TERMINATION OF PREGNANCY

In November 2003, the MSF international council discussed MSF policy regarding treatment of victims of sexual violence. They noted that while MSF had a policy towards raped women, including the provision of morning-after pills, this policy was poorly implemented due to field staff fears.

As there was a clear need for MSF as a movement to come up with a common position on termination of pregnancy (TOP), a working group was set up to tackle this specific issue. This issue was discussed during the 2004 mini-GAs and participants voted in favour of motions asking that MSF come up with a clear position on this.

Minutes from the MSF International Council Meeting, 21-23 November 2003 (in English)

Extract:
III. Sexual Violence
A presentation was made by Françoise Duroch.

Theoretically we now have a general policy throughout our programmes whereby we give treatment to women post-rape: prophylaxis and morning after pill. Nevertheless people are a little wary of this in the field – a little scared maybe. So the success of this policy very much depends on the motivation of the teams in the field and this is this policy's main weakness. Information has been given to the field and guidelines have been drawn up – we must make sure that the medical acts required are performed. Awareness raising has been through training/briefings, etc. […]

Re Abortion
A working group has been set up to tackle this specific issue. There is basic agreement with regard to therapeutic abortions. We can face different scenarios: abortion is criminalised for both the woman and the practitioner or abortion is authorised if therapeutic. MSF must look at possible ways to deal with this, the point being that we must prepare to be confronted on this issue. […]

Re Women's health
Françoise Duroch's recommendation is that it should include reproductive health, MST's & sexual violence.

Conclusion – we should tackle three issues:
• We should mainstream the medical help to women in the field
• We should treat/act medically (not sure we can do something with regard to causes)
• Abortion: need to come up with a common position for MSF as a movement.

Mini-GA on Abortion **Synthesis**, 2004 (in English)

Extract:
According to reports received, the topic of abortion obviously generated passionate debates during the Mini-GA. Various levels were taken into account in the discussions:
• Legal aspect -> legal status of abortion in the countries of intervention (in some countries, therapeutic abortion is legal while in others abortion as a whole is illegal).
• Cultural and religious aspects.
• Medical aspect (therapeutic abortion, medical consequences of clandestine abortion on women's health).
• Social and psycho-social aspects (consequences of undesired pregnancy on both the mother and the child).

A number of Mini-GAs also felt strongly that abortion is an ethical/moral debate and a very personal question -> it was therefore difficult to reach consensus in many Mini-GAs, which can explain the limited number of motions and recommendations proposed.

Therapeutic abortion: relative consensus that MSF should perform them -> proposal that these should be accompanied by counselling procedures adapted to local contexts and cultures.

Abortion in the case of undesired pregnancy: there is no consensus on whether MSF should perform them in countries where abortion is illegal -> should MSF go against the law and integrate the practice of abortion in our projects? Responses to this question often (but not only) oppose legal argument vs. humanitarian approach:
• No, because it can negatively impact on MSF activities as a whole in a given country (risk of being expelled, risk of an increase of consultations for abortion which can be detrimental to other medical emergencies that MSF has to face in a country). Instead, MSF could rather implement accompanying measures during pregnancy and after delivery.
• Yes, given the burden that clandestine abortions represent in precarious sanitary conditions + social consequences of undesired pregnancy on mother and child. One Mini-GA also made the parallel with the implementation of ACT and MSF going against national protocols.
• Specific case of abortion after a rape: even in such situations, no consensus was reached.

There is a rather clear consensus that MSF should at least do everything to change the law through témoignage and lobbying authorities. However, limitations and additional comments were raised:
• MSF should not impose its culture -> the issue of abortion cannot be dissociated from the local context (cultural, traditional aspects should be taken into account) -> further documenting the issue should be a prerequisite to taking a position.
• To what extend MSF can be involved in fights of a given civil society?
• Abortion shouldn't be disassociated from family planning -> abortion shouldn't be considered as a contraception measure

and MSF should raise more awareness on family planning and contraception, including condoms, contraceptive pill, and the 'morning after pill' (especially in case of rape).

All in all, motions and recommendations ask MSF to define a clear position with regard to abortion as staff are faced to this issue in the field. The need for a clear position is all the more acute in contexts of war and contexts where rape is a 'common practice'.

Finally, two Mini-GA raised the issue of MSF staff personal positioning: even if abortion is legal or planned in MSF projects, can MSF staff refuse to perform it? South Sudan answered yes to this question if decision of the staff is based on personal beliefs and arguing that doctor should be free to choose to perform abortions or not. Nicaragua responded no, arguing that individual opinions should not interfere with the content of a project or policy and insisting on respect for beneficiary's personal decision.

In November 2004, building on the outcomes from the mini-GA debates and on a draft of 'MSF Sexual and Reproductive Health Policy' produced by MSF medical directors, the IC acknowledged that abortion was still a neglected medical act in MSF programmes.
With the objective of giving both guidance and a consistent approach to the field, they issued a resolution stating that the provision of comprehensive reproductive health care was essential in all MSF general medical programmes, and that availability of safe abortion should be integrated as a part of reproductive health care.

Minutes from the MSF International Council Meeting, 19-21 November 2004, Geneva (in English)

Extract:
1. Abortion
Background:
The discussion was based on several documents including a draft 'MSF Sexual and Reproductive Health Policy' produced by the medical directors and the outcomes from the 2004 mini-GAs discussions. From a legal perspective, a paper is under preparation and some responsibilities have to be left also at field level. […]

Main outcomes of the discussion:
• A policy or not: there is potentially an operational difficulty to have a policy as such as it may focus on an issue that is not a core part of our activities. Our response to rape / aseptic abortion is a medical response to a medical problem. But the formulation in the dirmed draft policy ('in all programmes') is a problem as first, it is not realistic and because in some contexts, there are strict laws against abortion or groups not tolerating it -> we may therefore focus on something we should not focus on. Some argued to that that by having a better policy, we allow our staff to respond to needs at least with regards to safe abortion. Having a policy would also help avoiding new comers in MSF to challenge or question safe abortion as part of our programmes and the right for women for access to safe abortion -> differs from pushing for a policy for abortion everywhere.
• Human right based approach, medical ethics vs. political positioning: abortion cannot be justified by neither medical ethics nor human right -> we can justify it as a political position. In our medical culture, it is a normal medical act (MDs in Europe have fought to have the monopoly on the act in order to avoid medical problems when clandestinely practiced by non-medical).
• Breaking the law: abortion is not included in the international law. Only two countries strictly forbid abortion whatever the reason for practicing it. In other countries, abortion can be justified for therapeutic reasons. A clear consensus among IC members that medical necessity should take precedent over legal necessity.

Conclusion:
As an organisation, we have to acknowledge that this medical act is neglected in our practice. Whether it is legal or not, abortion is practiced -> no need for a policy as such -> rather give the teams in the field the means / resources to do it the safest way.
It was also emphasized that management of abortion should always be part of reproductive health -> abortion is only an epiphenomenon and should be part of a stronger perspective on reproductive health including political will to implement good quality family planning programmes -> IC resolution to emphasize on political will to implement comprehensive reproductive health care package including abortion.

Follow up:
Rowan will transmit IC's comments on the draft policy to the medical directors:
• Neither human-right approach nor medical ethics based
• The policy should not include legal elements -> only medical base
• Human resources element: we should refrain from putting MDs who are against abortion in certain contexts.

On 21 November, the IC adopted the following resolution:
The IC states that:
1. The provision of comprehensive reproductive health care is essential in all MSF general medical programs
2. Despite recent improvements and efforts, such care is still poorly accessible to patients in MSF programs
3. The availability of safe abortion should be integrated as a part of reproductive health care in all contexts where it is relevant.
4. MSF's role in termination of pregnancy must be based on the medical and human needs of our patients
14 in favour – 2 abstentions (UK, Denmark) – 2 absents (Austria, HK)

In September 2007, the reproductive health working group (RHWG) announced that the IC resolution had had no effect so far in the field, partly due to a lack of communication.
This was confirmed in December 2007 by the IC. While noting some progress in the dissemination of guidelines and strategies, they acknowledged the existence of barriers to the provision of safe environment for the teams to perform safe abortions, often due to legal and cultural constraints.

They reaffirmed the 2004 resolution and asked the executive to address the issue at both field and headquarters levels and the presidents to further disseminate the resolution to ensure its implementation.

Minutes from Reproductive health working group, 5-7 September 2007 (in English)

Extract:
Who has policies? Amsterdam, Barcelona, Brussels, Geneva and Paris.
It was the desire of the RHWG [reproductive health working group] to have a common (international) policy, but the medical directors didn't agree to work on developing consensus – time and effort. Practically, individual policies were the only way to move forward. With revisions and field experience we're coming closer together on the specifics.

Laure Bonnevie [international accountability coordinator] will contact RHWG permanent members individually to learn how the abortion policies were developed and the involvement of medical directors in it.

Regarding an indicator for the typology, it will not be possible to give the number of VTP cases, since not all projects are able to report this (security concern). We could give the number of projects where we have a solution for ensuring access to safe VTP.

Information to be collected by RH advisors during debriefings: are they doing VTP, the process they have to go through, difficulties they face (also from staff), and perhaps an estimate of the number performed.

On the effect of the IC resolution at field level, we said: nothing – because when asked about it, field staff were not aware of the resolution or didn't understand its meaning. On the other hand, everything – because the resolution stimulated the sections to develop and implement policies, and it affected our working practice in HRM (i.e., we now ask about people's willingness before posting them). [...]

How is it dealt with in recruitment? Via HRM (human resource management) (OCA and OCB).
Our position does discourage some potential volunteers and some donors.
We do have people in all departments who express a personal conviction against abortion and MSF involvement with it. Field staff report that people's biases come through in briefings.
We also need to be concerned about how our returned volunteers represent our activities on VTP when they're back home.
It needs sensitisation in all offices and associations, in order to be able to speak openly about it.

VTP, VVF [vesico vaginal fistula], and FGM [female genital mutilation] are 'sexy' issues for now, but they're not our largest activities. We need to reintegrate them into the comprehensive RH package. Most of the HR advisors spend a lot of time training for VTP and promoting the policy, way out of proportion to the actual weight of this component among all RH [reproductive health] activities. We feel others should also be involved in the sensitisation. For the long-term this should not be the major issue we focus on; issues related to quality of care should be our main focus.

Minutes from the MSF International Council Meeting, 1 December 2007 (in English)

Extract:
Implementation of IC medical resolution on Reproductive health and Abortion
Laure Bonnevie, international accountability coordinator, first presents the main outcomes of the report she did on the implementation of the November 2004 IC resolution on reproductive health and abortion.

Discussion
At first, Joanne [Liu, MSF Canada President] and Darin [Portnoy, MSF USA President] who were present when the 2004 resolution was passed wanted to asks for some precisions regarding the safe environment that should be provided to perform abortion and the human need, as those last were the main idea of the 2004 IC resolution.
According to Laure, people who may in the first place be reluctant to perform abortion in the field may regard MSF institutional responsibility as not clear enough and may therefore consider that safe environment is not provided. In addition, the fact that reproductive health as such is quite neglected in MSF can also be an explanation. Furthermore, people tend to forget the reference made to the 'human need' made in the resolution and only keep in mind or refer to the medical need of the patients, when approached by a woman asking for abortion.
Joanne considers quite outrageous that abortion is considered less important because it is not perceived as a medical saving act. Both her and Darin would like the IC to continue the follow up of this resolution and increase awareness on this issue and reinforce explanation of MSF policies to the HR leaving to missions. As for Geoff [Prescott, MSF Holland General Director], he is glad of the progresses made and is confident that more will come. In his mind, there are practical issues that need to be addressed, such as looking at the availability of the referral system in certain projects (Marie Stopes International), the need to upgrade the skills of the staff to perform abortion or the need of a surgical back up. Those obstacles should be looked into.
Joanne and Darin don't completely agree with those obstacles as safe abortion is a routine for doctors and surgical back up is not necessary.
For Jean-Hervé [Bradol, MSF France President], the resolution has been positive in the way that MSF position on abortion is now clearly stated for the staff that wants to perform it. He agrees that we have to reinforce practical measures of awareness of MSF position with regards to abortion. However, the obstacles mentioned in the report such as security are real ones. In his opinion we shouldn't analyze the number of abortions performed in the whole, but project by project, regarding also the context where it can be very dangerous. We should also take into account medical staff personal convictions.
Laure [international accountability coordinator] believes that the risk assessment organized by the OCs was aiming at analyzing the environment before a decision is made on whether to perform abortions or not in a given context/country. The fact that the OCs took different decisions in very similar context (e.g. Chad,

DRC, Somalia, North Sudan) raises questions and one can therefore wonder what the impact of personal conviction is in the final decision, which by the way is not necessarily taken by a medical person. She gives the example of a head of mission in DRC who put a veto on the practice. Also, it becomes a real problem (and it happened already) when on a sexual violence project, the whole expat team refuses to perform abortion despite the decision made after the risk assessment. No one argues on the personal convictions but in such projects, MSF needs to ensure that at least one staff member agrees to perform abortions.
In addition, Christopher [Stokes, MSF International Secretary General] considers that we tend to overestimate risks. Marie Stopes International performs safe abortion without any problem in countries where MSF doesn't. The real problem of the resolution is the reference made to 'human need' that opens all kind of interpretations and should be clarified both at HQ and field levels.
Arjan [Hehenkamp, OCA Director of operations] recognizes that the progresses are not as good as expected. However he would like to underlines that there is also a question of operational priority. MSF missions aim to respond to the needs of a target population. The efforts and energy are therefore put on those issues and safe abortion is not always prioritized. He agrees that we should be able to answer a patient's request for abortion, but there is a difference between responding a patient request and invest institutionally to systematically address the issue.
Isabelle [Ségui-Bitz, MSF Switzerland President] reckons that in MSF-CH the resolution was disseminated but it wasn't discussed neither at associative nor at field level, she therefore wonders which place has been given in HQ to express personal opinion on abortion. On that particular point, Laure refers to very interesting debates she attended which have been organized as part of trainings (OCG field co training, International reproductive health training course) and which give a very good illustration of where the debate stands.
Christa [Hook, MSF UK President] argues that in our communication we speak about saving life but never about abortion, maybe because we don't want people to leave mission or donors to stop giving money, however it is a real problem that people who apply with MSF don't know that abortion is part of what they apply for.
Anneli [Eriksson, International Council Vice-President] explains that it varies between sections. In Sweden for example, this issue is part of the recruitment process. In a reproductive health project people shouldn't have the choice to perform or not abortion.
Jean-Marie [Kindermans, MSF Belgium President] is not as categorical regarding the possibility of a choice for our staff as a principle. However he believes that people are selected to such programs because they agreed to perform safe abortion.
All IC members request another report to follow-up on the implementation. They hesitate between 12 months, which will give priority, and 18 months that are more realistic. Some of the IC members would like the report to be more general on women health but Arjan's feeling is that the Dirops would prefer something more specific to work on. Furthermore Christopher suggests proposing safe abortion as a subject for an international strategic review in 2009. This would allow a comparison between those contexts where some are providing abortion and others are not and the possibility to criticize each other. The IC welcomes the idea.

IC decisions on follow-up of the resolution

The IC reaffirms its November 2004 resolution (text of the resolution)
1) The provision of comprehensive reproductive health care is essential in all MSF general medical programs.
2) Despite recent improvements and efforts, such care is still poorly accessible to patients in MSF programs.
3) The availability of safe abortion should be integrated as a part of reproductive health care in all contexts where it is relevant.
4) MSF's role in termination of pregnancy must be based on the medical and human needs of our patients.

The IC acknowledges progress made notably on the technical side for the defining and dissemination of guidelines and clear strategies, and to a lesser extent on the implementation in our field programs. At the same time, we do acknowledge legal and cultural constraints in the situations where we are working.
The IC resolution was aimed at providing a safe environment for our field teams to perform abortions, which has not fully been achieved.
The IC considers that significant barriers for the implementation of this resolution remain and asks the ExDir to address them at both field and HQ level, and also asks to the presidents to further disseminate the resolution to ensure its implementation.
The IC requests a follow-up report on this issue in 18 months that includes as well a more in depth analysis for each context where we are involved in termination of pregnancy.
In addition, the IC encourages the Executive/RIOD to examine policies and practices in the field of women's health.

Unanimous

In June 2009, the international council reviewed the state of play of the implementation of its resolutions' and found that abortion was still a challenge. The reasons for this were stated to be personal convictions, a non-systematic training, legal issues and the fact that abortion as a lifesaving medical act was still not understood.
The international council reaffirmed its two previous resolutions and asked operations to make abortion one of their priorities.
A year later, while acknowledging the efforts made, the international council endorsed a recommendation from the medical committee asking the executive committee to provide a review by June 2012.

Minutes from the MSF International Council Meeting, 26-28 June 2009 (in English)

Extract:
Update on implementation of the IC resolutions
Presented by Myriam Henkens (international medical coordinator)
[…]
IC resolution voted Dec 2007 – Abortion
• *'The IC reaffirms its November 2004 resolution.*
• *The IC acknowledges progress made, notably on the technical side for the defining and dissemination of guidelines and clear strategies, and to a lesser extent on the implementation in our*

field programmes. At the same time, we do acknowledge legal and cultural constraints in the situations where we are working.
• The IC resolution was aimed at providing a safe environment for our field teams to perform abortions, which has not been fully achieved.
• The IC considers that significant barriers for the implementation of this resolution remain and asks the ExDir to address them at both field and HQ level, and also asks the presidents to further disseminate the resolution to ensure its implementation.
• The IC requests a follow-up report on this issue in 18 months that also includes a more in-depth analysis for each context where we are involved in termination of pregnancy.
In addition, the IC encourages the Executive/RIOD to examine policies and practices in the field of women's health.
Unanimous'

• Today we do not have reliable information, as in some countries abortion as such is an illegal procedure, therefore cannot be reported in MSF medical statistics.
• From the data reported, 57 projects can offer termination of pregnancies. Full report on abortion is not available.
• In general:
o Personal feelings, cultural background, conviction of MSF personnel influence performance or not of an abortion.
o Training and briefings should be more systematic.
o Legal, religious, security concerns for performing abortion are serious obstacles.
• Regardless of the two IC resolutions re abortion, within MSF the perception of abortion as a life-saving medical act is still not understood, people are not convinced.
• Briefings and information sharing should be more systematic.
• Unreliable data, no report, wrong perception – MSF operations should be able to analyse the situation and report on concrete obstacles which [make them] unable them to implement IC resolutions re abortion. Each OCs president can follow up on these resolutions and report back to the IC.

• The IC reaffirms the resolutions of November 2004 and December 2007.
• The IC requests the Operations to prioritise implementation of this resolution and asks one of the IC representatives of each OC to provide a report at the next meeting (Dec 2009) that includes an in-depth analysis of where and why we are involved in termination of pregnancy or not.
Unanimous (MSF Luxembourg president not present during this vote)

Minutes from the MSF International Council Meeting, 25-27 June 2010 (in English)

Extract:
<u>On Abortion:</u>
The IC endorsed unanimously the recommendation of the IC medical standing committee on the follow-up of the IC resolution re abortion.
IC Medical Committee acknowledges the progress made in the implementation of the IC resolution on abortion.
However, the medical committee believes it is important to keep a deadline for a review, and commits to maintain the momentum and push further on implementation of the IC resolution.

It requests the ExCom to ask the DirOp to provide a progress report in two years' time (by June 2012). This report should be presented to the IC, and should include more qualitative/quantitative information: e.g. percentage of missions where contextual analysis is done by coordination teams, number of countries where discussions are ongoing, possibly other indicators to be decided by cells/desks. This report could be done through an evaluation by an external/internal people/organisation.
The IC recommended maintaining positive pressure on medical and operational departments by requesting regular updates on the implementation of the IC resolution on abortion at the OC boards and the ICB. OC presidents are committed to providing regular updates to the IC Medical Standing Committee/ICB.

In October 2012, the IB reviewed the progress made on the implementation of the resolution on abortion. While efforts had been made to provide policies and tools to support the implementation less projects were offering abortion to patients. The executive was asked to give priority to this topic and to report in 2014 on the measures put in place.
In June 2014, in her annual report, the MSF International president stated that, since the first resolution 10 years ago, little headway had been made on providing safe abortion care to patients.

Minutes from the MSF International Board Meeting, 11-12 October 2012 (in English)

Extract:
Abortion
The IB reaffirms the 2004 IC resolution on the provision of safe abortion in MSF programmes, which includes:
'The availability of safe abortion care should be integrated as part of reproductive health care in all contexts where it is relevant. MSF's role in termination of pregnancy must be based on the medical and human needs of our patients'.
We are concerned that, despite the developments of policies and technical tools to support implementation, there is an apparent decline since 2007 in projects offering safe abortion to our patients. Unsafe abortion and unwanted pregnancy contribute significantly to the burden of ill-health, suffering and maternal mortality in the contexts where we work.
Although we recognise the operational difficulties faced in offering safe abortion in many contexts, we urge the executive to give this greater priority and support and ask the ExCom to report back by October 2013 on measures put in place and by April 2014 on preliminary results.

MSF International President report, 26-28 June 2014 (in English)

Extract:
a) Safe abortion care
It has been 10 years since the international council (IC) passed a resolution on the need to provide access to safe abortion care in all our projects whenever relevant and feasible. I was one of the presidents who pushed for this measure. The resolution was reaffirmed in both 2007 and 2012, and although we have expanded access to safe abortion care, little headway has been made to increase the number of women actually benefitting from this service.
The legal and cultural constraints in some contexts have to be acknowledged, but an effort is underway to address the important internal barriers to expanding safe abortion care in MSF projects. Some other organisations seem to have overcome these obstacles. For MSF this will require, among other things, more transparent internal and external communication on the subject.
Unsafe abortion has a significant impact on maternal mortality and it accounts for approximately 13% of all direct maternal deaths worldwide. Safe abortion care in MSF is not based on a rights rationale, but is instead a medical issue. Our objective is to reduce the suffering and death resulting from unwanted pregnancy and unsafe abortions.

There was an international council resolution that carried no weight at all at the time – the one dealing with abortion.

Dr Jean-Marie Kindermans, MSF Belgium President from 2001 to 2007 (in French)

In 2017, acknowledging that the provision of abortion care by MSF teams remained largely dependent on personal commitment, several MSF associations submitted a motion to the IGA requesting that the IB ensure that MSF did not deny termination of pregnancy to any patient. They asked MSF to maintain a clear public communication on MSF's position on abortion.

In 2019, MSF launched a first international communication campaign on safe abortion.

'Call to action Across the Movement to Enact the MSF Resolution on Safe Abortion', MSF IGA **motion**, 29 June-1 July 2017 (in English)

Extract:
Submitting associations:
MSF Australia, MSF Brazil, MSF Canada, MSF East Africa, MSF France, MSF Germany, MSF Greece, MSF Hong Kong, MSF Latin America, MSF Norway, MSF South Africa, MSF South Asia, MSF Sweden, MSF Switzerland, MSF UK

Motion Text:
MSF has long recognised the need to provide medical care to women and girls seeking to terminate a pregnancy. Safe abortion care, including for termination of pregnancy on request, is part of MSF medical care and aimed to reduce the mortality and suffering resulting from unwanted pregnancy and unsafe abortion. Related commitments are reflected in movement-wide agreements and policies. The associations of MSF Australia, Brazil, Canada, France, Germany, Hong Kong, Latin America, Norway, South Africa, Switzerland and the UK are concerned at the poor translation of policy into concrete medical practice in MSF field programmes. In many MSF projects, MSF staff continue to refuse women and young girls seeking this important medical service.
To address the imbalance between commitment and action, we request the IB and all Institutional Members to (i) ensure that MSF does not deny termination of pregnancy to women and girls who request it (ii) maintains unambiguous public communication of MSF's position on safe abortion care, including termination of pregnancy on request.

Background:
Since the 2004 international council (IC) resolution affirming MSF's support for the 'provision of termination of pregnancy, based on the medical and human needs of our patients', the movement has struggled to make access to safe abortion care a reality. In 2012, the International Board (IB) re-emphasised the need to do more to implement safe abortion care in MSF.
The resolution and reaffirmation to provide save abortion care aimed to ensure better health outcomes for women, with the full knowledge and understanding of the risks (reputational, ethical, identity) for MSF around such a politicised issue. Today, the main barriers to providing safe abortion care across the movement are internal resistance and inconsistent implementation of this specific aspect of medical care within MSF. Whilst some MSF staff do provide medical care for termination of pregnancy, most do not. At times, MSF staff members may personally support safe abortion care but are reluctant to implement it in their project due to concerns about its potential impact on MSF's operations and security. In this way, the provision of abortion care remains largely a personal commitment, and individual MSF staff members opt in or out according to their own criteria.

MSF IGA **minutes**, 29 June-1 July 2017 (in English)

Extract:
Motion: Call to Action across the Movement to Enact the MSF Resolution on Safe Abortion […]
The Day Chair calls the IGA to vote on the following motion:
Call to Action across the Movement to Enact the MSF Resolution on Safe Abortion
(two-thirds majority required)
For: 45 – Against: 0 - Abstentions: 0 - Absent: 4
Passed