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IMAP Statement on the importance of ensuring abortion care after 13 weeks' gestation

Introduction

This statement was prepared by the International Medical Advisory Panel (IMAP) and approved in November 2024.

Abortion after 13 weeks' gestation is a key component of comprehensive abortion care. Also referred to as second trimester abortion or later abortion, abortions after 13 weeks constitute 10-15% of all induced abortions worldwide, although rates may be up to 40% in some settings (1,2). Despite it being less common, two-thirds of all major abortion-related complications occur after 13 weeks, which are responsible for nearly half of all abortion-related deaths. The majority of these abortion deaths and related complications occur in countries where legal restrictions are the most severe and where there is a high prevalence of unsafe abortion (3).

The International Planned Parenthood Federation (IPPF) supports the rights of women and other people who become pregnant to end their pregnancy, and their right to be able to access safe abortion care when needed, including at later gestations. Pregnancy can be ended safely in the majority of cases regardless of gestational duration although risks associated with abortion complications increase as a pregnancy advances, particularly if the abortion procedure is unsafe. Gestational limits in policies and laws restrict access to care, often forcing women and pregnant people to turn to unsafe abortion.

Purpose of statement

This statement is intended to support and guide IPPF Member Associations (MAs) and other SRHR and women's organizations, including those providing information and services, engaged in advocacy and/or partnering with governments and other key stakeholders. It is designed to raise awareness on the importance of abortion care after 13 weeks' gestation and provide service providers and advocates with information and tools to support the provision of abortion services beyond 13 weeks.

NOTE: This document is inclusive of women and girls and all people who can become pregnant, including intersex people, transgender men and boys, and people with other gender identities that may have the reproductive capacity to become pregnant and have abortions. For the purposes of this document, references to "women and girls" refer to all people who have the capacity to become pregnant.

Why abortion after 13 weeks is needed

There are many reasons why clients may seek abortion beyond 13 weeks (4–7).These include:[1]

- restrictive abortion laws and policies
- contraceptives that interrupt menstrual patterns masking missed menses, delaying detection of pregnancy
- risk to the health of the pregnant person
- severe foetal abnormalities which may not appear and/or be diagnosed until after 13 weeks
- later maternal age pregnancies, with higher risk of foetal abnormalities or other health complications
- financial and logistical barriers which delay seeking care
- delayed detection of pregnancy
- failed abortion from earlier in the pregnancy
- ambivalence and/or difficulty deciding on abortion
- obesity, which has been associated with delays in recognizing pregnancy
- displacement caused by humanitarian crises with breakdown in supplies, infrastructure and health staff
- lack of available, trained providers
- provider preference and/or hesitancy to offer later abortions
- conscientious objection by providers
- providers refusing or delaying referrals

While most abortions occur before 13 weeks, unsafe abortion beyond 13 weeks is a significant cause of maternal death. Nearly half of all abortion related deaths and two-thirds of all major abortion-related complications are caused by unsafe abortion after 13 weeks (3). Factors contributing to these rates include restrictive abortion laws and policies which permit abortion only before 13 weeks and/or for specific indications. In countries with less restrictive abortion laws, unnecessary mandatory waiting periods, counselling or the requirement of a multiple visits, also act as barriers and add to further delays contributing to the need for abortion after 13 weeks (8,9). People who seek abortions after 13 weeks are often the most marginalised and underserved, such as youth, adolescents and victims of sexual and gender-based violence. There is little demographic difference between people seeking abortion before and after 13 weeks in terms of ethnicity, number of previous abortions or existing number of children (2,10–16).

How abortion after 13 weeks is provided: care options

Both surgical and medical methods are recommended for abortion at or after 13 weeks of gestation. Medical abortion and dilation and evacuation (D&E) when practiced using evidence-based, WHO-recommended methods are both safe and efficacious for inducing later abortion. Both have been successfully introduced into programs in low-resource settings, but logistical and regulatory environments may lead to one being easier to expand or introduce compared with the other (17).

When feasible, access to both methods should be available and offered to clients, as many have strong preferences for one modality over another.

For detailed information on the regimens and techniques described below, please see the Chapter 5 of the IPPF Client-Centred Clinical Guidelines (26).

Medical methods of abortion after 13 weeks:

- Combined medical abortion regimen: oral mifepristone followed by repeated doses of misoprostol; or
- Misoprostol alone, in repeated doses (where mifepristone is not available)

1 This statement does not specify an upper gestational limit beyond 13 weeks as need for abortion may vary, particularly as foetal abnormalities may only be detected at various later stages in pregnancy.

Induction of foetal asystole via intra-amniotic or intrafoetal injection is recommended before medical abortion where there is the possibility of foetal viability after expulsion (18). If other health/medical conditions (e.g. comorbidities or uterine anomalies) are detected that may cause or exacerbate complications, clients should be referred to an appropriate higher-level health-care facility for the abortion procedure and/or for other services, as needed. Clear referral mechanisms need to be in place to refer clients to a higher-level facility in case complications arise during the procedure or during recovery. Post-abortion contraception should be provided immediately for those who wish, or referred for these services, if not available on-site.

Surgical abortion at and above 14 weeks of gestation: dilatation and evacuation (D&E)

Dilatation and evacuation (D&E) is currently the recommended surgical method for pregnancies 14 weeks of gestation and above. Manual vacuum aspiration can also be used alone up to 14-16 weeks in the hands of experienced providers; however, after 15-16 weeks it is mainly used to evacuate fluid and the placenta while forceps are needed for foetal tissue (19,20). Trained, skilled providers and specific equipment must be available to provide D&E safely. D&E should be performed in a health facility and can be provided on an outpatient basis. D&E is more painful and takes longer than aspiration at early gestations. It also requires cervical preparation and a combination of aspiration and blunt forceps.

Implementation considerations:

- For all providers, more advanced skills and training are needed for D&E provision than for a vacuum aspiration done earlier in pregnancy.
- D&E includes the use of vacuum aspiration; therefore, equipment and skills providing vacuum aspiration are essential.
- Health workers providing abortion or caring for women undergoing abortion at gestational ages ≥ 13 weeks may have additional needs for professional and mentoring support, such as provider share workshops (21,22).

NOTE: As dilatation and curettage (D&C) causes additional pain and potential complications compared to aspiration and/or D&E, it is not recommended by WHO. WHO states that its use should be replaced by safe abortion methods (uterine aspiration/D&E or medical abortion). Additionally, it is considered incompatible with numerous human rights including the right to health (15).

Who can provide abortion after 13 weeks

Providers require additional skills and equipment for abortion at higher gestational ages. Generalist and specialist medical practitioners are the recommended cadre of service providers as per the updated WHO guidelines to offer both medical management of induced abortion and dilatation and evacuation (D&E) for surgical abortion. However, evidence is emerging that mid-level providers and midwives can be trained to safely provide abortion care beyond 13 weeks (17).

Other service providers such as traditional and complementary medicine professionals, midwives and associate clinicians may be trained to provide D&E. Health workers providing D&E should be involved in other tasks related to maternal and reproductive health and medical management of induced abortion with easy access to appropriate surgical backup and where proper infrastructure is available to address incomplete abortion or other complications (23).

Post-abortion care and contraception

All contraceptive options may be considered after an abortion after 13 weeks' gestation while equipping clients with the tools, knowledge, and resources required to make decisions that

align with their diverse life experiences (24). Ovulation can resume as soon as 8–10 days after an abortion and usually returns within one month, putting the client at risk of pregnancy if contraception is not adopted. Contraceptive counselling should be offered prior to the abortion to allow for immediate initiation. Intrauterine devices, if there is no evidence of infection, can be inserted as soon as the pregnancy is expelled or at the completion of a surgical abortion (25). Hormonal contraception may be initiated as soon as the first dose of the medical abortion regimen or immediately after completing a surgical abortion. Fitting a diaphragm requires a delay until after the first menses following the abortion. In case contraception is not initiated at the time of abortion, it is crucial that women are well informed about the rapid return to ovulation (and potential pregnancy), and how to access contraception if/when they choose to do so.

Counselling and information provision is an integral part of the provision of abortion services and any informed-decision-making, and it should be provided in a client- centered manner. For further guidance on counselling and informed decision making, please refer to IPPF's Client Centred Clinical Guidelines (CCCGs, Chapter 3: Counselling and Chapter 5: Abortion, 2.3: Information, counselling, and informed consent (26).

Recommendations for IPPF Member Associations and other organisations on how to support abortion after 13 weeks (27)

For service provision

- Abortion care after 13 weeks' gestation should be accessible and facilitated for those who need it, including for post-abortion care or any treatment needed by clients who have attempted to self-induce an abortion.
- Providers and facility managers should follow the clinical recommendations for provision of abortion care from WHO, including for post-abortion care and initiation of contraception.
- Dilation and curettage (D&C) is considered an obsolete method of uterine evacuation and should be replaced by WHO recommended methods such as D&E or medical methods.
- Training and institutional support for the provision of abortion after 13 weeks should be expanded to clinicians skilled in earlier abortion care.
- Reduce logistical and financial barriers to abortion services early in pregnancy to facilitate and improve access, which decreases the need for later services.
- A supportive environment should be created at facilities by offering or referring for services, and decreasing stigma surrounding later abortion services both for providers and clients.

For policy and advocacy

- Advocate for the removal of laws and other policies and regulations that prohibit abortion based on gestational age limits.
- Advocate for expanding health provider cadres to provide abortion services, in line with WHO recommendations.
- Support the decriminalization of abortion, including self-managed abortion.
- Develop advocacy messaging and communication materials that dispel misinformation about abortion after 13 weeks, which uses positive, destigmatizing language and imagery. See, for example, IPPF's Guide on How to Talk About Abortion: A Guide to Stigma Free Messaging (28) and How to report on abortion - A guide for journalists, editors and media outlets (29).

Further research gaps recommended to expand the evidence-base on abortion after 13 weeks:

- Improving pain management regimens.
- Management of failed medical abortion after 24 hours of treatment.
- Safety and management of medical abortion regimens in those with a uterine scar.
- Addressing provider stigma, burnout and support for providers of abortion services.
- Supporting the needs and preferences of

people who self-manage or accompany abortions at later gestations, particularly their interactions with the health care system.
- Incidence, needs and barriers abortion after 13 weeks among marginalized groups such as sex workers, persons with disabilities and LGBTQI+ populations.
- Effective training methods and models for healthcare providers to learn to provide abortions after 13 weeks.

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Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals

IPPF

4 Newhams Row
London SE1 3UZ
United Kingdom

tel: +44 20 7939 8200
fax: +44 20 7939 8300
email: info@ippf.org
www.ippf.org

UK Registered Charity No. 229476

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