

Training course in adolescent sexual and
reproductive health 2021

Safe abortion care

Enas Daryacoub Dajani

Y-PEER Network - Palestine

enas.dajani@hotmail.com

Question 1

What are WHO's recommendations on safe abortion care for adolescents?

With regard to safe abortion care, WHO guideline issues the following adolescent-specific recommendations on 4 levels:

1. **Policy:**
Ensure laws and policies enable adolescents to obtain safe abortion services.
2. **Community:**
Identify and overcome barriers to the provision of safe abortion services for adolescent girls.
3. **Health facility:**
Ensure adolescents have access to post-abortion care as a life-saving medical intervention, regardless of whether the abortion or attempted abortion was legal.
Ensure adolescents who have had abortions can obtain post-abortion contraceptive information and services, regardless of whether the abortion was legal.
4. **Individual:**
Enable adolescents to obtain safe abortion services by informing them and other stakeholders about the dangers of unsafe methods of interrupting a pregnancy, the safe abortion services that are legally available, and where and under what circumstances abortion services can be legally obtained (WHO, 2018b).

Question 2

A 19 year-old girl has decided after counselling to have a medical abortion for an unintended pregnancy of 12 weeks. What is the WHO recommended medical abortion regimen in this situation? To prevent a repeat unintended pregnancy, when could this young woman be recommended an oral contraceptive?

The World Health Organization in its guidelines of Medical management of induced abortion at ≥ 12 weeks of gestation suggests two ways of medical abortion:

1. A combination regimen; Mifepristone and Misoprostol (Recommended).
2. Misoprostol-only (Alternate).

However, in this specific case of a 19-year-old girl who is willing to have a medical induced abortion for a 12-week-old embryo, the WHO recommended medical abortion regimen is the combination regimen (because it is more effective):

WHO suggests the use of 200 mg Mifepristone administered orally, followed 1–2 days later by repeat doses of 400 μg Misoprostol administered vaginally, sublingually or buccally every 3 hours. (Evidence suggests that vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes, including buccal administration). The minimum recommended interval between use of Mifepristone and Misoprostol is 24 hours. Repeat doses of misoprostol can be considered

when needed to achieve success of the abortion process. In the guideline, WHO does not provide a maximum number of doses of Misoprostol, Health-care providers should use caution and clinical judgment to decide the maximum number of doses of Misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgment and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

Regarding the WHO recommendation on oral contraceptives, it is stated in the guidelines that for individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or the misoprostol-only regimen who desire hormonal contraception (oral contraceptive pills, contraceptive patch, contraceptive ring, contraceptive implant or contraceptive injections) are advised to be given the option of starting hormonal contraception immediately after the first pill of the medical abortion regimen. On the other hand, all individuals who can become pregnant should be provided with all of the necessary information to make an informed decision regarding the use of contraception (WHO, 2018a).

Question 3.1

What is the Global Abortion Policies Database?

Global Abortion Policies Database (GAPD), launched in 2017, is a tool that presents information of abortion laws and policies beyond the legal categories of abortion and includes additional access requirements, information related to service provision, and conscientious objection for all WHO member states. Data available in the GAPD has been used as of February 2019.

The content and wording of laws, policies, standards and guidelines, legal judgments, and other official statements (hereinafter referred to as “policies”) related to barriers identified in the Safe abortion guidance were reviewed. Each section within the results is begun alongside italicized information from the WHO guidance and report on the existence of policies related to limiting access to information; mandatory counseling, requirements for third-party authorizations, regulatory approval or registration for essential medicines, restrictions on the range of providers or facilities, refusal of care, and mandatory waiting periods.

Only countries where such policies would apply, i.e., where abortion is lawful on the woman's request with no requirement for justification and/or for one or more legal ground(s); were included. However, countries where abortion is prohibited in all circumstances, and countries where laws prohibit unlawful abortion but do not specify exceptions for lawful; were excluded. Further, countries where data on the policy and regulatory environment were not available in the GAPD were excluded too. Eight countries that may regulate abortion at the subnational level were also not included in the analysis. Thus, data for 158 countries was analyzed (Lavelanet et al., 2020).

Question 3.2

Review your country's profile in the Global Abortion Policies Database. What strikes you most in relation to access (or lack thereof) to safe abortion care in your country? Why?

Since Palestine is not listed in the Global Abortion Policies Database (GAPD), I have selected Jordan as a neighboring country that has very similar context in terms of social norms, culture and even laws and policies, specifying the West Bank which was part of Jordan at a certain time period due to political issues related to the Israeli Occupation of the Palestinian lands. Since then, the Jordanian Penal Code has been in Force in the West Bank and the Palestinian Draft Penal Code is in fact derived from it. It is worth mentioning that the Jordanian Penal Code is influenced by the French colonial Law regarding the abortion policy in particular, with reforms to adhere more closely to Islamic principles, including regarding fetal development, the commencement of life and punishment and compensation for illegal abortion.

According to the Country Profile of Jordan in the GAPD, abortion at the women's request is forbidden by law and criminalized in all cases except cases where the pregnant woman's life is at risk, or her health is endangered; which is the case in almost all countries in the MENA region.

What strikes me in these laws is that they forbid access to safe abortion even in cases of rape and incest; which means that the law considers "saving the life of the fetus" is more important than having an illegal and unidentified child into this world! Having a child in such circumstances in our countries is socially unaccepted and this child will suffer throughout all his/her life, besides the miserable life the mother will have.

In addition, it criminalizes an induced abortion for a woman whose mental health is not stable, and even despite the intellectual or cognitive disability of the woman; which is totally unacceptable to ignore the mother's mental health just to save a fetus's life! How will this mentally-sick mom raise this kid?

In my opinion, and based on my limited knowledge in Islam, I know by heart that there has been a Hadeeth by the Prophet Mohammad that says: (Necessities allow prohibitions), and while abortion is not stated as "Haram" in Quran, and that its prohibition is based on Fatawa, this Hadeeth shall be taken into consideration to allow this certain prohibition to achieve a necessity, which is to protect our communities and countries from the over-population, especially while we are living in a very hard economic crisis, while most of the Islamic countries have high percentages of poverty, hunger, illiteracy, violence, terrorism, wars and many other social issues that are caused by ignorance, lack of education, and other reasons (WHO, 2017).

Question 4

What is self-managed abortion? For whom does WHO recommend self-managed abortion? How safe is self-managed abortion?

- Self-managed abortion is when a person performs their own abortion without clinical supervision, as is required by law in most countries.
- Based on existing evidence, the WHO recommends self-managed abortion with medicines as a method of abortion for individuals who are less than 12 weeks pregnant and have “a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.”
- Self-managed abortion with medicines is much safer than invasive methods. With the advent of medical abortion, the practice of abortion without formal supervision of a health care professional has become safer and more widespread; and this therefore reduces the health risks arising from unsafe abortion. Researchers have attributed self-managed abortion with pills to a worldwide decrease in abortion mortality
- The safety of self-managed abortion depends on an individual’s knowledge, access to quality medicines and ability to seek follow-up care. An individual’s safety can also depend on the degree to which they face risk of arrest when self-managing their abortion (CRP, 2020).

Question 5.1

Name the two bases that the authors of the article identified as allowing for abortions in the Middle East and North Africa.

Abortion is generally forbidden in MENA countries based on the European laws which were incorporated into Middle Eastern legal systems during the colonization times in the late 1900s, and later due to Islamic fatwas. It has been concluded that Islam forbids abortion after the fourth month of pregnancy (after the fetus achieves ensoulment) except to save the woman’s life (if the pregnancy endangers the mother’s life or put her life at risk), and if it happens in the first trimester.

With time, there have been several changes on these laws based on other grounds for abortion (risk to physical health, risk to mental health, fetal impairment, rape, etc.). Countries in the MENA vary between taking or not taking these grounds to allow abortion.

In general, interpretations that allow for abortion are based on fetal development, gestational age and the circumstances of the pregnant woman; they rarely mention fetal rights or when life begins. It is accepted that maternal life takes precedence, at least until the fetus achieves the status of person.

In addition, the life of existing children is often considered more important than that of the fetus. If a woman becomes pregnant during breastfeeding, it is generally accepted that another infant might put the existing child at risk (Hessini, 2007).

Question 5.2

What were the three strategies used to advocate for legal reforms in abortion laws?

1. Research on the undesired consequences of unsafe abortion, its link to maternal mortality and a high rate of unwanted pregnancy.
2. Introduction of simpler and safer methods for treating post-abortion complications such as manual vacuum aspiration (MVA).
3. A cohort of trained providers of MVA (Hessini, 2007).

Question 5.3

Did the fact that Saudi Arabia has a fatwa that permits termination of a pregnancy if there is fetal impairment change the respondents' views about abortion?

Yes, it did! In a study among people with hemoglobin disorders in Saudi Arabia of attitudes towards antenatal diagnosis of disorders and abortion in cases of sickle cell anemia and thalassemia, most participants were unaware of increased risk with consanguinity and did not know about the Saudi Arabian fatwa permitting abortion in cases of fetal impairment. Close to half of the participants, who had initially rejected the idea of pregnancy termination, changed their minds when informed of the fatwa! (Hessini, 2007).

Question 6.1

Who are Lady Health Workers in Pakistan? What has been their role in increasing access to abortion services?

Lady Health Workers is a cadre of female health care workers in Pakistan, who act as a link between the communities and the health facilities. Their work includes disseminating information and educational material on health, family planning and sanitation, administering immunization campaigns, etc.

They are considered part of the mid-level providers, who were included -as the policy changes necessitated in Pakistan- in effective programmatic interventions for capacity building, in use of misoprostol and MVA for UE/PAC and bringing about commodity sustainability and service availability (Sharma et al., 2019).

Question 6.2

When dealing with a sensitive and stigmatized issue like abortion, what was identified by Ipas as the key to moving the agenda forward in Pakistan?

During Ipas's experience in Pakistan, it has been found that the key to making progress on a politically sensitive and stigmatized issue like abortion is desensitizing others to the topic through continuous conversations with a broad range of stakeholders, through partnering with the government – using evidence-based policy initiatives to highlight the need for safe abortion care.

Moreover, the advocacy efforts of professional associations and societies play a vital role to encourage progressive policies. Their opinions, public statements, and advocacy initiatives are an influencing force on the policy actions by Ministry and departmental officials. Ipas and other key partners have played a key role in mobilizing professional associations to advance the advocacy work with the Ministry (Sharma et al., 2019).

Question 6.3

What were the two key approaches used by Ipas to contribute to the improvement of the quality of abortion care in Pakistan?

Ipas and partner organizations tackled the aspects of quality of abortion care in two key ways:

1. A programmatic intervention by implementing Ipas's global Values Clarification and Attitude Transformation (VCAT) training model with all levels of service providers and health facility officials. These trainings are powerful tools that help individuals come to the realization that no matter what their beliefs are about abortion, no woman should suffer the loss of life because of lack of access and that, as providers, their professional responsibility trumps their personal values.
2. A policy initiative where Ipas worked with members of PRHTAC and the Pakistan Alliance for Post-Abortion Care (PAPAC), a cross-regional coalition of stakeholders from government departments, NGOs, UN entities and others collaborating to reduce unsafe abortions, to develop Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care (Sharma et al., 2019).

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