LAC. By providing information on the use of misoprostol for the safe termination of pregnancy, SAIHs have reduced risks and complications related to unsafe abortion, including maternal deaths in contexts where the practice is illegal or highly restricted.

Spreading information and awareness of safe abortion services: The Asian Safe Abortion Partnership provides education and rights-based advocacy about safe abortion through media campaigns and workshops. ASAP made an animated short film, *From Unwanted Pregnancy to Safe Abortion*, to raise awareness and knowledge about specific barriers to safe abortion and decrease maternal mortality and morbidity caused by unsafe procedures (Krishnan & Dalvie 2015).

Developing strong safe abortion advocacy groups and networks: Linking feminists and human rights groups, pro-safe abortion organisations and movements, societies of obstetricians and gynaecologists, healthcare and service providers and policy-makers has proved successful in implementing advocacy strategies to increase or expand access to safe abortion. For example, FIGO's *Advocating for Safe Abortion Project* (FIGO 2020) supports ten gynaecology and obstetrics national member societies in Africa and Latin America to strengthen their capacities as leaders on SRHR and safe abortion advocacy, to the extent permitted by law in their respective countries. Among the project's objectives are "establishing

coordinated and vibrant national networks of associations that are supportive of safe abortion for collective advocacy efforts" and "creating increased acceptance of safe abortion among health workers, policy makers and the general population" (Ibid.).

Strategies for changing the discourse on abortion: Strategies for changing discourse on abortion are also key to increasing access to safe abortion. Planned Parenthood's advocacy campaign 'Niñas, No Madres' ('Girls Not Mothers) is a strategy that aims to ensure that legal abortion is universally available and accessible to girls aged 9-14 in LAC (Berer & Hoggart 2019), where births among girls aged 15 and under are on the rise. The campaign brings together a coalition of 45 organizations to call on governments to provide comprehensive sexual and reproductive health and safe, legal abortion services to end forced motherhood in girls.

5.2 RECOMMENDATIONS

Below we include some recommendations ranging from advocacy and mobilization, to research, service delivery and efforts to bridge funding gaps which can contribute to expanding access to contraception and safe abortion. Furthermore, it is important to note that any efforts to increase women's and girls' sexual and reproductive health and rights can only happen if underlying causes such as gender inequality, poverty and social vulnerability are addressed simultaneously (Hekster 2015).

Advancing advocacy and mobilization

Advocacy around increasing access to safe abortion: Unsafe abortion is almost entirely preventable through access to contraception and provision of safe abortion services. It is quite simple—both the legalization and decriminalization of abortion save lives. However, abortion remains widely restricted in developing regions and represents a major public health concern in these contexts. Despite international recognition of women and people's right to access legal and safe abortion (OHCHR 2020), and admissions that governments must provide access to this fundamental right, thousands of women still die every year due to unsafe abortion procedures while millions are treated for unsafe abortion-related complications. Around the world, advocacy initiatives are inspiring and mobilizing support around the legalization and provision of safe abortion. The 2018 Ireland's referendum, which led to overturning the country's abortion ban, and the current '*Marea Verde*' (green wave) campaign for legal abortion in Argentina have galvanized momentum in the fight for legalization of abortion at the global and regional levels.

It is also important to understand the role that context plays in determining which advocacy strategies are more successful. In Ireland, for example, mutually reinforcing health and human rights discourses allowed to build momentum and paved the way for reform of the one of the most restrictive abortion bans in the world in 2018 (Taylor et al. 2020). Framing abortion as a woman's health issue was key for the successful law reforms; human rights advocacy also played an important role in maintaining political pressure and ensuring that the state could meet international human rights standards in terms of securing access to abortion care and abortion rights within the law (Ibid.).

Tackling abortion stigma: Abortion stigma remains widespread and represents one of the major barriers to safe abortion around the world. Negative attitudes about abortion can come from multiple sources: society, the community, family and peers, medical institutions and even individuals' own internalized stigma. Strategies to address and tackle negative attitudes and stigma against safe abortion are therefore necessary to increase expand access.

Advocacy around contraception and safe abortion financing: Current levels of funding are not enough to meet the increasing needs for contraception and safe abortion. Donor funding, from government and private donors has seen a revival after the 2012 London Summit on Family Planning; however, bilateral funding towards family planning has remained flat due to various donors' decline in investment in this area. National advocacy has a significant role to play in increasing funding for contraception and safe abortion (where allowed) at the country level. Advocacy strategies by NGOs and INGOs should try to mobilise policy-makers and the general population to increase domestic funding for contraception, through for example GFF loans.

The RHSC Global Contraceptive Commodity Gap Analysis can be a useful advocacy tool to increase contraceptives supplies financing. Advocates and organizations can present estimates at global, regional and country levels to donors. Donors, in turn, can use these estimates with aid recipient countries to promote accessibility of contraceptive commodities. In addition, it is important that advocates and organizations continue to advocate for financing which promotes universal health coverage, including access to contraception and safe abortion services and supplies and other essential and life-saving sexual and reproductive health care. Moreover, SRHR champions, donors and advocates should be strategic about their advocacy approaches around contraceptive supplies financing. For example, they should decide whether to have a more specific focal points; for instance, focusing only on supplies advocacy, or a broader focus by placing supplies within the context of contraception and safe abortion services, or wider health programmes. Choosing a clear focal point can achieve a better impact in advocacy work that aims to increase donor funding (Countdown2030 2018).

Building momentum in global advocacy: Recent initiatives such as SheDecides and the London Family Planning Summits (2012 and 2017) have been effective in mobilizing political and financial support by the donor community. International fora such as the CSW, ICPD and International Family Planning conferences provide opportunities to create and build momentum and support around SRHR and improving access to contraception and safe abortion.

Lobby and advocacy efforts need to keep a vigilant voice of like-minded groups in place. Within Share-Net, this could mean examining whether the combined strategies from the different Communities of Practice are addressing contraceptive and safe abortion access for all, including strategies to ensure that the most vulnerable groups can access these services. It would be worth examining how the various CoPs are working together to strengthen advocacy and efforts in the areas of contraception and safe abortion. At the same time, finding avenues to advocate in partnership with other initiatives, such as the Global Fund to Fights Aids, Tuberculosis and Malaria could be a good approach to improve services and strategies that reduce stigma for LGBTQI+ people.

Permanently end the Global Gag Rule through the Global HER Act: According to an analysis by CHANGE and PAI (2018), approximately 60% of US voters oppose the GGR and 77% believe that the US has a moral obligation to advance women's health worldwide. Hence, policy-makers and advocacy groups could potentially use this support to increase mobilization efforts within the US to push for the permanently end the GGR through the Global HER Act.

Increasing research and knowledge

Understanding women's reasons for non-use of contraceptive methods: To design effective contraception services, planners, decision-makers, providers and civil society organizations need to

understand the reasons why women with unmet need are not using contraceptives. With this knowledge, providers can ensure that women are presented with a balanced method mix that responds to their needs and preferences. Contraception services should be informed by the country's context and the specific reasons women cite for non-use. Community dialogues and participatory approaches can be appropriate in addressing this gap, as they can increase ownership, address norms and values and generate recommendations by women and communities themselves.

Expanding data collection on adolescents, abortion and impact of the GGR: There is a need to expand research and data on adolescent girls and young women, particularly young adolescents (aged 10-14), as many of the studies and reports available mainly focus on married or older women. In addition, data on abortion tends to be limited and current estimates have significant rates of underreporting and inaccuracy. Further, there is a clear and urgent need to continue documenting the implications of the GGR, and to assess its implications on disadvantaged populations who are not often reflected in the literature. Gathering data on these issues is necessary to gathered evidence-based knowledge and influence policy around contraception and safe abortion that addresses the needs of all groups.

Research is also needed to increase the availability of new contraceptive and safe abortion options. For example, more research can be devoted to identifying "effective methods with few to no side effects; semilong acting methods that are user-controlled; multi-purpose technologies that link both pregnancy and STI/HIV prevention; male hormonal contraception; combination of non-hormonal methods; methods that can be used both as contraception and for medical abortion; and early medical abortion methods that can be obtained from pharmacies or other providers for home use" (Hekster 2015:6). This can expand contraceptive choices, thereby addressing many concerns that currently discourage people from using a method.

Addressing funding gaps

Mobilize domestic resources: Many developing countries significantly rely on donor funding to implement their family planning programmes. While donor support is key for providing contraception and safe abortion services and supplies, it is important that countries develop their own strategies to increase domestic resources going to these services, through for example GFF loans. Furthermore, this increases country ownership and commitment which is essential for sustainable family planning programmes.

Ensure that funding towards services for the most vulnerable are prioritize: Household and individual outof-pocket expenditure represent the largest portion of funding (81%) going towards family planning services and the purchase of contraceptive supplies. Donors and national government should pay attention to the costs that households and individuals experience (e.g. economic barriers to accessing contraception) and the implications this has for aggravating economic and gender inequalities. Donors should recognize the significant impact of meeting the needs of the most marginalized groups while also understanding that achieving this requires substantial and sustained funding and resources. This can only be achieved through collaboration between donors, governments, civil society organizations and affected populations.

Avoid applying conditionalities on development funding for health, including counter-conditionalities intended to respond to the GGR: Organizations affected by GGR restrictions should not be forced to be caught between policy preferences of bilateral donors, as it happened with aid conditionalities imposed by SIDA to organizations and sub-grantees that signed the GGR. Advocates have suggested that SIDA should work with impacted organizations to find ways of working around GRR restrictions instead of phasing out

their funding (Edwards 2017). As Rios (2019:44) states, "counter-conditionalities can undermine the wellbeing of organizations, and ultimately the communities they serve, by forcing them to make the extremely difficult choice of whether to forgo one funding stream or another".

'There is no UHC without SRHR': Domestic governments should increase spending on healthcare and move towards universal health coverage (UHC) which includes SRHR as one of its key components. UHC should include coverage for low-income groups and those in the informal sector, and universal access to contraception and safe abortion services should be made an affordable choice for everyone. This can only be achieved by strengthening political leadership and support around SRHR at the country level. At the same time, donors should include SRHR as part of their funding for UHC in developing countries. As Schäferhoff et al. (2019:5) underline "the mantra should be 'there is no UHC without SRHR'".

Improving service delivery environment

Contraception and safe abortion services should prioritize reaching out to and including vulnerable populations: Donors and NGOs should concentrate on addressing the needs of adolescents and other vulnerable populations and should support contraception and safe abortion services that focus on reaching far more people through community-based interventions and mobile outreach initiatives. One way of addressing limited coverage of the health system is to bring services directly to the communities where people live. This also involves supporting UNFPA's work to deliver family planning services and safe abortion access for women and girls in humanitarian and emergency settings.

Strengthen the provision of medical abortion through all possible safe channels: In many countries and regions the use of self-managed medication abortion on the rise given the legal and practical barriers for accessing safe abortion. Medical abortion, which requires relatively little training of health providers, and which can be safely self-managed by women at home (usually up to ten weeks of gestation) with adequate instructions can increase access to safe abortion in many parts of the world, particularly in countries where abortion is highly restricted and access to surgical abortion can be extremely difficult.

Work from human rights and intersectional approach: Contraceptive and safe abortion services should be informed by a human rights and intersectional approach to make sure they are inclusive, rights- and needsdriven, community-based, culturally appropriate and youth-, disability- and LGTBQI+-friendly. These services should be available to everyone free of stigma, discrimination and coercion to make sure that everyone can make a voluntary and informed choice regarding contraception and safe abortion.

Tailor programmes and initiatives to adolescents and young people: Provide youth-friendly programmes that can address adolescents' barriers to contraceptive use. These initiatives must prioritize education and comprehensive sexual education to make sure adolescents can access and utilize information and resources to make informed decisions about contraceptive methods and safe abortion. Furthermore, services for adolescent and young women and men should be provided without stigma or judgement. Community dialogues involving youth and using media, such as soap operas, have been successful in raising awareness about sexual health and the need for contraception (Fallon 2016).

Involve boys and men: Engaging young men in sexual and reproductive health programmes can increase gender equality attitudes and acceptance of contraceptive use and safe abortion. A promising initiative is Men Care, a global fatherhood campaign coordinated by Promundo and Sonke Gender Justice and implemented in 50 countries. Men Care engages men in conversations around gender norms and

pregnancy prevention, including contraceptive use and violence prevention thereby leading to behaviour change among men and greater levels of gender equality (MenCare 2020).

5.3 CONCLUSIONS

Contraception and abortion estimates and trends

Current contraception and safe abortion trends and estimates presented in this review show that millions of women and girls in developing regions are deprived from the right to exert autonomy over their bodies and to decide whether and when to have children. As of 2019, an estimated 218 million women in developing regions have an unmet need for modern contraception. Unmet need is highest in Sub-Saharan African, where almost 1-in-4 women want to avoid a pregnancy but are not using modern contraceptive methods. In LAC, unmet need is 10% and 16% in South Asia.

Unmet need in young women remains significantly higher than among all women in reproductive age (43% vs 24%), and approximately 12 million adolescents (aged 15-19) and 777,000 girls under 15 years give birth each year in developing regions (WHO 2020). This is overly concerning, as early fertility has significant health and social implications for adolescent mothers and their babies.

Unsafe and illegal abortion remains another catastrophic, yet preventable, public health issue in developing regions. Although 50 countries have liberalized their abortion laws since ICPD 1994, an estimated 45% (35 million) of all abortions that take place yearly are unsafe. Maternal mortality resulting from unsafe abortion-related complications accounts for up to 8-13% deaths worldwide, and other hundreds of thousands of survivors live with long-term complications, including infertility, chronic pain and disability.

Women and girls face various barriers to accessing contraception and safe abortion. Most common reasons for non-use of contraception are concerns about side-effects and health risks, infrequent sex, not having resumed menstruation after a birth, opposition to family planning by the women themselves or others, or not being married for unmarried women. Supply chain failures and unavailability of a wide variety of contraceptive methods also lead to non-use and contraceptive discontinuation among women in LMICs. Barriers preventing women from accessing safe abortion services include anti-abortion policies, women's lack of awareness of the legal status of abortion, gender norms that hinder women's decision-making autonomy, abortion-related stigma and economic costs. Legal reform on abortion does not automatically translate into access to services, as women still face numerous medical, political, institutional and social barriers, even in contexts where the practice is allowed.

Wide disparities and inequality in access to contraception and safe abortion remain across regions and countries, with women in the lower wealth quantiles, those with less education and those living in rural and remote areas facing the most barriers and challenges to accessing comprehensive and adequate care.

International policy and funding for contraception and abortion services and supplies

Funding international contraception and safe abortion levels of need is cost-effective. Most importantly, investing in these areas saves lives, expands the rights of women and girls and improves the wellbeing of communities and societies around the world. Nonetheless, significant funding gaps remain which required considerable and sustained investments from multiple actors and stakeholders.

In the 2015-2020 period³⁶, international policy and the financial landscape around contraception and safe abortion services and supplies have seen a revival in the interest of donors in these areas. However, the reinstatement of the GGR is considerably affecting funding streams towards contraception and safe abortion programs. Although other donors have promptly mobilized funding to mitigate the effects of this harmful policy, the gap left by the US is significant, and it is unlikely that donors will be able to remediate it or whether current initiatives will be sustainable in the long-run.

The GGR's impacts on vulnerable populations

There is no evidence supporting the effectiveness of the GGR in decreasing abortion rates. Instead, evidence highlights that abortion rates increase during the years it is in place. Although the full impact of the policy's new version, the PLGHA cannot be fully quantified yet, the current picture is disheartening. The policy has brought significant disruptions to youth-, sex worker-friendly and LGTQI+-friendly programs. Organizations and providers who were the most efficient in providing comprehensive health care, including sexual and reproductive health services, and who most importantly welcomed vulnerable populations and understood their needs, are now being displaced by organizations that uphold a regressive, anti-SRHR, anti-rights agenda. This has detrimental implications on the wellbeing of disadvantaged populations who now find themselves without a 'safe space' or peer support. The PLGHA is also likely to increase economic pressures for these groups and aggravate already existing inequalities. Thereby the policy is already backtracking the limited progress made towards reducing the structural barriers that limit vulnerable populations' access to critical health services.

Moving forward

The year 2020 marks a critical time to take stock of progress and shortfalls towards achieving UHC and other health-related SDG targets by 2030. Sexual and reproductive health is a key element of UHC, and this of course includes access to contraception and safe abortion. Current trends show that despite significant progress, millions of women and girls across the world are still deprived from the right to decide whether and when to have children. Addressing unmet needs and gaps in contraception and safe abortion services and supplies in a comprehensive and efficient manner can only be achieved through the implementation of diverse, creative and sustained strategies, including advocacy and research, investments and financial commitments, and collaboration between donors, governments and civil society organizations focusing on various SRHR areas and populations. Civil society organisations, funders, researcher and activists need to continue their strategic, deliberate and nuanced approaches to build on the recent successes to continue challenging the barriers the impede women, girls and individuals to control and make informed decisions about their fertility, health and wellbeing. Contraception and safe abortion are essential and life-saving health care and they are fundamental rights for all people. This should be the norm rather than the exception, for every person, in every corner of the world.

³⁶ The COVID-19 pandemic has also put significant pressures to the funding landscape around contraception and abortion and will be likely to cause major disruptions (see Ahmed & Sonfield 2020; UNFPA 2020) in the provision of contraception and abortion services and supplies, and other SRHR-related services. The international policy and funding environment will need to adapt to the current context to meet the needs emerging from this crisis.

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ANNEX

Annex 1. List of keywords and inclusion criteria

Criteria	Included
Торіс	Contraception
	 Search terms: Contraception, Contraception availability, Contraception distribution, Contraceptive needs, Unmet contraceptive needs, Unmer need for modern contraception, Unmet need for family planning Contraceptive use, Contraception choice, Access and uptake of modern contraception, Commodities, Unintended pregnancy, Family planning Trends, Vulnerable populations, Married women, Unmarried women Adolescents, Sex workers, Post-partum, Knowledge gaps, Demand creation, Economic returns.
-	Abortion
	 Search terms: Abortion, Abortion access, Abortion services, Abortion supplies, Unsafe abortions, Unmet abortion needs, Abortion legality and safety, Abortion stigma, Family planning, Trends, Vulnerable populations, Married women, Unmarried women, Adolescents, Se workers, Post-abortion, Knowledge gaps, Demand creation, Economi returns.
-	International policy and funding support
	 Key words/search terms: SRHR funding, SRHR funding gap, Global healt funding, Donor government funding, Global Gag Rule, Mexico City Policy PLGHA.
Settings	 Global, Developing regions, Sub-Saharan African, Asia (South Asia an South East Asia), Latin America and the Caribbean.
Populations	 Women, girls, adolescent women and girls, sex workers, LGBTQI+ peopl
Type of	Academic sources
study/document	 Peer-reviewed articles (systematic reviews of trends in contraceptio and abortion considering levels of access and use among specif population groups; qualitative studies; mixed-method studies).

	Gray literature
	 Surveys and reports of trends in contraceptives and abortion Survey and reports of contraception and abortion needs of vulnerable populations (adolescents, sex workers, LGBTQI+ people) Reports, policy briefs and other relevant documents published by multilateral institutions, NGOs, CSOs, private foundations and research organizations: UNFPA, WHO, PAI, Guttmacher Institute, FIGO, SheDecides, Share-Net International, Global Financing Facility, FP2020, the Bill and Melinda Gates Foundation, CIFF
Language	 Documents in English
Publication date	 Published from 2015 onwards (2015 – 2020).