

ORIGINAL RESEARCH ARTICLE

Documenting activism and advocacy around medication abortion in Central, East, and West Africa

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Abstract

Medication abortion, a safe and effective method for terminating pregnancy in the first and second trimester, can reduce overall maternal mortality. However, little is known about how advocates for abortion view medication abortion in their communities, particularly where abortion is legally restricted. We conducted in-depth interviews (2018-2019; N=24) with health workers and community leaders in the Democratic Republic of the Congo, Kenya, Nigeria, Malawi, and Tanzania identified from the Mobilizing Activists Around Medication Abortion (MAMA) network. Interviews focused on the role of advocacy in medication abortion provision. Participants identified benefits of medication abortion to women, including privacy, accessibility, and safety, and community benefits, including perceived reduction in maternal mortality. Participants described challenges to providing support for medication abortion, including difficulties operating in legally restrictive environments and stigma. Findings highlight the role of grassroots advocacy to overcome challenges and provide an alternative model of abortion access and care to women. (*Afr J Reprod Health* 2023; 27 [1]: 84-94).

Keywords: Self-managed abortion, medication abortion, activism, advocacy, qualitative research

Résumé

L'avortement médicamenteux, une méthode sûre et efficace pour interrompre une grossesse au cours du premier et du deuxième trimestre, peut réduire la mortalité maternelle globale. Cependant, on sait peu de choses sur la façon dont les défenseurs de l'avortement considèrent l'avortement médicamenteux dans leurs communautés, en particulier là où l'avortement est légalement restreint. Nous avons mené des entretiens approfondis (2018-2019; N = 24) avec des agents de santé et des dirigeants communautaires en République démocratique du Congo, au Kenya, au Nigeria, au Malawi et en Tanzanie identifiés dans le réseau Mobilizing Activists Around Medication Abortion (MAMA). Les entretiens se sont concentrés sur le rôle du plaidoyer dans la fourniture d'avortement médicamenteux. Les participants ont identifié les avantages de l'avortement médicamenteux pour les femmes, y compris la confidentialité, l'accessibilité et la sécurité, et les avantages pour la communauté, y compris la réduction perçue de la mortalité maternelle. Les participants ont décrit les défis liés à la fourniture d'un soutien pour l'avortement médicamenteux, y compris les difficultés à opérer dans des environnements juridiquement restrictifs et la stigmatisation. Les résultats mettent en évidence le rôle du plaidoyer de base pour surmonter les défis et fournir un modèle alternatif d'accès à l'avortement et de soins aux femmes. (*Afr J Reprod Health* 2023; 27 [1]: 84-94).

Mots-clés: Avortement autogéré, avortement médicamenteux, activisme, plaidoyer, recherche qualitative

Introduction

As of 2018, over 75% of the more than eight million induced abortions in Africa every year were considered unsafe by WHO standards^{1,2}. In total, unsafe abortion is estimated to account for

approximately 14% of maternal mortality worldwide³. For this reason, addressing unsafe abortion remains a key factor in reducing maternal mortality⁴. Medication abortion has the potential to reduce unsafe abortion, thereby reducing maternal mortality. There are many barriers to increasing the

proportion of safe abortions, particularly in settings where abortion is legally restricted or inaccessible. Countries in the African region have some of the most restrictive abortion laws globally⁵ and access to medication abortion is also limited by unnecessary regulatory barriers⁶.

Medication abortion (i.e., misoprostol alone or in combination with mifepristone) is an effective, safe, and reliable method for terminating a pregnancy in the first and second trimesters of pregnancy^{7–11}. Widely used since the 1980s, medication abortion has been identified as a cause of decline in severe abortion-related morbidity and mortality^{2,12}. The medication abortion (MAB) regimen is widely accepted by users, reduces the need to visit a clinic for a surgical abortion procedure, and has been demonstrated to be safe when provided by non-clinically trained providers. The regimen for medication abortion are included in the World Health Organization's (WHO) Essential Medicines List^{6,13} and endorsed as a safe and reliable combination therapy for abortion. Currently, misoprostol and mifepristone are exempt from routine follow-up care in the absence of complications¹⁴.

Medication abortion is a model of abortion access that many people prefer. Medication abortion is frequently characterized in terms of its safety and accessibility, as well as the privacy, autonomy, and comfort that it may afford women⁸. Particularly in settings where abortion is legally restricted or permitted but not widely accessible, medication abortion is a critical component of the abortion access landscape. The WHO's abortion care guidelines embrace that medication abortion can be administered and effectively used by women without an institutionalized system of medical care because it can be self-managed outside of the formal healthcare system^{15,16}. Self-managed abortion (SMA) refers to the practice of ending a pregnancy without the formal supervision of a health care professional and forms part of the self-care interventions in health¹⁷.

In cases where abortion is self-managed with no or minimal contact with the formal health system, pregnant people may still access support from other sources, such as text or phone hotlines that provide support and guidance to those who have initiated a medication abortion or community organizations that provide in-person information on SMA. A 2019 review of medication abortion in

seven countries in the Africa region found that lay people can provide accurate information about medication abortion when given the resources to do so⁷. The work of feminist organizations that bring the medications to local communities¹⁸ or internet-based services that combine information with service delivery by postal or courier services¹⁹, have been instrumental in ensuring improving access to and demonstrating the safety and effectiveness of SMA.

SMA is also a key aspect of a broader task-shifting approach to healthcare that reduces the burden on under-resourced healthcare systems by expanding health worker roles at all levels^{20,21}. Implementing a task-shifting approach to the provision of medication abortion is an opportunity to increase health equity via timely and accessible abortion care, reduce abortion-related stigma, and relieve the burden on already overloaded and under-resourced healthcare systems²².

In this study, we explore the perspectives of community health workers and leaders living within areas served by the Mobilizing Activists Around Medication Abortion (MAMA) network. MAMA is a multi-country network of organizations that aims to increase access to medication abortion in the African region^{7,23}. Focusing on five countries—the Democratic Republic of the Congo (DRC), Kenya, Nigeria, Malawi, and Tanzania—this study examines the benefits and challenges of providing medication abortion within and outside of formal healthcare systems.

Methods

Between November 2018 and April 2019, we conducted 24 in-depth telephone and in-person interviews with health workers and leaders with varying roles in MAMA network organizations in the Democratic Republic of the Congo (DRC), Kenya, Nigeria, Malawi, and Tanzania. In-depth interviews allowed us to explore barriers to abortion care and amplify the voices of advocates working to improve access to abortion.

Local partners in all five countries recruited a convenience sample of health workers and leaders to participate. After eligible community members were identified, the study team contacted potential participants to tell them about the study and invite them to participate. Eligible participants were community health workers or recognized

community leaders who lived in or near the areas served by the MAMA organization.

The research team developed semi-structured in-depth interview guides with input from the MAMA partners in each country. MAMA partners translated the guides into the participants' preferred languages in each country. The semi-structured design of the interview guide ensured consistency across interviewers, while also providing space for new themes to emerge based on the participant's experience. The major domains covered in the interview guide included safe abortion activism and advocacy, experiences with the MAMA organization, and the impact of safe abortion services and information provided by the MAMA organization in each community. Interviews were conducted in Chichewa, English, French, and Swahili.

All interviews were digitally recorded, transcribed verbatim, and translated into English. We analyzed the 24 transcripts using a thematic coding process facilitated by Dedoose qualitative software. The research team used the in-depth interview guide as a framework to develop an initial codebook²⁴. The initial codes were based on the broad topics covered in the interviews (e.g., community views of abortion, abortion laws). Three members of the research team independently coded two interview transcripts using this codebook. After coding the two transcripts, the team came together to reconcile the code applications and collaboratively identify and define sub-codes based on common themes within each broad topic. The final codebook was determined based on consensus of the three coders²⁵. One research team member then applied the final codebook to 22 transcripts and a second team member reviewed each coded transcript. Throughout the process, the research team met regularly to discuss the coding process, emergent themes, and any changes to the codebook. After coding the transcripts, we used code sorts to examine patterns within the data and more finely examine sub-themes.

All study participants gave verbal informed consent prior to the interview and were given the equivalence of \$10 (USD) as compensation. All study procedures were approved by the [blinded] Institutional Review Board (IRB).

Results

In total, we conducted and analyzed 24 interviews. All participants were leaders involved in a local organization that focused on providing support for medication abortion (one organization per country). In addition to their roles as community health workers and leaders, participants self-identified as abortion activists and had a range of formal roles within their communities, including pharmacists, health educators, volunteers, and village chiefs. The majority (n=18) of participants identified as women. Participants ages ranged from 23-58 years, and more than half of participants reported some university education (n=14) (Table 1).

Emerging from the topics within the interview guide, participants discussed a range of issues related to support for medication abortion and SMA. We present the most common themes according to individual-level benefits to women, community-level benefits, and challenges to providing support for medication abortion and SMA, which included widespread stigma and restrictive legal environments.

Participants used the terms SMA and medication abortion interchangeably, making few distinctions between a medication abortion that was initiated at a clinic, pharmacy, or home. However, participants distinguished between medication abortion and abortions that required surgery and took place at a hospital or other medical facility. They also made distinctions between medication abortion, surgical abortion, and methods of abortion using herbs or non-medical abortifacients, which they largely considered unsafe. In discussing support for medication abortion, participants referred to services provided by the MAMA organization they were affiliated with, including abortion hotlines, health education sensitization activities, community health workers, and community-based non-physician health workers (e.g., pharmacists).

Individual benefits of support for SMA

Participants identified multiple benefits of support for medication abortion. Benefits included privacy, accessibility/affordability, and safety.

Table 1: Participant demographic characteristics (N=24)

	n (%) / mean (range)
Gender	
Female	18 (75%)
Male	4 (17%)
Not reported	2 (8%)
Age	37 (23-58)
Country	
DRC	4 (17%)
Kenya	5 (21%)
Malawi	5 (21%)
Nigeria	5 (21%)
Tanzania	5 (21%)
Education level	
None	1 (4%)
Some primary/completed primary	3 (13%)
Some secondary/completed secondary	6 (25%)
Some university	3 (13%)
Completed university	11 (45%)

Privacy

Participants from all five countries overwhelmingly emphasized the importance of privacy. In particular, going to a hospital or clinic for an abortion was considered a major risk to privacy that SMA could alleviate. Not only did women risk being identified by someone in their community, but the medical staff themselves were seen as likely to violate a woman's privacy if she sought an abortion.

A participant in Kenya noted that medication abortion afforded women privacy, even if they needed to seek the medication from a relatively public source, such as a pharmacy. A benefit of medication abortion was that women could obtain the medication without identifying themselves as the person who needed it.

“Even if you give those medicines to someone, you won't be sure if she really used them or she's just [got] them for another person [...] One may say [the pills are] for her sister or for her friend, but in reality, it's for herself because she knows nobody will know if she uses them by herself in privacy.–Female, 50, Kenya

Participants considered a high level of anonymity to be necessary when seeking medication for abortion. Stigma and shame associated with abortion predicated the need for privacy. All participants who discussed privacy as a benefit of medication abortion shared that women needed privacy to

avoid judgement and stigma from their families and communities:

“[Women] know that when you use the abortion pills, you are going to be safe, you are not going to over bleed, [...]and be taken to hospital, that will make everyone know that you were doing the process [of abortion]. By using the pills, I think the information is going to be [private] and it's not going to be the community thing.”–Female, 27, Kenya

Participants felt strongly that women needed to be able to keep their abortion a secret, which was seen as possible only through medication abortion. One participant suggested that it was a matter of women preserving their dignity.

“The user's dignity is preserved [when using medication abortion] because no one will be speaking behind your back about your abortions. This can't happen because nobody knows that you have taken abortion pills, no one knows where you have been.”– Male, 58, Malawi

Another component of privacy that participants noted was that medication abortion mirrored natural biological processes, such as menstruation. This allowed women to use the method without fear of having symptoms specific to abortion.

“Most times people who use the pills just keep it to themselves that they went to the clinic and got some pills, they just use the pills privately at home. They are safe because the pills just make it look like they had their normal menstruation. Therefore, it is not possible for anyone to talk about anything concerning them.”–Female, 38, Malawi

Another participant noted that, in case of a complication from medication abortion, even a doctor would not be able to tell that a woman had an abortion if she used medication (Female, 30, Kenya).

In some cases, the need for privacy extended beyond the fear of others 'finding out' about the abortion. According to a few participants, women would risk their physical privacy by seeking a surgical abortion (e.g., they would need to undress in front of a medical professional) and that they could face violence and discrimination by healthcare providers. One participant described the humiliation a woman might experience by going to a medical professional:

“Compared to abortion with pills, there’s too much humiliation with surgical abortion. There may be two doctors who know you well, and with [that] medical equipment, they take off your clothes to leave you naked. They look at your naked body, and sometimes they can keep you unconscious, and therefore they can do anything they want, they can even have sex with you.”—Female, 32, Tanzania

Accessibility and affordability

Participants noted that women’s comfort having an abortion at home made medication abortion more accessible. Participants felt that women were more relaxed having an abortion at home, both due to privacy, as well as general benefits of being in a familiar space. For example, one participant discussed how having an abortion at home impacted women’s emotional states during the abortion process:

“[Pills] are far easier for [women] and they are in a comfortable environment, their home, so the mindset is that I am in my place, am in my home, so they can relax. They are in a very good mood so they... can do it without fear and all that.”—Female, 42, Nigeria

Participants also noted that medication abortion entailed minimal disruptions to their personal lives, enhancing autonomy and allowing people to rapidly return to their activities. One participant noted:

“It is more affordable and in terms of privacy you can do it in your own private closet without anybody knowing and after that you can still walk around and do your normal activities.”—Female, 45, Nigeria

Participants identified that women had easier access to medication abortion outside of a health facility than an abortion within a health facility. Accessibility was discussed primarily in terms of cost, although some discussed distance from a health facility and travel time as well. Traveling to receive an abortion in a health facility could be expensive and took women away from their household and economic activities, including childcare and farming. One participant from Kenya noted that a medication abortion was much less expensive than an abortion within a health facility, both because of the procedure itself, as well as in terms of recovery time:

“Going to the hospital is more expensive. Maybe one is not able to afford such kinds of method[s]. So, the pills are cheaper. Being admitted to the hospital and spending time there will cost you.”—Female, 52, Kenya

An abortion within a health facility was not considered a one-time expense. Instead, there were often a cascade of financial implications associated with getting an abortion at a health facility. Participants noted that the costs could accumulate, particularly when getting an abortion required multiple visits to a health facility or consults from multiple doctors. A participant from the DRC explained how the various steps women needed to take to have an abortion within a health facility compounded, making it cost-prohibitive for most women:

“In terms of cost when we talk about surgery, automatically she has to be consulted, go to hospitals... for surgery there is consultation that we must pay, the technique we must pay, if it is hospitalization we must pay, the treatment and the care that they will give you, we must pay... Here at home, we know that it is no less than \$100-150 to be consulted, get the surgical treatment... Better the pills for \$5. And there we find that poor people, the women who do not have means, can do it.”—Male, 30, DRC

Safety

With few exceptions, participants felt that medication abortion was a much safer option for women than a surgical abortion within a health facility. A surgical abortion procedure was widely considered to be a risk to a woman’s life, while medication abortion was viewed as having fewer and more manageable risks. Participants also associated surgical and unsafe abortion with other health complications, such as excessive bleeding, infertility, and cancer. These consequences were not seen as risks of medication abortion. Others worried that incompetence of medical staff would be a risk to women’s health:

“I would say using pills is much better because there are no dangers. I am not sure about going to the hospitals. I’ve heard stories about operation tools being left in the abdomen after an operation, and that causes health problems for the victim. So, I think pills are far safer.”—Female, 52, Kenya

In contrast, one participant from Tanzania noted that a surgical abortion with a doctor was a safer option than medication abortion because a doctor would have the resources to save a woman's life if there was a complication.

"[People] believe it's safer with surgical abortion than abortion with pills [...] because you can use abortion pills on your own, but where will you go in case you get complications? But when you get complications with surgical abortion, a doctor will do whatever it takes to save your life because [they are] afraid."—Female, 32, Tanzania

In addition to comparing medication abortion to surgical abortion, several participants also compared the safety of medication abortion to unsafe abortion practices, such as invasive methods and non-medical abortifacients. Universally, medication abortion was viewed as safer than non-medical methods. Participants in all five countries noted that medication abortion was safer than 'traditional'² methods.

"There are traditional methods that women use here, [but] pills guarantee the safety of the life of the woman. It protects them."—Female, 28, DRC

"Many women used to die, many destroyed themselves, a lot lost their wombs through unsafe abortion, but from what we have seen in modern times with this abortion with pills, such cases have been reduced if not eliminated."—Female, 47, Nigeria

Along with safety, participants emphasized that medication abortion was less painful than a surgical abortion, and therefore preferable to women.

"People in the community find abortion with Miso pills causes no pain and it's very cheap, but abortion with surgical methods causes a lot of pain."—Female, 40, Tanzania

"People are afraid of the pain that they feel with surgical procedures which is said to be very extreme, but with pills, all they have to do is swallow and everything else happens without much fuss."—Gender not indicated, 30, Malawi

Safety of abortion was also associated with the above-mentioned advantage of privacy. The process is "discreet" and allows people to decide if,

when and how to share their abortion, enabling them to manage social and legal risks. One participant explained:

"Women who use this method [pills] consider it safe simply because no one knows that they have had an abortion except themselves. There is also no physical sign and you can go about your regular routine so women feel that it is safe."—Gender not indicated, 26, Malawi

While participants advocated for medication abortion because of benefits in terms of privacy, accessibility, cost, and safety, they also felt that women who sought a medication abortion needed support. Participants noted that women needed education about how to take the pills correctly and what to expect, along with the support of a friend, family member, or community member in case of an emergency.

Community benefits of support for medication abortion/SMA

In addition to the individual benefits of SMA and medication abortion broadly, participants discussed how medication abortion served as a tool to increase awareness and reduce stigma related to abortion in their communities. They connected reduced stigma to fewer women resorting to unsafe abortion methods and a reduction in maternal mortality.

Awareness and stigma

Participants across the five countries noted that the increased availability of medication abortion was contributing to abortion becoming more acceptable in their communities. One participant in Kenya discussed the cumulative benefits of supporting women in accessing medication abortion.

"Whenever you help one, she will also help others [...] Maybe one or two women tries to do an abortion with the pills and it is successful. She also tells a friend and another friend and we find that in most cases, we get lives saved."—Female, 30, Kenya

Reduced stigma was a benefit of increased awareness and access to medication abortion. A participant in Nigeria noted that when medication abortion was available to women, it reduced

abortion related stigma. This participant also explicitly connected reduced stigma of abortion to reduced mortality from abortion. As abortion became safer and less associated with complications and mortality, it was discussed more openly. Open discussions about abortion helped reduce the stigma associated with it.

“Before now, we used to hear abortion as something that is unheard of, something that you can’t talk about in public, something that, ‘wow she committed an abortion.’ You know it used to be a topic and a lot of people are being stigmatized, that was why so many people have died in the time past because you can’t even share your experience.”—Female, 47, Nigeria

Other participants noted changes in their communities since medication abortion became more widely available. Women were more open to talking about abortion with their friends. Information and support for medication abortion was more widespread and women could share resources with each other.

“Now you see women discussing [abortion] themselves... [asking each other], ‘why are you not in that program? Do you know about the pills? Were you given the hotline?’ and so you see women discussing with themselves. Their knowledge has been broadened for safer abortion and then they know how to access it.”—Female, 40, Nigeria

“People have information, so [they] know how to take good care of themselves. [Medication abortion] really helped a lot [in] reducing the death rate of the community and people are more aware of where to get the services, who to talk to, and where to go.”—Female, 37, Kenya

Maternal mortality

Participants observed that, as access to medication abortion increased in their communities, mortality from abortion was becoming less common. According to participants, this was evidence that women were able to successfully self-manage a medication abortion, either by themselves or with out-of-clinic support. In all five countries, participants noted that they perceived a reduction in mortality due to unsafe abortion.

“The death rate has drastically reduced, at least I am talking about my community where I live, people don’t die anyhow from unsafe abortion. Hence, they can get the pills and use them the way they are directed to use them.”—Female, 47, Nigeria

“Many people benefit from [medication abortion] because the number of girls and women with physical disabilities due to complications from abortion is dropping. Incidences of death as a result of abortion are also decreasing [...] These days we see more girls staying in school because they are no longer afraid of complications of abortion.”—Male, 58, Malawi

Challenges to providing support for SMA

Along with the range of benefits associated with medication abortion that participants shared, they also identified significant challenges. Participants in all five countries discussed legal restrictions at the national level as a barrier to providing education and support for medication abortion. Participants also felt stigmatized for their role in facilitating medication abortion and for their involvement with organizations that provided out-of-clinic support for SMA.

Legal environment

Participants often shared that the laws around abortion in their countries were ambiguous. This was particularly notable in the DRC, where multiple participants shared that abortion was allowed only if three to five doctors agreed that an abortion was necessary. In theory, abortion was legal, but in practice, it was nearly impossible for women to meet this requirement for obtaining an abortion.

“Congolese law that says no, [it] does not allow abortion. But Congolese law [also] tends to allow abortion. Why? Because we say when you want to do this abortion, the opinion of the doctors is required; the opinion of three or four doctors, but ultimately it is still allowed in my opinion.”—Male, 40, DRC

“...to have an abortion, we must consult five doctors to approve. These are the laws that are still used in the DRC [...] the problem lies for example in a woman who resides in a village where there is

no doctor [...] How or where to find the five doctors?”—Male, 40, DRC

Participants in all five countries described laws around abortion as complex and context specific. In most cases, participants thought that abortion was legal in the case of a threat to a woman’s life or if she were pregnant because of rape. In Tanzania, one participant reported that abortion was legal if a woman was ill or if she had a child who was less than a few months old, but this is not an explicit provision in Tanzanian law.

“Abortion in Tanzania isn’t allowed just for anyone. It’s not like you can become pregnant today and decide to abort it tomorrow. Abortion is only allowed under certain circumstances, for instance, if you become pregnant and you’re sick, and in order to recover you must have an abortion, then you can be allowed. Or abortion can be allowed when a woman becomes pregnant at the time when she has a few months old baby. For this, abortion can be allowed so as to save this baby.”—Female, 32, Tanzania

Participants in Malawi felt that abortion laws were particularly unclear and were often modified at the local level by community leaders. Several participants from Malawi said that there were no specific laws about abortion, while others said that abortion was illegal or only allowed in specific situations. Two participants shared that Malawian abortion laws were contradictory:

“The law is somehow contradictory. The same law says abortion is illegal, yet it also allows it. The same law strictly forbids abortion, yet it also provides circumstances for which abortion is recommended.”—Gender not indicated, 26, Malawi

“Some say abortion is illegal, some say it is legal, some say it is only allowed based on the circumstances under which the mother became pregnant. Some are victims of rape and some get pregnant while they are not mature, abortion is legal in such circumstances. If the woman is mature, she is expected to retain the pregnancy. Therefore, somehow abortion is legal in some circumstances.”—Female, 45, Malawi

Restrictive legal environments were viewed as barriers to safe abortion (e.g., medication abortion), but not to unsafe abortion. Indeed, participants

shared how legal restrictions around abortion often led women to use unsafe abortion methods.

“As long as that law exists, it means abortion is not allowed [...] One may say she doesn’t want the pregnancy or she cannot afford to raise the baby. Under this situation, and regardless under the existing law, women will still do abortion. But since it’s illegal, they will do it secretly using unsafe methods. They will not even try to access safe abortion pills in pharmacies for fear they will be asked many questions [...] and the law prohibits the abortion.”—Female, 50, Kenya

In some cases, participants noted that they or someone else in the community who helped women get an abortion could face criminal charges, but this did not deter participants from continuing to advocate for medication abortion and support women.

“When someone [has] an abortion and the news come out, she can be arrested and sent to court. Even if [...] you helped a girl to do abortion, you’ll face a [law]suit.”—Male, 24, Tanzania

“[Police] will ask the woman ‘where did you buy the drugs?’ and the one in the pharmacy, the one who gave her the drugs will be guilty. The person who did that, whoever [provided] the house [where the abortion took place] is also guilty. [They] say that all those people who are in the field of abortion, we are going to call them criminals.”—Male, 30, DRC

Stigma

Participants shared that they were stigmatized or viewed negatively by their communities because they were involved in supporting women’s access to medication abortion. While this was a challenge, most participants indicated that they would continue to support women due to their own convictions about the importance of abortion access and their desire to reduce unsafe abortion in their communities. In several cases, participants felt that they, along with women who had abortions, were viewed as committing a crime for their role in facilitating women’s access to abortion.

“[The community] perceives you as a killer or they connect you with something bad, as in they take you as [if] you are advocating about death, not even abortion.”—Female, 30, Kenya

“I can say it is the stigma, there is stigma attached to the abortion. Talking about abortion in the community, they see you as a sinner, as a killer, you have terminated a life, you are going to hell and all.”—Female, 40, Nigeria

However, participants across the five countries noted that community views about people who helped women get abortions were beginning to change. Many felt that they were starting to be viewed more positively for their role in helping women have safe abortions.

“Opinions are split, some say offensive things and accuse [abortion] doers of murder, while some understand that we are simply trying to help the women because if they go to traditional doctors, they will be given dangerous herbs, which sometimes abort the pregnancy and kill the mother at the same time, which means two deaths.”—Gender not indicated, 30, Malawi

“For years, the community was completely against people like us [people who educate on abortion], but due to globalization, the community view now has mixed attitudes... some accept what we’re doing but some don’t.”—Male, 24, Tanzania.

Discussion

The countries represented in this study have some of the most restrictive abortion laws in the Africa region. In the DRC, abortion is illegal without exceptions. In Malawi, Nigeria, and Tanzania, abortion is only legal to save the life of a woman. In Kenya, abortion is allowed to preserve a woman’s physical health²⁶. Such legal and regulatory restrictions severely impact access to safe abortion in these countries. As in other studies, we found that participants had a basic understanding of abortion laws in their country, but often felt that the laws were ambiguous and contradictory^{1,27}.

Results from our study demonstrate that medication abortion provides privacy, is perceived as safe, and is a more affordable option than surgical abortion. All participants emphasized that privacy was a primary benefit of medication abortion when compared to abortion within a health facility. Medication abortion’s edge over surgical abortion within a facility was safety, described as the likelihood of survival with minimal or no

complications. Participants in our study considered the medication to be affordable, particularly in comparison to health facility surgical abortions. Similarly, a 2017 study in South Africa found that women frequently preferred medication abortion outside of the formal health system because of its lower costs and the privacy that it afforded²⁸.

Most participants in our study perceived that medication abortion was safer than a surgical abortion within a health facility. Participants felt that some clinicians who offered abortion services were unqualified, judgmental, and potentially abusive. They also felt that health facilities were under-resourced and not equipped to handle emergencies, which were viewed as common in a surgical abortion. This echoes existing literature showing that health care providers often lack training, rely on outdated procedures that place women at increased risk of complications, and actively shame and stigmatize women for seeking abortion care⁷. Perceptions of safety may also explain why people are increasingly choosing medication abortion to terminate pregnancies outside of the formal healthcare system¹⁸. Participants shared that they perceived medication abortion as a contributing factor to a reduction of maternal mortality in their communities.

Participants had an expansive idea of what a safe abortion entailed, which went beyond direct bodily harm or mortality from abortion. In some ways, privacy was a component of abortion safety. In addition to medical complications, health facility abortions were also considered unsafe because they were not deemed to be private. Participants felt that entering a clinic risked potential exposure to community members who may be at or around the clinic, or by clinic staff who may disclose their visit to someone else. These findings are supported by a recent study exploring the abortion experiences of young people in Argentina, Bangladesh, Ethiopia, and Nigeria, in which participants’ perceptions of quality of abortion care—including stigmatizing experiences with judgmental service providers—impacted their perceptions of safety associated with different abortion methods²⁹. Indeed, other studies have suggested that the definition of a safe abortion should be expanded to include women’s preferences for privacy³⁰ and control over their own decision-making³¹. Keeping an abortion private is a matter of safety for some women so that they can

control if, when, and with whom they share their abortion, and to manage the associated social and legal consequences.

While considerations for privacy are critically important to women, it is important to also understand privacy within the context of abortion stigma. In some cases, the need for privacy is inherently derived from abortion stigma^{29,30,32}. Research from Kenya, for example, has found that women keep their abortion a secret due to community stigma and social norms³³. Stigma operated on multiple levels within the present study. Participants felt stigmatized for their role in facilitating medication abortion, yet some also held views about abortion that were potentially stigmatizing (e.g., the need to ‘vet’ a woman’s reason for having an abortion before helping her). Although specific viewpoints on abortion varied, participants were strong advocates for medication abortion, persisting in their work despite threats of stigma. This is not an indication that the ramifications they faced were benign, but rather that they had the internal and external resources to continue their work despite experiencing stigma. Pervasive stigma, even among advocates, underscores the need for policy interventions to decriminalize abortion, as well as community-based interventions to destigmatize abortion broadly, and especially among healthcare workers.

Conclusion

Findings from our study highlight the power of grassroots advocacy and activism to provide an alternative model of abortion access and care while simultaneously combatting the failure of governments to provide basic healthcare services. Our findings demonstrate that expanding access to information about medication abortion has a profound impact on individuals that need abortions and their communities. Despite the legal restrictions and stigma that people face when seeking abortion care, our research shows the role of activism in ensuring access to safe abortion while shifting understandings of safety and quality of abortion care. Women, girls, and pregnant people who benefit from the information provided by MAMA organizations can support others, which may create a powerful chain of knowledge sharing. While unsafe abortion remains a challenge, grassroots activism can help people uphold the human right to

reproductive autonomy. Increased engagement of activists in dissemination of medication abortion information has enormous potential to improve access to safe abortion, and to change attitudes toward sexual and reproductive health.

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