Geneva 2022

SAFE ABORTION CARE

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DEFINITIONS

- **Induced abortion:** Intentional loss of an intrauterine pregnancy due to medical or surgical means.
- **Safe abortion**: Abortion that meets all three criteria (i) is done with a method recommended by WHO (medical abortion, vacuum aspiration, dilatation & evaluation) (ii) is appropriate to the pregnancy duration (iii) is provided by/supported by a trained health-care provider.
- **Less safe abortion:** Abortion that (i) is done by a trained health-care provider, but with an outdated method e.g. sharp curettage (ii) is done using a WHO recommended method but without information and support from a trained individual.
- **Least safe abortion:** Abortion provided by untrained individuals using dangerous methods e.g. ingestion of caustic substances.

RATIONALE -1/2

- Unsafe abortion is an important problem: An estimated 5.7 million girls aged 15-19 years undergo abortions every year in LMICs, the majority of which are unsafe.[1]
- Unsafe abortions in adolescents have major health consequences: Compared to older women, adolescents are more likely to seek abortions from untrained providers, to have a self-induced abortion, to terminate pregnancies after their first trimester, to delay seeking medical care for complications following unsafe abortions.[2] They are also less likely to know about their rights concerning abortion and post-abortion care, & to report having had an abortion.[2]

RATIONALE -2/2

- Safe abortion carries low health risks: While the risks differ depending on the duration of the pregnancy, the method used, and the people carrying out the method, safe abortion can have a lower risk than an injection of penicillin or carrying a pregnancy to term.
- Abortion related-laws & policies, the provision of good quality services need attention: Access to safe abortion services is highly restricted in many countries despite evidence that restrictive abortion laws are associated with higher levels of maternal mortality. When safe abortion is legally allowed for adolescents, it is often not adolescent friendly.

HUMAN RIGHTS OBLIGATIONS

- States are obliged under human rights law to provide safe abortion care.
- Implementation of measures to prevent unsafe abortion & to provide post-abortion care are part of the core obligation of states to uphold the right to sexual & reproductive health.
- States are obliged to ensure universal access to a comprehensive package of sexual & reproductive health interventions including safe abortion care & post-abortion care (the latter whether or not abortion is legal).
- Human rights mechanisms have called for the decriminalization of abortion & removal of barriers such as third-party consent requirements.
- Denial of abortion and forced continuation of pregnancy have been identified as a form of gender-based violence.

KEY CONCEPTS TO CONSIDER

- Restrictive laws & policies often force adolescents to seek illegal & unsafe abortions: Laws & policies should promote the respect & protection of women & girls. This includes ensuring timely access to safe abortion & addressing stigma & discrimination against those who seek abortion services or post-abortion care.
- Adolescents are less likely than adult women to obtain safe abortion services: Adolescents & other stakeholders should be informed about the dangers of unsafe abortions, the safe abortion services available, & the circumstances in which they can be legally obtained.
- Abortion services & health care providers are often not adolescent friendly: Health care providers must be trained & supported to inform, counsel & provide services to adolescents according to their evolving capacities, & to be responsive to the needs of different groups of adolescents.

WHO GUIDELINES

- ***Medical management of abortion (2018).***
- ***Safe abortion: technical & policy guidance for health systems (2012).***
- ***WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries (2011).***
  - **Policy**- ensure laws & policies enable adolescents to obtain safe abortion services;
  - **Community**- identify & overcome barriers for the provision on safe abortion services;
  - **Health facility**- ensure adolescents have access to post-abortion care regardless of whether the abortion or attempted abortion was legal;
  - **Individual**- inform adolescents & other stakeholders about the dangers of unsafe methods of interrupting a pregnancy, safe abortion services legally available & under what circumstances they can be obtained.
- ***Health worker roles in providing safe abortion care and post-abortion contraception (2015).***
- ***Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations (2014).***
- ***Consolidated guideline on sexual and reproductive health and rights of women living in HIV (2017).***

COMPLEMENTARY DOCUMENTS TO WHO's GUIDELINES

- Clinical practice handbook for safe abortion, WHO, 2014.
- Interagency statement: preventing gender-biased sex selection, WHO, 2011.
- Sexual health, human rights and the law, WHO, 2015.
- Sexual health and its linkages to reproductive health: an operational approach, WHO, 2017.
- Renner R-M, de Guzman A, Brahmi D. Abortion care for adolescent and young women. Int J Gynecol Obstet. 2014;126(1):1–7.
- Adolescents' need for and use of abortion services in developing countries. New York: Guttmacher Institute; 2016.
- Provision of abortion care for adolescent and young women: a systematic review. Chapel Hill, NC: Ipas; 2013.

Specific measures for delivery of services in the context of COVID-19 – 1/2

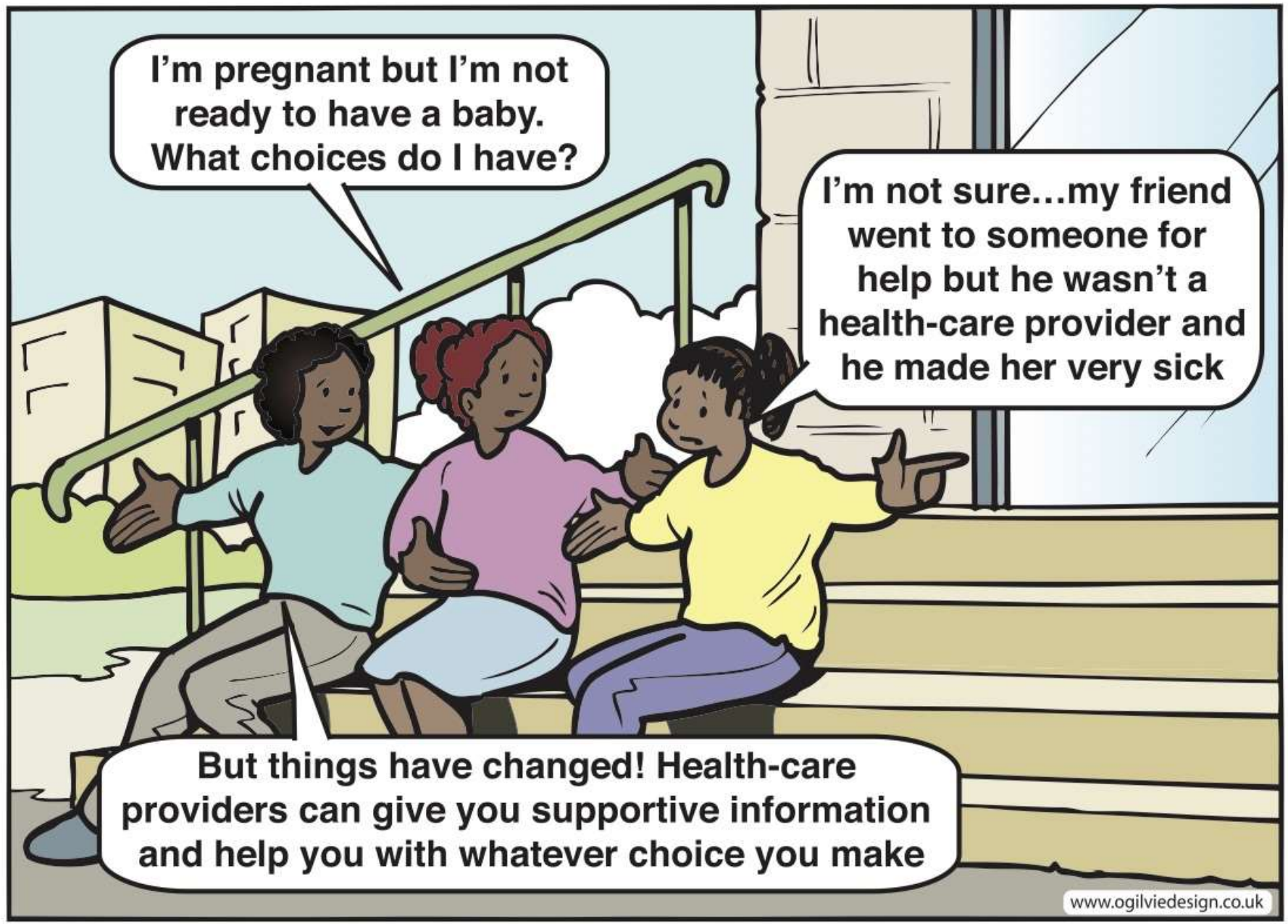
- Inform adolescents where and how to access comprehensive abortion care, including safe abortion to the full extent of the law and post-abortion care, through appropriate channels.
- In health facilities, ensure that comprehensive abortion care remains available for adolescents, is safe and is provided respectfully and confidentially.
- Consider relaxing policies to enable the use of telemedicine for the provision of medical abortion to adolescents to avoid unnecessary clinical visits.
- Consider reducing barriers that delay access to care and therefore increase risks of adolescents reverting to un-safe abortion practices. In particular, consider waiving restrictions (if these exist), such as on age, parental/spousal consent or marital status, and providing services subsidized or free of charge within the relevant legal framework and inline with international guidelines.

Specific measures for delivery of services in the context of COVID-19 – 2/2

- Ensure that gender-based violence prevention and treatment services are available to the adolescent during the care encounter, or that the adolescent is referred based on their individual situation.
- Ensure that sexually transmitted infection (STI) services are available to the adolescent during the care encounter, or that the adolescent is referred based on their individual situation.
- Counsel adolescents on, and provide, post-abortion contraception, where desired, to avoid rapid repeat pregnancy.

Considerations for resumption of normal services in the context of COVID-19

- Where possible, promote the institutionalization of good practices in improving accessibility and quality that were put in place during the period of closures and disruption.


I'm pregnant but I'm not ready to have a baby. What choices do I have?
I'm not sure…my friend went to someone for help but he wasn't a health-care provider and he made her very sick
But things have changed! Health-care providers can give you supportive information and help you with whatever choice you make
www.ogilviedesign.co.uk

SAFE ABORTION CARE

A Regional Perspective

Access to legal, safe and comprehensive abortion care, including post-abortion care, is essential for the attainment of the highest possible level of sexual and reproductive health. (WHO, c2022)

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Number of abortion cases in the EMR

	Total abortions per year*	Safe abortions		Less-safe abortions		Least-safe abortions		Unsafe abortions (sum of less-safe and least-safe abortions)	
		n	% (90% UI)	n	% (90% UI)	n	% (90% UI)	n	% (90% UI)
Worldwide	55 700 000	30 600 000	54·9% (49·9–59·4)	17 100 000	30·7 (25·5–35·6)	8 010 000	14·4 (11·5–18·1)	25 100 000	45·1 (40·6–50·1)
Developed countries	6 580 000	5 760 000	87·5% (81·9–89·6)	818 000	12·4 (10·2–17·9)	5180	0·08 (0·0–1·36)	823 000	12·5 (10·4–18·1)
Developing countries	49 100 000	24 800 000	50·5% (45·2–55·9)	16 300 000	33·2 (27–38·3)	8 010 000	16·3 (13·1–20·7)	24 300 000	49·5 (44·1–54·9)
Northern America	1 190 000	1 180 000	99·0% (97·7–99·8)	11 200	0·9 (0·2–2·3)	†	0·0 (0·0–0·03)	11 200	0·9 (0·2–2·3)
Europe	4 290 000	3 800 000	88·8% (80·3–91·7)	480 000	11·2 (7·8–19·3)	3770	0·0 (0·0–0·02)	483 000	11·2 (8·3–19·7)
Southern	750 000	684 000	91·2% (85·6–92·9)	65 400	8·7 (6–13·9)	820	0·11 (0·0–2·9)	66 200	8·8 (7·0–14·5)
Western	562 000	525 000	93·5% (90·6–96·1)	36 500	6·5 (3·9–9·4)	†	0·0 (0·0–0·03)	36 500	6·5 (3·9–9·4)
Northern	349 000	341 000	97·9% (92·8–99·6)	7370	2·1 (0·4–6·8)	†	0·03 (0·0–0·9)	7370	2·1 (0·4–7·2)
Eastern	2 630 000	2 250 000	85·8% (73·3–91·1)	370 000	14·1 (8·4–26·5)	2950	0·11 (0–2·4)	373 000	14·2 (8·8–26·7)
Asia	34 500 000	21 000 000	62·1% (54·8–67·2)	10 500 000	29·7 (23·5–36·6)	2 950 000	8·3 (4·9–13·3)	13 500 000	37·8 (32·8–45·2)
Eastern	12 800 000	11 300 000	88·9% (78·3–95·7)	1 410 000	11·1 (4·1–21·3)	5730	0·04 (0·0–0·6)	1 420 000	11·1 (4·3–21·7)
South-eastern	5 140 000	3 070 000	59·6% (38·4–77·7)	1 380 000	26·9 (10·8–45·9)	694 000	13·5 (2·3–30)	2 080 000	40·4 (12·3–61·6)
South-central	15 700 000	6 620 000	42·2% (34·1–49·6)	7 040 000	44·9 (35·1–53·3)	2 020 000	12·9 (7–19·2)	9 060 000	57·8 (50·3–65·9)
Western	1 870 000	962 000	51·5% (40·9–66·4)	678 000	36·3 (19·2–48·5)	229 000	12·3 (1·2–23·4)	907 000	48·5 (33·7–59·1)
Latin America	6 420 000	1 510 000	23·6% (8·8–47·0)	3 830 000	59·7 (32·7–72·2)	1 070 000	16·7 (8·8–33·4)	4 900 000	76·4 (53·0–91·3)
Caribbean	519 000	132 000	25·4% (6·7–47·6)	258 000	49·6 (23·8–64·9)	129 000	24·9 (15·1–40·8)	387 000	74·6 (52·4–93·3)
Central America	1 310 000	241 000	18·4% (10·6–28·9)	684 000	52·1 (37·7–63·5)	388 000	29·6 (16·9–40·3)	1 070 000	81·6 (71·1–89·5)
South America	4 590 000	1 140 000	24·9% (4·7–53·7)	2 890 000	63 (28·9–79·3)	555 000	12·1 (3–31·9)	3 440 000	75·1 (46·3–95·4)
Africa	6 860 000	2 010 000	24·4% (18·6–33·6)	2 280 000	27·6 (21·2–37·0)	3 950 000	48·0 (36·5–52·9)	6 230 000	75·6 (66·4–81·4)
Eastern	2 650 000	634 000	23·9% (17·0–33·0)	774 000	29·2 (19·9–37·6)	1 240 000	46·9 (36·5–54·9)	2 020 000	76·1 (66·9–83·0)
Middle	1 020 000	120 000	11·8% (5·5–30·4)	195 000	19·2 (6·7–40·7)	702 000	69·0 (38·0–81·2)	897 000	88·2 (69·6–94·6)
Northern	1 920 000	557 000	29·0% (11·0–49·9)	510 000	26·6 (10–46·3)	852 000	44·4 (19·5–58·9)	1 360 000	71·0 (50·1–89·0)
Western	2 140 000	327 000	15·3% (10·4–24·1)	698 000	32·6 (24·1–42·8)	1 120 000	52·1 (40–59·8)	1 820 000	84·7 (75·9–89·6)
Southern	510 000	375 000	73·5% (27·7–93·2)	98 800	19·4 (1·5–62·1)	36 400	7·1 (2·6–11·1)	135 000	26·5 (6·7–72·3)
Oceania	144 000	95 700	66·3% (61·4–77·7)	11 200	7·8 (3·5–17·9)	37 400	25·9 (11·5–31·1)	48 600	33·7 (22·3–38·6)

- **Modelled estimates**

- **Western Asia:**

1,870,000 abortions per year
Of which, 51.5% are safe, and 48.5% are unsafe

- **Northern Africa:**

1,920,000 abortions per year
Of which, 29% are safe and 71% are unsafe.

Source: Ganatra et al., 2017.

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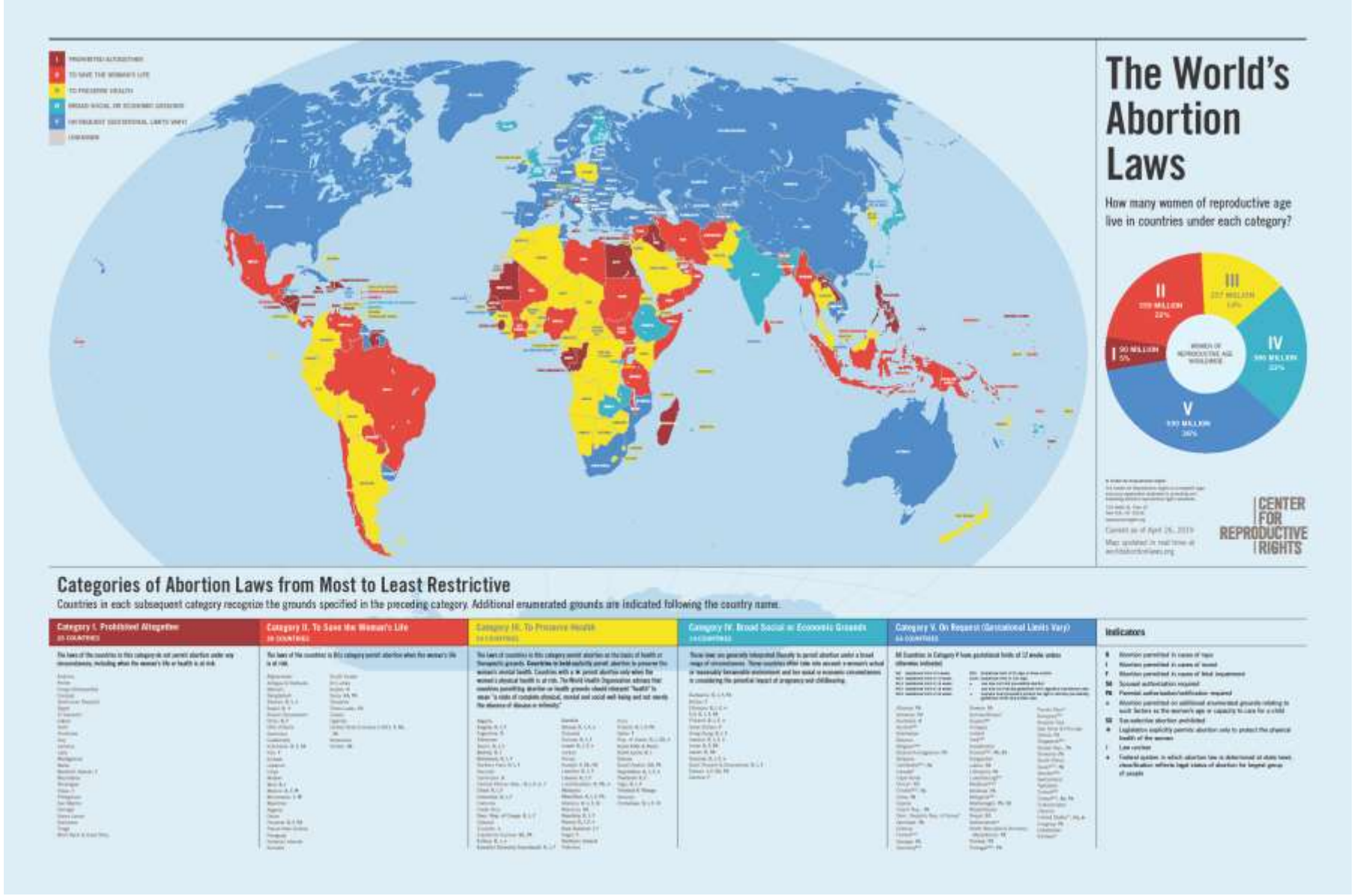
Laws and policies on abortion

Current situation

Most countries of the EMR have restrictive laws/policies on abortion. However, some countries have certain provisions related to abortion. The regional Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy Survey 2019 provide some information on **Abortion Policies in the member states** (1):

I. 11 out of 16 countries include abortion as a component of their Reproductive Healthcare National Policy.
II. 15 out of 16 countries include vacuum aspiration as supplies and equipment indicated for use in pregnancy, childbirth and postpartum care in their National Commodities List.
III. 6 countries (Afghanistan, Bahrain, Egypt, Oman, Morocco, and Pakistan) include contraception in post-abortion care (2).



EMR countries have most restrictive abortion laws

Source: Center for Reproductive Rights. The World's Abortion Laws. Center for Reproductive Rights; c 1992-2021.

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Table 1: Legal ground under which abortion can be permitted

Source: UNFPA. Addressing unintended pregnancy in the Arab region. UNFPA; 2018.

Country	On request	Fetal impairment	Rape	Incest	Mental health	Physical health	Health of women	Life
Algeria	-	-	-	-	+	+	-	+
Bahrain	-	-	-	-	-	-	-	+
Comoros	-	-	-	-	-	-	-	-
Djibouti	-	-	-	-	-	-	-	-
Egypt	-	-	-	-	-	-	+	+
Iraq	-	+	-	-	+	-	+	-
Jordan	-	-	-	-	-	-	+	+
Kuwait	-	+	-	-	-	-	+	+
Lebanon	-	-	-	-	-	-	-	+
Libya	-	-	-	-	-	-	-	+
Mauritania	-	-	-	-	-	-	-	-
Morocco	-	-	-	-	-	-	+	+
Oman	-	-	-	-	-	-	-	+

Muslim-Majority Countries Position on Abortion by Number of Abortion Rights (NAR) Based on Seven Dimensions in a Country (Ramirez and McEneaney, 1997)

Table 4 Number of abortion rights in Muslim-majority countries (2011)

NAR	1	2	3	4	5	6	7
Countries	Afghanistan L	Comoros L.PH	Algeria L.PH.MH	Burkina Faso L.PH.F.I/R			Albania
	Bangladesh L	Iran L.F	Chad L.PH.F	Guinea L.PH.F.I/R			Azerbaijan
	Brunei L	Jordan L.PH	Gambia L.PH.MH				Bahrain
	Djibouti L	Mali L.I/R	Kuwait L.PH.F				Kazakhstan
	Egypt L	Maldives L.PH	Malaysia L.PH.MH				Kyrgyzstan
	Guinea-Bissau L	Morocco L.PH	Niger L.PH.F				Tajikistan
	Indonesia L	Pakistan L.PH	Qatar L.PH.F				Tunisia
	Iraq L	Saudi Arabia L.PH	Sierra Leone L.PH.MH				Turkey
	Lebanon L	Sudan L.R					Turkmenistan
	Libya L						Uzbekistan
	Mauritania L						
	Nigeria L						
	Oman L						
	Senegal L						
	Somalia L						
	Syria L						
	United Arab Emirates L						
	Yemen L						
Total (%)	18 (38.30%)	9 (19.15%)	8 (17.02%)	2 (4.26%)	0	0	10 (21.28%)

Grounds: L: Abortion allowed to save the life of the woman; PH: Abortion allowed in cases where the pregnancy threatens the woman's physical health; MH: Abortion allowed in cases where the pregnancy threatens the woman's mental health; F: Abortion allowed in cases of foetal impairment; I/R: Abortion is allowed in cases of incest or rape; SER: Abortion allowed on additional enumerated grounds relating to such factors as the woman's age or capacity to care for a child.

Note: This table is the author's compilation. Abortion legislative data were compiled through analysing cross-country compilations of the WHO (1971); Centre for Reproductive Rights (2008); UN (UN DESA 2002, 2011); Guttmacher Institute (2012), as well as research by Roemer 1967; Cook and Dickens 1978; Rahman *et al.* 1998; and Boland and Katzive 2008.

*Please see notes for the seven dimensions of abortion rights

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Laws and policies on abortion

Implications of the current situation

According to an analysis by UN DESA (2014), reproductive outcomes in countries with restrictive laws/policies on abortion are worse compared to countries with liberal laws/policies.

Reproductive outcomes	Countries with restrictive laws/policies on abortion	Countries with liberal laws/policies on abortion
The average rate of unsafe abortion	26.7/1000 women 15-49	6.1/1000 women
Rate of maternal death	223 maternal deaths/100,000 live births	77 maternal deaths/100,000 live births
Fertility rate in adolescents (15-19 years)	69/1000 births	24/1000 births

Barriers to adolescents' access to safe abortion care in the region

I. **Lack of data:** Most countries in the region lack official statistics on abortion. This is especially true of official statistics on abortion among marginalized women (e.g., unmarried women, adolescent girls).
II. **Barriers to accessing services:** Lack of information, lack of infrastructure, cost, and fear of confidentiality breeches prevent adolescents, unmarried women/girls, and women/girls with unregistered marriages from accessing safe abortion services.
III. **Legal/policy restrictions:** Restrictive laws and policies on abortion prevent women, and especially adolescent girls, from accessing safe abortion and push some to seek unsafe abortion services (1,2). An Iranian study showed that one-third of 33% of abortions in studied population were performed by nonmedical providers (3).
IV. **Stigma associated with abortion:** Across the EMR, there is a perception that improving access to safe abortion services will increase the abortion rate (4).

Barriers to adolescents' access to safe abortion care in the region

V. **Lack of political commitment:** Politicians refrain from engaging in efforts to expand and modernize the provision of safe abortion care (1).

VI. **Choice and competency of service provider:** Lack of availability of preferred service providers and lack of adolescent-friendliness of existing service providers discourage many girls from seeking safe abortion care. For example, an Iranian study showed that one-third of abortions in studied population were performed by a nonmedical providers (2).

VII. **Humanitarian settings:** The political conflicts in various countries increase adolescents' vulnerability to unplanned pregnancy and thus increase their possible need for abortion services.

Case study: Abortion in the West Bank

Assessment of Safe and Unsafe Abortion among Palestinian Women in Hebron Governorate in Southern West Bank - Palestine.

Mixed-methods study conducted by Palestinian Family Planning and Protection Association (PFPPA)

Quantitative component

- A total of 541 women attending the PFPPA clinics at four urban and rural sites were selected using purposive non-random sampling method.

Findings

- They were women who had at least one abortion experience during their lifetime
- More than 70 % of the women had an abortion at least once
- Two-thirds (66 percent) of women who ever had an abortion had more than one.

Case study: Abortion in the West Bank

- ***Assessment of Safe and Unsafe Abortion among Palestinian Women in Hebron Governorate in Southern West Bank - Palestine.***

Individuals with prior knowledge about the abortion	Frequency	Percent
Nobody at all	263	67.6%
My husband only	75	19.3%
My husband and mother-in-law	17	4.4%
My husband, mother-in-law and own mother.	29	7.5%
Close friend only	5	1.3%
Total	**389**	**100.0%**

Person and place of induced abortion	Frequency	Percent
By myself at home	98	31.2%
By the Arab *daya* at her home	58	18.5%
By a doctor in his private clinic	21	6.7%
By a doctor in a health center or hospital	137	43.6%
Total	**314**	**100.0%**

Abortion in humanitarian settings

Increasing recognition of the importance of providing SRH in humanitarian settings. Yet abortion services rarely provided.

- Why are abortions an issue in humanitarian settings?
    1. Sexual violence and rape often increase in humanitarian crisis
    2. Access to contraception may be limited or disrupted and so women may experience unwanted pregnancies
    3. Women who experience unwanted pregnancies and who do not have access to safe abortion services may resort to unsafe abortions

- Adolescents in humanitarian settings are at increased risk for unintended pregnancy, due to their psychosocial development, existing gender and social power dynamics, socio-economic status, sexual violence and coercion, and traditional/cultural values that prevent access to SRH information and services.

- Adolescents often lack awareness of and access to contraceptive methods to prevent pregnancy.

- Adolescents are more likely than adults to seek unsafe abortions and/or to wait longer to seek abortion care, out of fear of stigma, policy constraints and structural barriers such as transportation costs, or delays in realizing they are pregnant.

Source: McGinn and Casey, 2016

Regional opportunities

WHO guidance on self-care:

Can be a shift towards combatting stigma and privacy challenges by removing the need for a health care personnel (HCP) middle-person.

Digital technologies:

Provide some opportunity for support and counseling and even abortion care.

REGIONAL INITIATIVE 1
Marie Stopes International in Afghanistan (1,2,3)

Marie Stopes International (MSI, an NGO) in Afghanistan is one of the largest providers of family planning services and post abortion care in the country.

Aim: By 2030, no abortion will be unsafe and every individual who wants access to contraception will have it. To accomplish this:

- Provide services where and when women and girls need them without discrimination
- Remove un-necessary stigma, legal, and policy challenges, where possible
- Ensure women and girls know their legal rights and entitlements
- Ensure the provision of affordable care
- Provide real choice in contraceptive methods and health service providers

Presence in the country:

- 36 centers offering a comprehensive range services, including contraception and post-abortion care
- 40 Marie Stopes Ladies and 10 mobile outreach teams that bring services to women and girls living in urban slums and some hard-to-reach rural areas

Impact :

- 156,000 unsafe abortions averted in 2019 (1)
- 286,000 unintended pregnancies were avoided in 2019 (1)

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REGIONAL INITIATIVE 1
Marie Stopes International in Afghanistan, cont. (1,2,3)

Specific initiatives:

1. The Integrated Reproductive and Maternal Health Project: Aims to improve the availability, accessibility, quality, and acceptability of SRH information and services for vulnerable and marginalized women, girls, men, and boys in six provinces of Afghanistan. The project is aligned with the national development goals of Afghanistan and contributes to the enhancement of the rights and status of women and girls and the reduction of poverty and inequality.

2. Smash Abortion Stigma Campaign: Aims to increase community acceptance for SRH services by engaging with key stakeholders e.g. religious leaders and their wives. In 2015, an estimated 30% of clients were referred through religious leaders or religious leaders' wives.

3. Response to COVID-19: Aims to engage with partners to ensure that contraception, safe abortion, and post-abortion care are defined by governments as ‘essential services’ and available in the basic package of services.

REGIONAL INITIATIVE 2
IPAS initiative in Pakistan (Sharma et al., 2019)

IPAS (an NGO) is the only international organization solely focused on expanding access to abortion and contraception.

Aim: To engage with the government of Pakistan to stimulate political norm change on abortion through the entry point of maternal mortality.

Approaches used from 2012-2018:

I. Advocacy campaign: Hosted key provincial stakeholders to discuss the impact of unsafe abortion on women and girls, and to identify a solution for mitigating this impact, primarily by advocating for the use of the latest WHO endorsed uterine evacuation technologies.

II. Establishment of coordinating committees: Supported the establishment of the Punjab Reproductive Health Technology Assessment Committee (PRHTAC) and the Sindh Reproductive Health Technologies Assessment Committee (SRHTAC).

III. Expansion of availability of services: Supported the PRHTAC to include misoprostol and manual vacuum aspiration in the Essential Package of Health Services and essential lists as the reproductive health technology of choice for providing safe uterine evacuation and post-abortion care. As a result, **the Department of Health in Punjab procured 10 million misoprostol pills from the government's budget by 2015**.

REGIONAL INITIATIVE 2
IPAS initiative in Pakistan, cont. (Sharma et al., 2019)

Approaches used from 2012-2018, cont.:

IV. Task-shifting:
- Trained midlevel providers in uterine evacuation and post-abortion care.
- Included provision of misoprostol in the midwifery curriculum, given the non-surgical and less-skilled nature of the technology.

V. Quality of services:
- Supported the implementation of a values clarification and attitude transformation (VCAT) training programme with service providers to increase support for the idea that no matter what an individual service provider's beliefs are about abortion, no woman should suffer the loss of life because of lack of access to safe abortion services.
- Contributed to the development of service delivery standards and guidelines for high-quality safe uterine evacuation and post-abortion care.

VI. Scaling up:
- To Sindh, the second most populous province with the formation of Sindh Reproductive Health Technologies Assessment Committee (SRHTAC) in 2016

VII. Spotlighting of the national situation in the global human rights arena:
- Highlighted the challenges that Pakistani women face in relation to safe abortion care in the UN Human Rights Committee.
- The service delivery standards and guidelines for high-quality safe uterine evacuation and post-abortion care, which were endorsed by the MOH in March 2018. The MOH issued a related statement **which mentioned the important needs of adolescents and disadvantaged women and girls in rural areas** in December 2017.

Lessons learned from the regional initiatives on the provision of safe abortion services, where it is allowed

I. **Expand data availability:** Improve the availability of data on safe and unsafe abortion in the region (including abortion data in country's DHS and other population-based surveys, HMIS, special studies), and the quality of data that are provided.

II. **Improve access to services:** Improve the the quality of SRH care and access to safe abortion care by addressing law/policy restrictions, strengthening providers' competencies and attitudes, exploring opportunities for task-shifting, and disseminating information about the legal status of the abortion in the country and available services, including for adolescents.

III. **Address determinants through prevention:** Expand the availability of comprehensive sexuality education in schools to improve knowledge about SRH, prevent early marriages, increase the availability and quality of family planning services and post abortion care.

Sources: Moroccan Family Planning Association (MFPA); 2016 and Zaidi et al., 2014.

Lessons learned from the regional initiatives on the provision of safe abortion services, where it is allowed cont.

IV. **Create networks of supportive stakeholders for an enabling environment at the policy level:** Identify potential areas of collaboration between civil society (including religious leaders), obstetrics/gynecology professionals, midwifery and nursing associations, and policy makers to look beyond pregnancy termination and focus more on maternal death and the negative health impacts associated with unsafe abortion and its burden on health systems.

V. **Use pragmatic and health-oriented approaches:**
   - Include post-abortion care, including post-abortion contraception, in the package of comprehensive reproductive health services.
   - Prevent and manage the complications of abortion in the context of health rights, to improve the status of women and girls.

VI. **In humanitarian settings:** Ensure that contraception, safe abortion and post-abortion care are defined by governments as 'essential services' and are made available in the basic package of services.

Sources: Moroccan Family Planning Association (MFPA); 2016 and Zaidi et al., 2014.

References

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